GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

Policy Directive pursuant to the Health Insurance Law (No 11 of 2013) of the Emirate of Dubai

Policy Directive Number 1 of 2014 (PD 01/2014)

Subject of this Policy Directive	Complaints handling
Applicability of this Policy Directive	This Directive applies to all parties involved in the sale, distribution, marketing and administration of health insurance plans in the Emirate of Dubai, specifically, insurance companies, health insurance claims management companies and health insurance intermediaries
Purpose of this Policy Directive	To specify the minimum requirements and standards that are to be adopted by the parties in dealing with complaints
Authorised by	Dr Haidar Al Yousuf, Director Health Funding
Drafted by	Robin Ali, Consultant, Health Funding department
Publication date	21 September 2014
This document replaces	Not applicable
This document has been replaced by	Not applicable
Effective date of this Policy Directive	Immediately upon publication
Grace period for compliance	One month from the effective date

Objectives of this Policy Directive

- Improve customer confidence in the health insurance market
- Improve customer confidence, satisfaction and loyalty in respect of market participants
- Promote the dealing by companies with customer dissatisfaction in a swift, effective and fair manner
- Provide a clear escalation process regarding complaints received both internally and externally
- Use complaints to enhance procedures and correct procedural or policy deficiencies
- To allow customers to report instances where parties are not complying with the Health Insurance Law

Complaints procedure

All companies must have a formally documented complaints procedure.

Definition of a complaint

Any expression of dissatisfaction by a customer, potential customer or other business partner or any regulatory body made to the company either directly or indirectly which is related to a product or service provided by the company or which is related to an employee of the company or which is related to a service provided by an intermediary acting on behalf of the company or provided by another business partner of the company such as but not limited to a health claims management company, hospital, clinic or physician.

What is not a complaint?

Any expression of dissatisfaction concerning denial of coverage for a consultation, treatment or procedure which is **clearly** not covered under the policy or where the cost of the treatment exceeds the monetary limits under the terms of the policy are not complaints. However, where the cause of the complaint relates wholly or in part to vague wording or unclear definitions in the policy wording, terms and conditions or table of benefits this **will** be considered a complaint.

Identifying a complaint

An explicit comment or statement such as “I want to make a complaint” or “Who do I complain to about this?” indicates the existence of a complaint

An expression of dissatisfaction such as “I am not happy with…” or “I am not satisfied with what you are saying…” or “This policy that I was sold does not meet my needs” indicates the existence of a complaint

A statement that expectations were not met such as “I was told that…..but this has not happened” or “You promised to… but…” or “I asked for…but did not receive…” indicates the existence of a complaint.

Complaints from multiple members of the same group scheme relating to the same subject

The company is allowed to log such complaints as a single complaint.

Complaints logging

All complaints must be logged, preferably in an automated system. As a minimum, the complaints log must detail the following:

- Name of complainant
- Name of patient (where applicable)
- Date of complaint
- Name of staff member receiving and registering the complaint
- Name of staff member to whom the complaint has been directed
- Identification of a repeat complaint (that is a repeat of an earlier complaint made by the same complainant)
- Policy detail (if an existing insured member) including Policy Number, Member Number, Company name (if a corporate scheme)
- Intermediary name (if applicable)
- Category of complaint (see below)
- Detail of the complaint
- Source of complaint (telephone, email, personal visit, online facility, via a third party, etc)

Complaint ownership

The complaints procedure must specify who will own the complaint. This must be a named person or a specific jobholder title. The complaint holder cannot be a department. He or she must be a clearly identifiable staff member.

The complaints procedure must specify the reporting lines for complaints handling. Complaints cannot be handled by the person about whom the complaint is made nor by a department which is the subject of the complaint.

Facilitating complaints channels

The company must provide complaints reception channels of varying types including by telephone (freefone), SMS, email, personal visit, and company website.

All channels must be offered (where technologically feasible) in languages appropriate to those spoken by at least 70% of the insured members .

Complaints procedures must be openly and actively publicized (in policy documentation, on websites, in sales literature and in offices).

Reporting

A monthly report of all complaints received and the status of ongoing complaints must be submitted to the Chief Operations Officer, Chief Risk Officer or similar.

An annual report covering the calendar year must be submitted to Dubai Health Authority, Health Funding Department no later than 7 January each year. (See key Performance Indicators below for report content).

Categories of complaint

All complaints must be categorized in the complaints log as relating to one of the following:

- Denial of coverage
- Rejection of claim
- Accuracy of documentation provided
- Delays in process (refunds, reimbursements, approvals, issue of membership cards, additions or deletions of members)
- Administrative or operational process or procedures
- Product dissatisfaction or suitability
- Changes to policy terms (exclusions, conditions, renewal, premiums, network coverage)
- Service provided by staff or departments (efficiency, attitudinal, behavioural, knowledge)

Key performance indicators

The company must produce reports as detailed below:

- Complaints actual TATs
- Number of complaints outstanding at end of each calendar month
- Number of complaints unresolved after 15, 30, and 90 days
- Number of complaints escalated for outside deliberation or arbitration.
- Complainant satisfaction with outcome of internal dealing with the complaint (as a minimum a scoring system with 1= fully satisfied, 2= largely satisfied, 3= largely unsatisfied, 4= completely dissatisfied)
- Number of complaints by category
- Number of complaints fully upheld
- Number of complaints partially upheld
- Number of complaints denied (prior to any external escalation)

Staff training

The company must demonstrate that it has a program to train staff in complaints handling procedures, how to identify a complaint and how complaints should be dealt with and recorded.

The company must keep a record as part of its Training Log to record which staff have received such training and when.

Complaints escalation process

The Complaints Procedure must contain a clear written policy and process for the escalation of complaints both internally and externally. It should also contain a clear written policy and process for ensuring that the complainant is kept fully informed of the progress of their complaint.

Complaints process flowchart

The company must develop and maintain a clearly understandable flowchart identifying the complaints procedure from end to end. The flowchart must be made available to both customers and prospective customers. As a minimum it should be published on the company website and be included with policy documentation for new customers.

Complaints review procedures

The company must have a documented process describing how it will review the outcome of all complaints and make necessary adjustments to its policies, services, products, processes or procedures to avoid repetitions of upheld complaints.