PRIVATE HEALTH INSURANCE
COMPLAINTS COMMISSIONER

Quarterly Bulletin Issue 6
1 October - 31 December 1997

Welcome to our second Quarterly Bulletin for 1997/98, providing a statistical summary of the Complaints Commissioner's operations between 1 October 1997 and 31 December 1997. Comparisons with previous quarters are also provided.

Highlights this quarter

- 488 *complaints* were received (a decrease of 6% on the 520 complaints received in the previous quarter);
- the issue which attracted the most complaints was cost (24%) which was also the most complained about issue last quarter (29%);
- 58% percent of complaints were resolved within a week, which is similar to the previous quarter;
- 335 *inquiries* were made during the December quarter (down slightly from 355 in the September quarter);
- Overwhelmingly, it is health fund members that lodge complaints.

Distribution and suggestions

- Quarterly Bulletins are provided to the Minister for Health and Family Services, members of the Senate Community Affairs Legislation Committee, health funds, the Australian Health Insurance Assocation (AHIA), Health Insurance Restricted Membership Association of Australia (HIRMAA) and officers of the Department of Health and Family Services.
- Please direct any questions or concerns you may have about this Bulletin to Samantha Gavel, Policy and Project Officer on (02) 9261 5855. Samantha is happy to take on board any suggestions for future issues of the Bulletin.
- To be included on our mailing list, please telephone Kathryn Gilhooley on the same number, or e-mail us at info@phicc.org.au.

Mary Perrett
COMPLAINTS COMMISSIONER
March 1998

Background

Who are we
The Complaints Commissioner provides consumers and other key stakeholders with an independent means of resolving their health insurance problems. The Commissioner aims to provide a world class complaints and advice service that:

- is accessible to the privately insured;
- is effective at resolving disputes
- is driven by the needs of its customers;
- is independent of health funds, private and public hospitals and government;
- works cooperatively with interested parites to resolve problems
- provides high quality information and advice to people with, or who are seeking to take out, private health insurance;

Comtacing the Commissioner
A national freecall Complaints Hotline (1800 640 695) is staffed between 8.30 am and 5.00 pm (Sydney time), Monday through Friday. The Commissioner does not require complaints to be in writing before they are investigated. Complaints may also be lodged from out internet site.

Some callers do not want to make a complaint but want further information about private health insurance generally or about their own health insurance fund. These calls are regarded as “inquiries”. Callers with complaints about private health insurance regulatory or policy issues are also recorded as inquiries.

Complaints can be made by health fund members, hospitals, doctors, some dentists, health funds and people acting on behalf of any of the above.

The Complaints Commissioner does not have the power to enforce any recommendations and relies on the health funds, hospitals, day surgery centres, doctors and dentists to implement the remedies that are proposed.

Further information
Further printed information about the Complaints Commissioner is available by telephoning Kathryn Gilhooley on (02) 9261 5855. Available brochures include:

- The 10 Golden Rules of private health insurance
- Can we help with your health insurance complaint? (available in a variety of community languages)
- Our Mission
- Service Charter
- Insure? Not Sure? Your quick guide to private health insurance
- Private Patients’ Hospital Charter
- When the Doctor’s bill makes you ill.

