



**CHF**

Australia's  
Health Panel

## RESULTS

# Results of Australia's Health Panel survey on the private healthcare system

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Consumers Health Forum of Australia (2021)  
*Results of Australia's Health Panel survey on the  
private healthcare system, Canberra, Australia*

P: 02 6273 5444

E: [info@chf.org.au](mailto:info@chf.org.au)

[twitter.com/CHFofAustralia](https://twitter.com/CHFofAustralia)

[facebook.com/CHFofAustralia](https://facebook.com/CHFofAustralia)

**Office Address**

7B/17 Napier Close  
Deakin ACT 2600

**Postal Address**

PO Box 73  
Deakin West ACT 2600

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# Introduction

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*"At the moment we have a system that hasn't been designed but instead has developed over time and therefore doesn't meet Australia's health care needs. Out of pocket costs and the way that some charges are covered by Medicare/insurance but others are not is a significant part of the problem, but not the only one. We need a system that is designed to meet Australia's needs. Once we've decided on this, we need to decide what the roles of the public and private systems are and then decide how to pay for them, including how insurance will work. If insurance is to exist, then things like significant out of pocket costs, and non-covered items, must be removed so that insurance is truly insurance and not some weird hybrid that doesn't meet people's needs."*

– AHP Panellist

On 9 September 2021 the President of the Australian Medical Association, Dr Omar Khorshid, [announced that he will call for a national summit](#) aimed at reforming the private healthcare sector.

It is widely asserted that there are fundamental problems with the private health system in Australia. Having paid thousands of dollars in premiums, insured consumers often face significant gap fees for private services. [Medical devices cost 30-40% more than they do in other countries](#) and the industry has been analysed by respected commentators as [being in a "death spiral" as young people increasingly opt-out](#). Additionally the COVID-19 pandemic has [led to major spikes in profits](#) for private health insurers as Australian's continue to pay their monthly premiums but [are unable to claim on benefits](#).

[CHF has previously called for](#) a Productivity Commission inquiry to examine government funding of the health system and the role subsidised private health insurance plays.

We [previously ran a survey of consumers](#) on their costs and experiences with private health insurance in 2015 and believe that the time is ripe for us to see how things have changed in the consumer view. So the October/November 2021 Australia's Health Panel survey asked what Australia's Health Panel thought about the private health system in Australia.

## Demographics

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For this survey 192 panellists participated. They were mostly female (79%), aged 56 or older (67%) and lived in major cities of more than 250,000 people (71%). Panellists came from across every state and territory. Panellists generally reported as being reasonably healthy, with only 10% reporting they were in poor health while on 66% reported they were in good or excellent health. Additionally, 2% identified as Aboriginal or Torres Strait Islander, 8% as LGBTIQ+, 8% as culturally or linguistically diverse and 17% as a person with a disability.

Panellists overwhelmingly had Private Health Insurance (PHI) – with 81% currently having it, 14% previously having it and only 6% never having had it. No panellists were unsure as to whether they did or didn't have PHI.

## Private Health Insurance Holders

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Panellists who currently hold PHI overwhelmingly had "Hospital and Extras" (80%), with an additional 14% having just Hospital and the remaining 6% having only Extras. 0% reported they were unsure what type of PHI they held. Within those who had Hospital PHI, Gold coverage was the most common (48%) and Silver the next most common (30%). Bronze was the least common (6%), with more panellists having Basic (8%) or being unsure what level they had (8%).

Panellists with PHI were long term users of the system, with 77% having had PHI for over 20 years and 14% having had it for 11-20 years. Correspondingly most panellists (64%) had not paid a Lifetime Health Cover penalty on their hospital premiums, although a sizeable minority (24%) were unsure if they'd paid a penalty.

Given the age profile of the participating panellists, this skew towards the higher levels and longer periods of coverage is unsurprising as it reinforces [previous research and reporting has found that increasing numbers of people have PHI as they age](#).

*"Greatest reasons for keeping private health insurance: I have the Dr [sic] of my choice, I have treatment when I want it, there are no waiting lists."*

– AHP Panellist

## PHI Reasoning

When asked *why* they had PHI, the only two reasons selected by a majority of panellists were a shorter wait time due to public waiting lists being too long (69%) and having a choice of doctor (57%). This suggests that there are a myriad of reasons that collectively cause people to decide to take out PHI. Notably there was no overall sentiment that private treatment was better than public treatment, with only 27% of panellists selecting that option. For the full breakdown of reasons see Table 1.