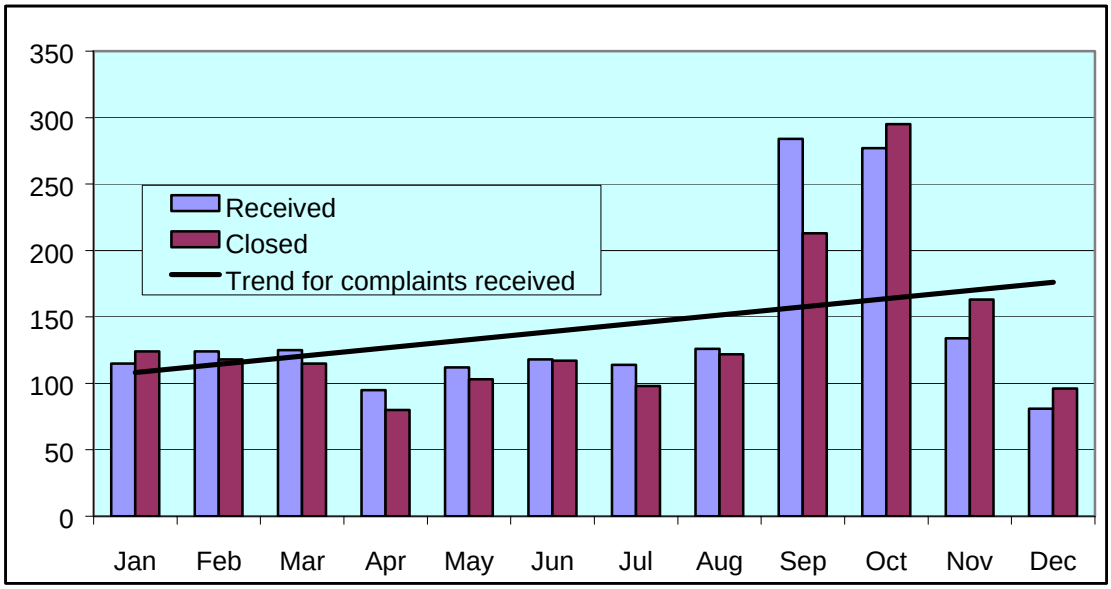
Wold Wide Web

We are also on the internet at http://www.phicc.org.au. Copies of our brochures and the 1996/97 Annual Report are available on the site.

Complaints

There was a small decrease in the number of complaints received in the December quarter (488 complaints compared with 520 in the September quarter, but still well up on the 325 complaints received in the June quarter). As in the September quarter, a significant number of complaints was received from members of one helath fund following a significant premium price rise and product restructure.

Figure 1: Complaints received and closed by month



Who Complains?

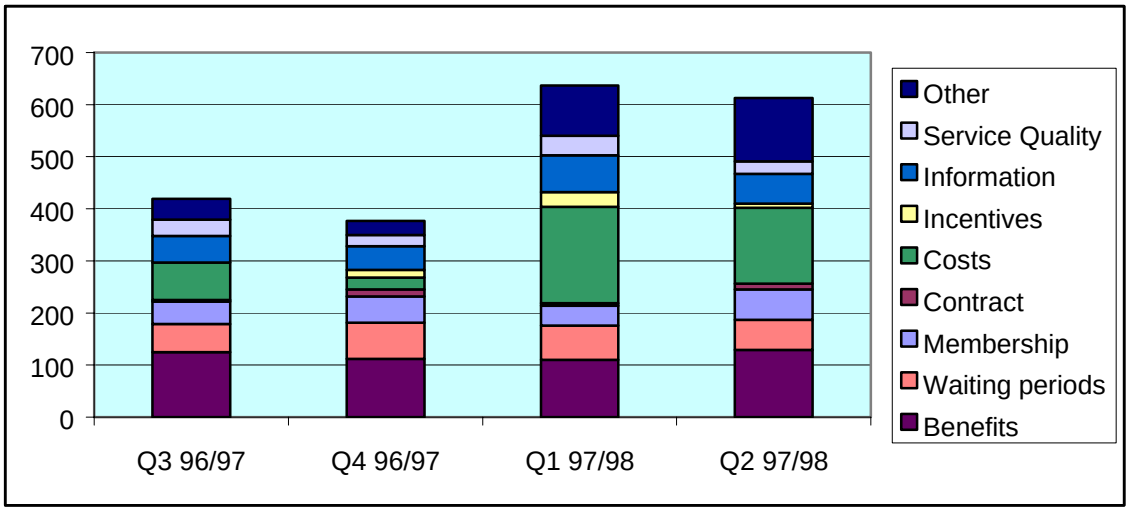
During the December quarter, the overwhelming majority of complaints were made by members of health funds. In addition, there was one complaint made by a hospital and one complaint made by a fund. No complaints were made by doctors in the December quarter.

What issues are complained about?

The 488 complaints received were about 600 different issues. The most complained about issue was cost (144 issues or 24%), which is similar to the previous quarter, when 185 or 29% of complaint issues were specifically about cost.