*Table 1- Panellist responses to question "What are all the reasons that you are covered by Private Health Insurance?"*

Reason for having Private Health Insurance	% Selected
A shorter wait for treatment-public hospital waiting lists are too long	69%
To have a choice of doctor	57%
General security/peace of mind- want to avoid getting charged fees and costs in the absence of insurance e.g. Ambulance fees	43%
Makes treatment affordable that I otherwise would not get e.g. Extras benefits for Dental.	42%
I or my family are elderly/getting older and are likely to need treatment that can be expensive if not covered by private health insurance	37%
To not rely on public healthcare system and not take public health resources from those who can't afford private health	34%
To avoid financial penalties e.g. the Medicare Levy, Lifetime Cover Surcharge etc	31%
I or my family members have an illness/condition that requires treatment that can be expensive if not covered by private health insurance	30%
Allows treatment as private patient- private health treatment is better quality than public health	27%
For the tax benefits e.g. the PHI rebate	10%
No particular reason- I have just always had private health insurance.	4%
I and my partner are thinking of having a baby	3%
I am covered under my parents/family policy that someone else organises and pays for	1%
I get private health cover through my job	1%
I require private health cover for my job	0%
Other (please specify)	6%

In the free text 'Other (please specify)' section, panellists mostly expanded upon other listed options however one additional benefit highlighted was the ability to have privacy e.g. your own room, when being treated as a private patient.

## PHI Understanding and Affordability

Only 27% of panellists reported that they had a complete understanding of what was covered by their PHI and to what extent, while an additional 55% reported they 'had a general idea but didn't know the specifics'. Given both the demographic profile of the participating panellists and the length of time they'd had PHI, having only 27% with a complete understanding is a concerningly low proportion. This suggests that the wider Australian population could have limited understanding of their PHI coverage and be at risk of getting "caught out" on the details when going to use their PHI.

When asked if they believe that PHI was affordable, only 18% of panellists believed it was, with an additional 37% reporting that it was maybe affordable. Similarly, only a small minority (14%) believed that they were getting value for money from their PHI and a majority (51%) believed it *definitely* was not value for money.

When PHI costs are considered as a proportion of household income, it was found that the proportions had remained relatively static since CHF’s previous research in 2015 (see Table 2). This indicates that the unaffordability of private health has been an issue for some time and is not a recent problem e.g. induced by the COVID-19 pandemic.

Table 2- Comparison of proportion of household finances spent on PHI in 2016 and 2021.

	2015- “Combined insurance premiums and out-of-pocket expense as percentage of household income” (n=407)	2021- “How much of your overall household expenses does your private health insurance cost?” (n=135)
<2%	16%	20%
2%-3.9%	25%	20%
4%-5.9%	19%	24%
6%-7.9%	13%	12%
8%-9.9%	8%	6%
>10%	19%	19%

The only movement in the last six years appears to be out of the 2-3.9% range, but in either direction with both the <2% and the 4%-5.9% groups increasing. It is not clear from this data what could be causing this dual movement, so further investigation in this area of proportional expense is warranted.

*“Recently we tried to access a private hospital for my son as they had a range of outpatient programs that would be beneficial for his condition. We could not afford the fees that they charged. One appointment cost more than a weekly disability payment making it impossible for any person who does not have alternative income or support. They are the only hospital that offer these programs but they are out of our price range. ”*

– AHP Panellist

[Note- Panellist has “Silver” level Hospital PHI].

## Provider Choice

Interestingly most panellists had changed their PHI provider either once (45%) or multiple times (23%) which shows a propensity to 'shop around' and not 'set and forget' with a specific provider. Recurring reasons for why panellists had changed their provider were:

- They found or were offered a better deal in terms of coverage or costs by a different provider.
- Their previous provider had raised costs or reduced coverage to an unacceptable degree.
- Their personal circumstances had a major change e.g. got married, had children, partner passed away, got a new job (with PHI benefits), they moved where they lived.
- They had a negative experience with a previous provider e.g. bad customer service, poor treatment when making a claim.

*"You get nothing for being loyal and staying with the same fund, provided you take the same level of cover there are no waiting periods."*

– AHP Panellist

Recurring reasons for why panellists had not changed their PHI provider included:

- Having had a condition develop since taking out their PHI which would cause them to be penalised if they switched.
- Being concerned that they might miss some 'fine print' in switching and get caught out with not being covered when they need it.
- Liking the non-profit nature of their current provider.
- Getting a discount on the costs through a corporate package making it the most affordable one.
- Not having the time, capacity or inclination to compare different provider options.
- Having done some comparisons and finding that they couldn't get a better deal elsewhere.
- Loyalty.