Complaints about benefits were the second most complained about issue during the December quarter (130 issues, or 22%). This was followed by membership issues and waitihing periods(with 59 and 58 issues respectively, each about 10% of the total number of issues complained about). Many of the 'Other specifica complaints (134) werhe about health fund rule changes. Rule changes acconunted for 80 or 13% of all issues complainted about. A summary of this information is provided in the graph on page 4 and a complete list of issues appears in the table on page 9.

Figure 2: Complaint issues



How do people complain?
The majority of complaints in the December quarter were made by telephone (91%, compared with 92% in the September quarter).

Other complaint vehicles included letter (8%, compared with 6% in the previous quarter), fax (1% in each of the previous two quarters). There was one personal visit during the December quarter down from three previously.

The Complaints Commissioner encourages people to telephone with details of their complaint. It is not necessary to lodge a complaint in writing. Complaints may also be lodged from our World Wide Web site or by e-mail.

Who is complained about?
Complaints received by the Complaints Commissioner can involve one or more of the following: a health fund, hospital, doctor or dentist. During the December quarter, as in previous quarters, the majority of complaints involved health funds, with almost half the complaints referred to the relevant fund for investigation.

What action is taken about complaints?
Where a complainant has not attempted to resolve their problem with the health fund, hospital, doctor or dentist, the complainant is usually referred back to the service provider on the spot over the telephone, so that the service provider has an opportunity to resolve the problem before the intervention of the Complaints Commissioner. These are recorded as 'complainant directed back to fund'.

Some complaints can be resolved by staff of the Commissioner without the need to directly contact the health fund, hospital, doctor or dentist concerned. These are shown in Figure 3 as complainant dealt with in-house.

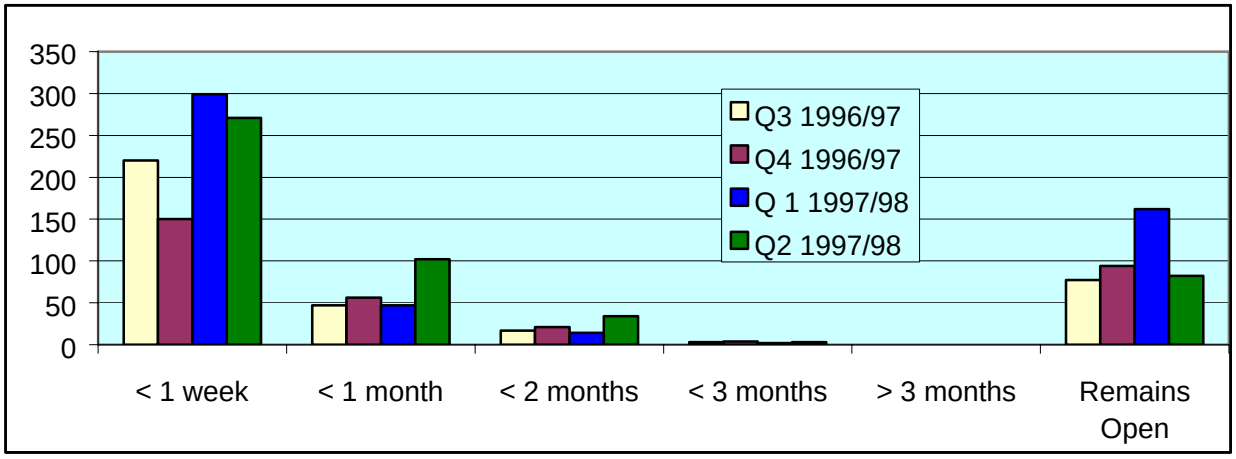
Other complaints are referred to the health fund, hospital, doctor or dentist for investigation and/or comment. This may be done in writing or by telephone.

Figure 3: Object of complaint & type of action taken - Oct to Dec 1997

		1997/98		1997/98	
	1996/97	Sept Q	Oct	Nov	Dec
Action taken by Complaints Commissioner	%	%	No.	No.	No.
Complainant directed back to fund	19	16	41	31	13
Complainant dealt with in house	28	38	100	34	9
Complaint referred to fund	53	46	135	62	46
Total complaints about funds	*100*	*100*	*276*	*127*	*68*
Complainant directed back to hospital	13	23	0	0	1
Complainant dealt with in house	27	41	1	0	1
Complaint referred to hospital for comment	60	36	3	2	1
Total complaints about hospitals	*100*	*100*	*4*	*2*	*3*
Complainant directed back to doctor/dentist	27	38	0	3	2
Complainant dealt with in house	46	46	1	1	1
Complaint referred to doctor/dentist for comment	27	15	1	1	4
Total complaints about doctors/dentists	*100*	*100*	*2*	*5*	*7*

Time taken to resolve complaints
Around 55% of complaints received in the December quarter were resolved within a week, which is similar to the 57% last quarter.

Figure 4: Time taken to resolve complaints

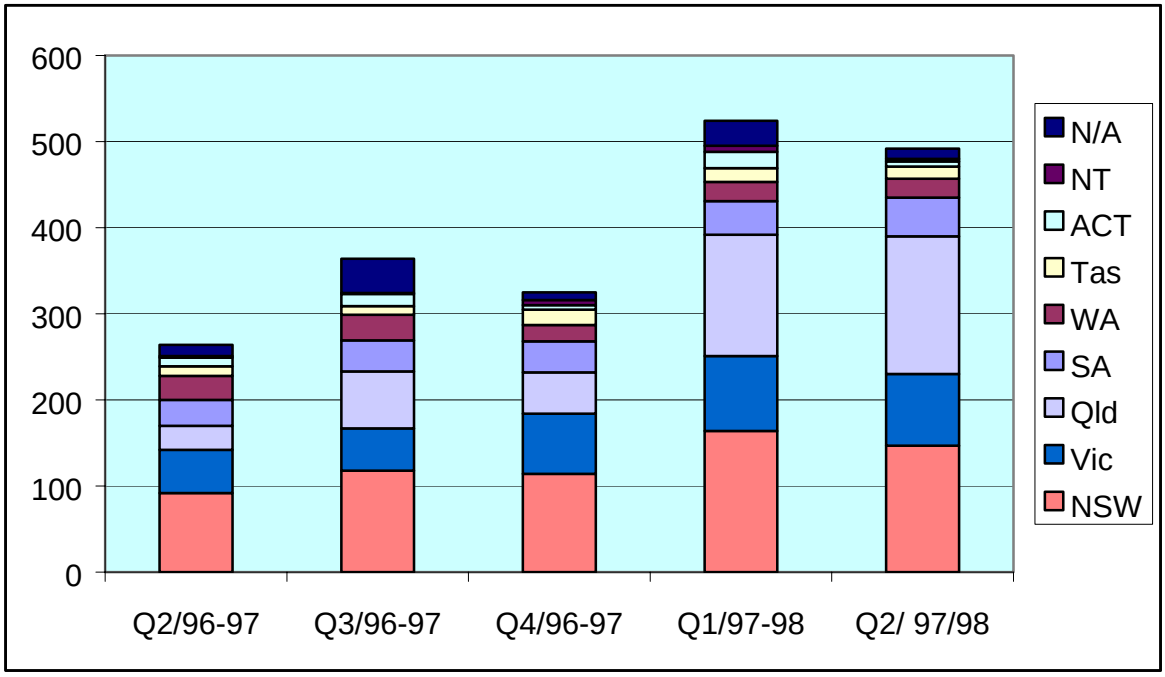


Where do complainants live?

During the December quarter, Queensland residnets lodged 162 complaints, up from 142 in the previous quarter. This si the first time that Queensland residents have lodged more complaints than NSW residents have. The rise was probably due to widespread pubnlicity in some regional centres in Queensland about premium increases and hospital contact negotiation with one large health fund. Complaints from South Australia also recorded an increased from the previous quarter.

All other states and territories recorded complaint decreases. In NSW, the number of complaints fell from 173 to 149, and in Victoria the number of complaints fell marginally from 92 to 88. In Tasmania, complaints fell from 16 to 14, in WA from 26 to 22, in the ACT from 21 to 6 and in the NT from 7 to 3.

Figure 5: Complaints by State



What were the outcomes?