*"We have an old insurance cover that if we changed now, it would cost more and cover less, we are still covered for maternity care! We are quite elderly."*

– AHP Panellist

A large majority of panellists reported that they had ‘shopped around’ to see if their current PHI was the best option available for them, with the main variation being how often they had checked. A slim majority (51%) reported that they checked once every few years, with 22% reported they had checked once (when they initially signed up) and 13% checked at least once per year. The remaining 14% reported they had never shopped around.

*“You really need to shop around regularly. Our fees were going up every year and when we shopped around we were able to get the same cover for significantly lower cost.”*  
 – AHP Panellist

However only a minority (31%) reported they had used the official Government website privatehealth.gov.au to look at different options. Most panellists (53%) reported they had never even heard of the website and an additional 12% reported they’d heard of it but not used it. Given the large number of panellists who do look to ‘shop around’ with different PHI providers, these low levels of awareness and use of the government website are concerning, highlighting the need for these independent resources to be better promoted.

*Claim experience*

Panellists generally made active use of their PHI with 69% having made a claim within the last three months (see Figure 1). Favourably panellists also generally found the process of making a claim to be either very easy (65%) or easy (20%).

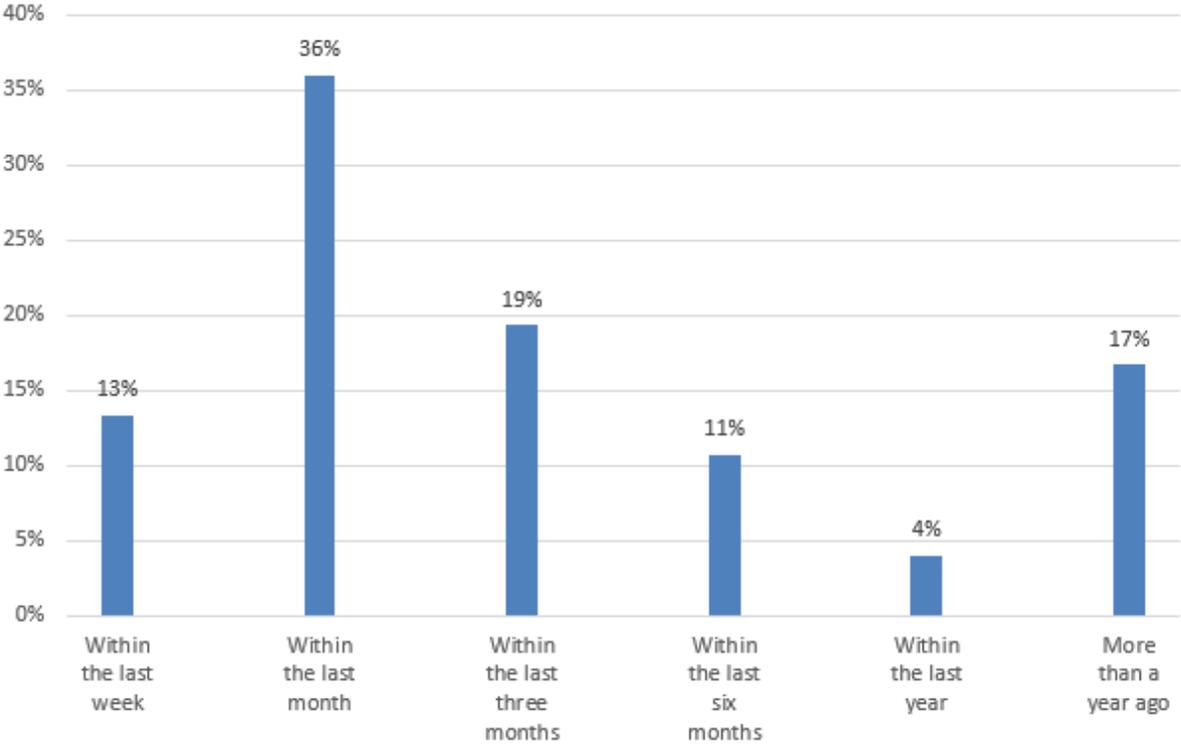


Figure 1- Panellist responses to question "When did you last make a claim on your private health insurance?"