Of the complaints closed during the quarter, 34% were referred directly back to the object of complaint, because there had been no attempt to resolve the problem with the fund, hospital, doctor or dentist. This compares with 21% last quarter. The rest of the complaints that were closed were dealt with in the following way:

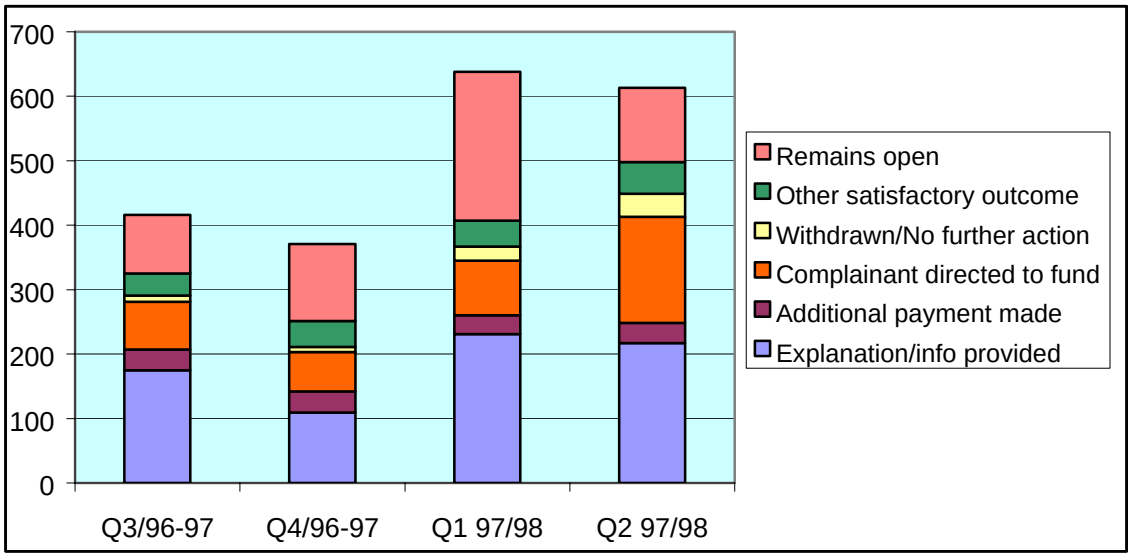
- providing complainants with additional information or an explanation of their problem, including confirmation of advice originally provided by a health fund (47% of complaint issues were dealt with this way in the December quarter, compared with 57% in the previous quarter);

- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (7% of complaint issues);

- the fund reversing its previous decision eg. to deny continuity of membership, or where a hospital or medical account is written off (11% of complaint issues).

In a small number of cases (1%) the complaint was withdrawn by the complainant or closed by the Complaints Commissioner where the complainant failed to provide additional information requested by the Commissioner.

Figure 6: Outcomes for complaints received



Inquiries

The Complaints Commissioner received 335 inquiries in the December quarter, a slight decrease on the 355 inquiries received in the September quarter and 349 inquiries received in the June quarter. Most inquiries were about genral health service and health insurance issues.

The majority of inquiries came from Queensland, followed by NSW and Victoria. Callers in 25% of cases did not identify the State/Territory of their residence.

Most inquiries were resolved by providing additional information or an explanation, including providing a brochure (72% of inquiries). 9% of callers werher referred to another agency and 11% were referred to a health fund. The remaining inquiries required no action on the part of the Complaints Commissioner or were withdrawn before the inquiry could be dealt with.

Case Studies

Benefits
A long standing health fund member contacted the Commissioner to complain about changes to his cover which had been introduced by the fund 18 months earlier. Under the changes, he was no long eligible for all of the benefits to which he had previously been entitled. The fund had advised its members who were affected by these changes in writing some months earlier, but the member had not realised the changes applied to him, because his cover was an old one which was not usually mentioned in current brochures.

Staff of the Commissioner contacted the fund to request that the member be allowed to upgrade to a higher level of benefits and backpay the difference. The fund agreed to do this, because the member was a longstanding member.

Fund Recognition of Providers

One area which is a regular cause of complaint by health fund members is provider recognition, where funds will only pay benefits for providers recognised by them. Often consumers are not aware in advance of whether their provider is recognised by their fund, or are caught out when the fund withdraws its recognition of a particular provider.