However, in less positive results, the majority of panellists (83%) did not have the entirety of their healthcare costs covered by their PHI claim. Of concern was that only a minority (44%) expected there to be a gap payment, while nearly as many (40%) had their claim cover less of the treatment cost than they expected. Which reinforces the earlier finding that consumers are unfamiliar with the details of their PHI and at risk of getting “caught out”.

*Private hospital cover is very straightforward and, with one exception, I have never had any problems with it. Extras cover, however, is a minefield and does need review. My most recent claim, on dental treatment, has proven incredibly difficult as the problem is a mixture of errors by the dental practice and rigidity on the part of the health insurer.*

– AHP Panellist

### *COVID-19 Response*

Despite the statements put out by many PHI providers that they would ‘give back’ the profits generated during the COVID-19 pandemic, the majority of panellists (64%) reported that their PHI provider had not offered anything and they had not received anything.

For the minority of people who did report they had received a benefit from their provider, by far the more common was ‘discounted or free coverage for a period of time’ (17%), with direct refund of money a distant second (7%).

Given this, it is perhaps unsurprising that panellists were overwhelmingly unsatisfied with the response. Only 14% of panellists reporting they were satisfied with what their provider had returned to them to them. This dropped to only 8% if those who hadn’t been promised anything, and thus had no prior expectations/knowledge before completing the survey, were included.

This is an unambiguously strong indication that the broader Australian public is not satisfied with how the actions of PHI providers have measured up with the promises that were made.

*Medibank provided an acceptable & appropriate refund in 2020 though not advertised well. In 2021, particularly for Victorians it was disgraceful: 5 days...worth nothing. Yet services were restricted just like 2020 for a comparable period of time.*

– AHP Panellist

## Private Health Insurance Lapsers

When explaining why they had stopped having PHI, this subsection of panellists most commonly cited the costs as the underlying reason. The top three reasons were all around different areas of cost: it simply being unaffordable/too expensive (78%), it not being value for money (67%) or dissatisfaction about having to pay out-of-pocket costs on top of their monthly premiums (44%). This reinforces the previous finding that cost and unaffordability are major issues within the private health system. See Table 3 for the full breakdown of reasons.

Table 3- Panellist responses to question "Why did you stop having private health insurance?"

Reason for stopping Private Health Insurance	% Selected
I couldn't afford it as it's become too expensive	78%
There is a lack of value for money and it's not worth the cost	67%
I became disillusioned about having to pay out of pocket costs or gap fees for individual services as well as monthly premiums	44%
For me Medicare cover is sufficient	30%
I went on to a Pensioner/Veteran's affairs/health concession card	30%
It's just not high priority for me	11%
I became a high risk category and couldn't get coverage	7%
I don't need medical care --- I am in good health and have no dependants	7%
I am prepared to pay costs of treatment from own resources	7%
I refuse to pay for both Medicare and private health insurance premiums	4%
I was added on to someone else's insurance e.g. my family insurance, work insurance	0%
Other (please specify)	11%

In the Other (please specify), an additional reason emerged of panellists giving up PHI as the facilities they attended were not able to give them the 'benefits' they were paying for e.g. they weren't able to get a private room in a hospital as the hospital ward was overcrowded.

*"I felt tricked and cheated to "run for cover", first time I claimed turns out I was not covered so I stopped paying. Now the 30% penalty is a huge disincentive"*

– AHP Panellist

These panellists generally reported that they had looked around to see if there was a better option for them (54%), although again only a minority (26%) had used the Government website [privatehealth.gov.au](http://privatehealth.gov.au). Reinforcing the previous finding that there is a significant lack of awareness and underutilisation of this Government service.

When asked what would need to change in order for them to re-acquire PHI, the common responses amongst the panellists were:

- A reduction in the premiums so that it was a more affordable item relative to people's income and other expenses
- An increase in what was covered by private health insurance to make it better value for money
- Removal of gap payments
- Removing or reducing the financial penalty, i.e. Lifetime Health Cover loading, for signing up 'late'
- Nothing. In other words, no conceivable changes to the system would have them re-acquire PHI.

*"Lower costs. No co-payments. Coverage of everything. Medicare Private told me that they would no longer cover me for hip and knee replacements on my plan, so I moved to Extras only. Then after a while decided that it might cost less just to pay [for healthcare] myself."*

– AHP Panellist

## No Private Health Insurance

When explaining why they had never obtained PHI, this subsection of panellists most commonly indicated that “there is a lack of value for money and it’s not worth the cost” (see Table 4). Further reinforcing the previous findings around the systemic issue of cost and affordability, although limited conclusions can be drawn for this group given the small sample size (n=11).

Table 4- Panellist responses to question "Why do you not have private health insurance? "

Reason for not having Private Health Insurance	% Selected
There is a lack of value for money and it’s not worth the cost	64%
I can’t afford it as it’s too expensive	36%
I am disillusioned about having to pay out of pocket costs or gap fees for individual services as well as monthly premiums	36%
I have a Pensioner/Veteran’s affairs/ health concession card	27%
For me Medicare cover is sufficient	27%
I am prepared to pay costs of treatment from own resources	18%
I’m in a high risk category and can’t get coverage	9%
I don’t need medical care --- I am in good health and have no dependants	9%
I refuse to pay for both Medicare and private health insurance premiums	9%
It’s just not high priority for me	9%
I am included in someone else's cover e.g. family cover, work cover	9%
Other (please specify)	27%

Only a minority of these panellists (33%) had ‘shopped around’ to see if there was a PHI option that would work for them and a minority (25%) had used the official government website [privatehealth.gov.au](http://privatehealth.gov.au), with 50% having never heard of the website. Again, it is not possible to draw strong conclusions from these statistics given the small sample size, this does support the findings for the other subgroups that the Government website is being systematically underutilised and not known about.

When asked what could change in order to make them take out PHI, echoing the PHI Lapsers this subgroup of panellists reported two factors:

- Abolishing the Lifetime Health Cover loading, as the additional cost was a major disincentive for them to join now
- Improving the balance between the benefits (i.e. services covered) and the costs (i.e. premiums and gap payments), as currently it was not value for money.

*The age based loading is the deciding factor for me. I was not in a financial position to purchase when I turned 30 and when my financial position improved the loading just makes me angry. I am healthy and would definitely purchase insurance if the loading wasn't in place.*

– AHP Panellist

# The Private Health System

In regard to the broader health system, panellists were split as to whether they supported the current 'two pillar' system of public health (via Medicare) and private health: 38% supported it, 35% did not support it and the rest were uncertain, see Figure 2.

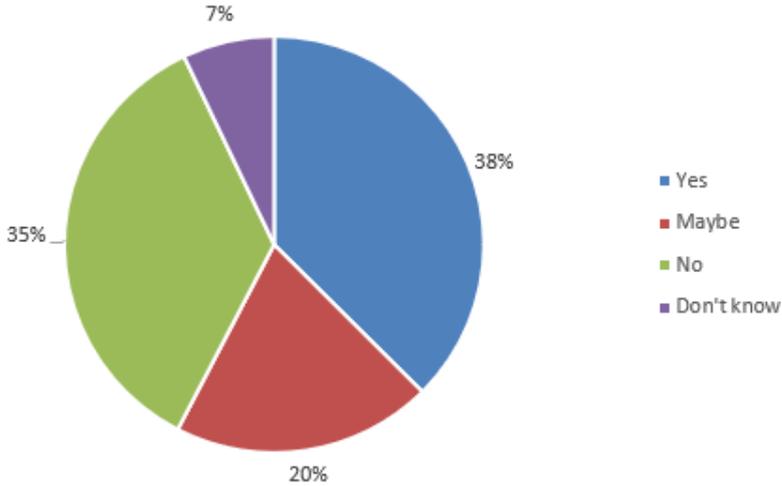


Figure 2- Panellist responses to question "Do you support Australia's current "two pillar" healthcare system of public care via Medicare and private care via private health?"

Panellists were also somewhat split as to whether they believed that the private system reduced the pressure on the public system: the plurality believed it did (44%) and a further 24% believed that maybe it did, with 27% believing it did not and the remaining 5% being unsure. Despite this, panellists did not think that the current public health system would be able to cope if the private system was abolished - only 5% believed it would while a slim majority (56%) believed that it would not. A further 28% believed that the public health system could cope but only if the public funding given to the private health system was redirected to the public system (see Figure 3).