A health fund member complained to the Commissioner that her fund had rejected her claim for glasses on the grounds that the fund had withdrawn its recognition of the service provider. The Commissioner contacted the fund on the complainant's behalf and the fund suggested that she re-submit the claim. The member did so and the fund paid the claim.

Orthodontics

Claims for orthodontics are a regular cause of complaint, because funds have many different ways of calculating benefits and there is a myriad of exclusions. In particular, difficulties arise when members change funds halfway through a course of orthodontic treatment, as the following case study illustrates.

A fund member's daughter commenced orthodontic treatment, for which the member's fund paid 50% of benefits midway through treatment and the remaining 50% at the completion of treatment. The member had received the first 50% of the cost when he decided to transfer funds. His original fund told him he could not claim for the rest of the benefit until the treatment was completed.

Following completion of the treatment, the member went back to his original fund to claim the final payment. The fund refused to pay, because he was no longer a member. The member then approached his new fund. Even though he had transferred with "full cover and no qualifying periods", the new fund also refused to pay because it paid orthodontic benefits up front and there was no provision to pay after treatment was finished.

When the member approached the Commissioner, she was concerned that a long standing fund member who had had continuous coverage would be out of pocket. Staff of the Commissioner spoke with staff of both funds and advised that the funds should sort the matter out between themselves, as the member clearly had continuity of cover and should not be left out of pocket.

Initially, both funds refused to change their respective positions. However, following letters from the Commissioner to both funds, a compromise was reached and both funds contributed to fund the outstanding claim.

Complaints received by issue								
	Total 1996/97				December Qtr 1997/98			
Issue	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
Benefits								
Extent of cover			209	44.9%			65	46.1%
Amount			81	17.4%			13	9.2%
Delay			13	2.8%			5	3.5%
Excess			27	5.8%			7	5.0%
Limit reached			28	6.0%			6	4.3%
Gap payment			53	11.4%			17	12.1%
Out of State			4	0.9%			0	0.0%
Other			50	10.8%			28	19.9%
Subtotal Benefits	***465***	***32.3%***		*100.0%*	***141***	***23.0%***		*100.0%*
Information								
Oral			96	53.9%			33	57.9%
Printed			35	19.7%			10	17.5%
Radio/TV			12	6.7%			2	3.5%
Written			13	7.3%			2	3.5%
Lack of notification			22	12.4%			10	17.5%
Subtotal Information	***178***	***12.4%***		*100.0%*	***57***	***9.3%***		*100.0%*
Waiting Periods								
General			22	9.3%			9	15.5%
Obstetrics			38	16.1%			8	13.8%
Pre existing ailment			176	74.6%			41	70.7%
Subtotal Waiting Periods	***236***	***16.4%***		*100.0%*	***58***	***9.5%***		*100.0%*
Membership issues								
Who is the contributor?			29	17.9%			4	6.9%
Arrears			12	7.4%			8	13.8%
Cancellation/suspension			88	54.3%			23	39.7%
Transfer/continuity			33	20.4%			23	39.7%
Subtotal Membership	***162***	***11.3%***		*100.0%*	***58***	***9.5%***		*100.0%*
Costs								
Premiums			123	80.9%			134	91.8%
Fees and services			27	17.8%			11	7.5%
Dual charging			2	1.3%			1	0.7%
Subtotal Costs	***152***	***10.6%***		*100.0%*	***146***	***23.8%***		*100.0%*
Other specific issues								
Acute Care Certificates			4	1.6%			3	2.0%
Contracts			29	11.7%			11	7.2%
Confidentiality			4	1.6%			1	0.7%
Discrimination			9	3.6%			2	1.3%
Incentives			15	6.1%			8	5.2%
Language & culture			3	1.2%			0	0.0%
Quality of service			86	34.8%			24	15.7%
Private patient election			8	3.2%			1	0.7%
Premium payments			39	15.8%			12	7.8%
Other complaint NEC			26	10.5%			11	7.2%
Fund rule change NEC			24	9.7%			80	52.3%

Subtotal Other	***247***	***17.2%***	*100.0%*	***153***	***25.0%***	*100.0%*
TOTAL	1440	100%		613	100%	