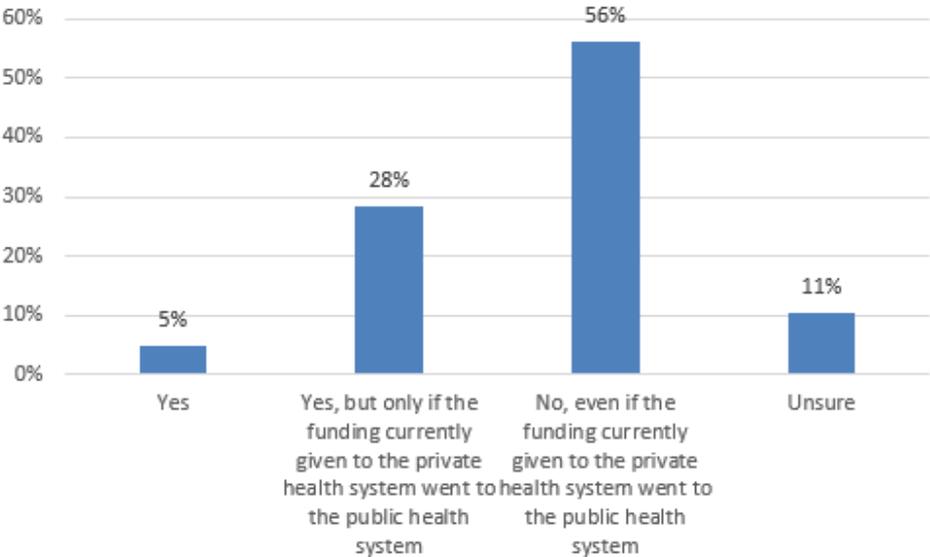


Figure 3- Panellist response to question "Do you believe that the public health system would be able to cope with the extra demand if the private health system was abolished?"

On the question of Government funds and subsidies going into the private health system, currently between \$6-12 billion, the plurality of panellists (48%) believed that that money would be better spent funding public health services and a further 27% thought it might be better off being spend on public health services. Only 18% did not believe it would be better spent that way and 7% were uncertain. This suggests that there would be support from the community in redirecting public funding currently spent subsidising the private health sector into funding for public health services.

When asked which types of private health providers should be eligible to receive government support, 40% thought it should be just non-profit providers, 24% thought it should be all (for-profit and not-for-profit) providers and only 1% thought it should be just for-profit providers. 19% thought that no private health providers should get government subsidy and the remaining 18% were unsure (see Figure 4). Collectively this suggests that most people would likely be favourable towards not-for-profit private health providers receiving government subsidies but they are not comfortable with for-profit providers receiving those same subsidies.

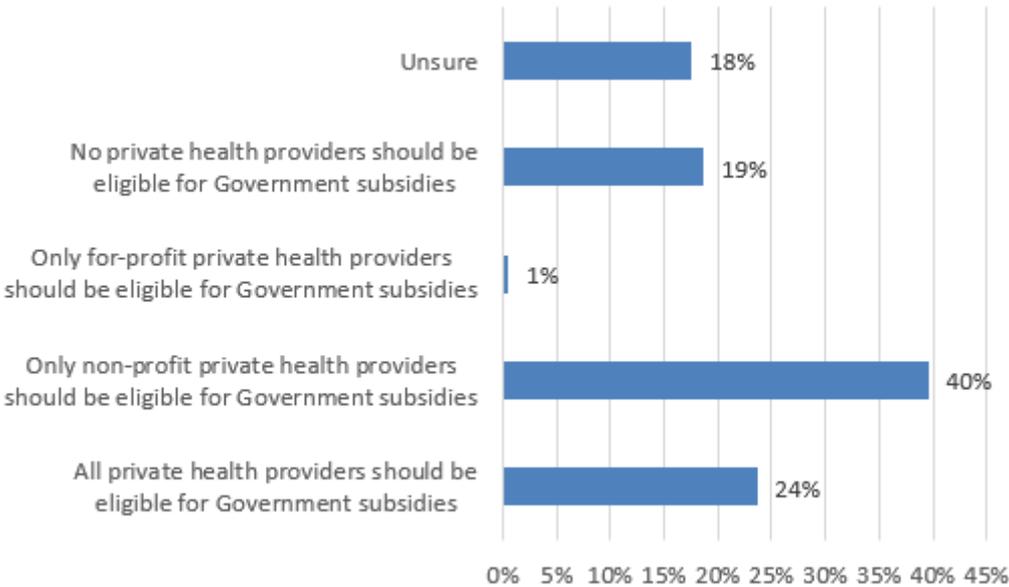


Figure 4- Panellist response to question "Currently the Government provides approximately \$6-12 billion in subsidies every year to the private health sector, which is made up of both non-profit and for-profit providers. Which of the following best aligns with your view?"

Panellists were strongly in favour of a formal and independent investigation (e.g. a Productivity Commission investigation) into the private healthcare system being conducted with 77% believing such an investigation was needed.

*A Productivity Commission Inquiry is needed – if only a step towards getting something done to reduce the costs of devices, medical equipment and drugs– where we pay far more than other countries and risk having 'old' products dumped on Australia.*  
 – AHP Panellist

In the free text responses, additional themes that emerged from panellist responses included:

- A pushback against the idea that the quality of healthcare in the private system was “better”, with many panelists reporting they had experienced the opposite, particularly for major health issues such as cancer.
- A concern that the current system creates a two-tier structure for the “haves and have-nots” based on wealth, undermining societal concepts such as fairness and equality.
- Dislike for the increasing number of “holes” in private health system- whether it be gap payments generally getting bigger/more frequent or the increasing number of services not being covered.
- Concerns about the lack of transparency or regulation into how prices are determined in the private health area.
- A view that those living outside major cities were particularly disadvantaged by private care due to a significant reduction in facilities and services available to them.
- Concerns about the way that costs spiraled out of control for those who needed healthcare the most but often have limited disposable income particular among elderly retirees, people living with disabilities and people living with chronic illnesses.
- A belief that some health services should be moved from the private to public system, in particular dental and ambulance.
- Support for the promotion of preventative care activities e.g. gym membership, fitness classes etc through the private health system.
- A view that while, in principle, they did not like the concept of a private health system, a systematic underfunding of the public health system had made the current private health system a necessity.

## Conclusion

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In summary, this Australia’s Health Panel survey found that Australians have a diverse but negative-leaning view of the private health system.

Australians have a good general idea of what is and is not covered by the private health system, although find that the specifics can be very difficult to compare and understand. They also believe that private health insurance is generally unaffordable and not “value for money”, with the poor cost-benefit ratio being by far the leading factor for people to stop having PHI or not get PHI in the first place. This indicates that some fundamental and systematic restructuring of the funding and costs of the private health system is required, in particular for those with reduced access e.g. rural Australians or increased need e.g. elderly Australians.

Unexpectedly the Lifetime Health Cover (LHC) loading was found to be a *disincentive* to joining rather than an *incentive*. Given the broader socioeconomic trends that are impacting on young people in particular, such as the housing crisis and wage stagnation, it would appear that the age limit of 31 is set too low and should be raised. People are unable to afford to get PHI when they turn 31 and the LHC then keeps them out of the system.

Those who do have PHI find the process of making a claim easy and do so relatively often, but many find themselves surprised by the size of the gap payment required. Many Australians “shop around” different private health providers to try get a better deal, but very few use or are even aware of the official Government comparison tool [privatehealth.gov.au](http://privatehealth.gov.au). This shows that more

needs to be done to ensure that Australians are accessing and using independent tools to help them choose what is best for them, rather than using other tools that have different priorities.

Australians are quite clearly unsatisfied with the actions of the private health sector, particularly PHI providers, regarding the COVID-19 pandemic. Many are unaware of the promises that have been made in regard to “giving back”, but when told about them they have overwhelmingly found what they have received to be generally inadequate.

Finally, the Australian community is generally split in regard to the concept of the ‘two pillar’ system. However, while they are split as to how the public-private systems should interact, there was a strong view that public funding and subsidies should not be provided to the private system in general and for-profit providers in particular. And while many had in-principle opposition to the idea of healthcare being provided on the basis of wealth rather than the basis of need, they felt the current state and funding for the public system made the private health system an unfortunate necessity.

*“There is also a really strong tension between the idea of treatment being prioritised on clinical need and treatment being more readily available (more immediately accessible) to those who pay substantial amounts of money for private health insurance. This is an ethical dilemma that is not well addressed by our system. Surely private health insurance should be paying for more than ‘hospitality’ (hotel) type services, but then how do you justify making people in significant pain wait for interminably long periods for so called ‘elective’ treatments so that (presumably) richer people can ‘jump the queue’?”*

– AHP Panellist

The Consumers Health Forum of Australia would like to thank all panellists for giving up their time to participate in this survey.

Any questions about this survey and its findings can be directed to [info@chf.org.au](mailto:info@chf.org.au).