Damned if you do, damned if you don't: Older people and private health insurance

June 2024

National Seniors AUSTRALIA

National Seniors ABN: 81 101 126 587

Ethics approval: The NSSS-12 received ethical approval from the Bellberry Human Research Ethics Committee (Approval 2023-11-1424).

Suggested citation:

National Seniors Australia (2024) *Damned if you do, damned if you don't: Older people and private health insurance.* Canberra: National Seniors Australia.

ACKNOWLEDGEMENTS

We are grateful to everyone who participated in the 2024 National Seniors Social Survey and whose responses provide the data for this report. We would also like to thank Charles Maskell-Knight for reviewing sections of this report.

National Seniors Australia is located in Brisbane and Canberra. We acknowledge the traditional custodians of the land and waters in which we operate, the Turrbul and the Ngunnawal and Ngambri Peoples. We honour and value their continuing cultures and contributions and pay our respects to their elders, past and present.

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EXECUTIVE SUMMARY

The Australian healthcare system relies on a mix of public and private funding, with Medicare, private health insurance, and individuals' out-of-pocket payments all playing a role.

Based on a 2024 survey of 4564 people aged 50+, this report shows that a large proportion of older Australians have private health insurance (PHI) and appreciate it. They value what it can offer both to their peace of mind and to control over their healthcare. Many wish to maintain it even at great cost to themselves.

However, older people also have numerous reasons for complaint about the PHI system.

Foremost among these is its cost. Cost has multiple dimensions, but most prominently includes the purchase price of premiums themselves, and also the out-of-pocket costs that are increasingly demanded of people with private cover, even at top cover levels.

Respondents directed their displeasure at PHI providers, individual healthcare professionals, and healthcare institutions such as hospitals when discussing the issue of cost.

Routine premium increases coupled with diminishing returns have caused many to question the value proposition of PHI, whether for hospital cover or extras.

An additional issue is the Lifetime Health Cover loading, which financially penalises older people who can now afford to purchase PHI but could not do so earlier in their lives. Conversely, the loading is a source of pressure for some older people to retain their PHI even if they are now struggling to pay for it.

The complexity and confusing nature of PHI policies is also frustrating for older people. Many are not sure what exactly they are covered for or what they would lose by shopping around. The ability to find out is stymied by some providers' poor service or communication inadequacies.

As a result of these issues, some older Australians have reduced their PHI or dropped it altogether.

Unsurprisingly, full pensioners were less likely than people with other income sources to have any private cover at all. Among the full pensioners surveyed, 45% had no PHI, compared to just 16% of other survey respondents. Full pensioners were also more likely to be considering cost-saving strategies if they did have PHI.

Similarly, respondents with lower savings levels (including superannuation and other investments) were less likely to have PHI than those with high savings levels, and more likely to be considering cost-saving measures.

Respondents with self-reported poor health were also less likely to have PHI.

This presents a paradox for the health system. If older people drop out of private health this will lower premiums, especially if those people have poorer health. The impact on the public system is it will require more funding and taxes to support the influx of older sicker patients. Good for private, bad for public.

This report therefore advocates a full review of the private health system, to be initiated by government as a matter of urgency to ensure it is operating efficiently and providing adequate benefits for consumers.

As an interim measure, the report supports increasing the federal government's PHI Rebate for lower-income and lower-wealth older people.

This will make PHI more affordable for those who want to retain access to private health care during this cost-of-living crisis and beyond.

BACKGROUND

Funding the Australian healthcare system

The Australian healthcare system relies upon a mix of public and private funding.

Prior to the emergence of nonprofit 'self-help' financial organisations, friendly societies and mutual funds, health care costs were born by individuals. Modern private health insurance emerged in the 1930s, often tied to a workplace or community (ABS 2001).

Over time private health insurance became the dominant means of insuring against health costs, attracting government subsidies to encourage take up from the 1950s until the mid-1970s (Duckett and Nemet 2019).

After several unsuccessful attempts to introduce universal health insurance through the twentieth century, the Medicare system of universal insurance was brought in by the Hawke government in 1984 (DHAC, 2024).

The introduction of universal health insurance coincided with a fall in private health coverage. Private health insurance (PHI) is now offered by 37 registered providers and covers around half of the population (Biggs, 2017; Duckett and Nemet 2019).

Funded through the tax system, Medicare pays for hospital treatment and some other healthcare costs, including part or the whole of GP consultations, specialist consultations, and diagnostic imaging and tests across both public and private settings (DHAC, 2021).

PHI, on the other hand, can be used to cover hospital treatment as a private patient (including choice of doctor and sometimes a shorter waiting period), and 'extras' services not covered by Medicare such as dental or optical (DHAC, 2021).

Commonwealth and state/territory governments still fund the lion's share of health expenditure in Australia. The most recent statistics (AIHW, 2023a, 2023b) show that of the $241.3 billion spent on healthcare in the year 2021-22, the breakdown of funding was as follows:

- 72.9% - government ($176 billion)
- 14.0% - individuals ($33.7 billion)
- 7.2% - private health insurance providers ($17.5 billion)
- 5.9% - other non-government sources such as compensation insurers ($14.2 billion).

With 14% of the total cost of health care coming from individuals' pockets, this illustrates that public and private insurance does not provide full coverage for the Australian population.

Prevalence of private cover

At December 2022, 45% of Australians had some form of private hospital cover (APRA, 2023). This is much less than the approximately 78% who had hospital cover in the early 1970s, prior to the Whitlam government's introduction of Medicare's predecessor, Medibank (DHAC, 2021). With the creation of Medibank, hospital coverage dropped rapidly by around 15%.

The Fraser government's restriction of benefits in the early 1980s saw a temporary resurgence in people taking up hospital cover, but it dropped again with Medicare's introduction soon after.

The proportion with private hospital cover then continued to decline, reaching a record low of around 30% in the late 1990s (DHAC, 2021). The low may suggest most people at that time

were relatively happy with the public hospital system. Alternatively, it may suggest there was an 'adverse selection' spiral, in which people with a lower risk of needing to claim on health insurance (for example because they were healthier) did not join to avoid subsidising people who were more likely to claim (Duckett and Nemet, 2019).

In 2000, the Howard government introduced Lifetime Health Cover (LHC) with the intention of increasing the uptake of private hospital cover. An LHC loading is added to the hospital cover premiums of people who take it up after the age of 30, or who take it up earlier but allow it to lapse for a significant period (ATO, 2023; PHIO, n.d.). Thus, LHC was designed as an incentive for those who want hospital cover to take it up earlier in life and continue it for at least 10 years (Biggs, 2017).

At the time this policy was introduced, the proportion of the population with hospital cover rose swiftly to around 45%, where it has stayed ever since (DHAC, 2021).

When including extras and ambulance only cover, 55% of the Australian population had some form of health insurance at June 2023 (ACCC, 2023).

The Medicare Levy Surcharge (MLS) of 1% was introduced in 1997. This penalises higher income earners who do not have private hospital cover, via the income tax system.

Around the same time, an early version of the PHI Rebate, the Private Health Insurance Incentive Scheme (PHIIS), was introduced. It provided a fixed dollar subsidy to PHI holders on low incomes, before changing to a 30% PHI Rebate for all policyholders.

The 2000s saw refinements to PHI incentives and disincentives (Duckett and Nemet, 2019, Finity 2023). The PHI Rebate was adjusted for age and means, making PHI premiums cheaper for older people on lower incomes.

A higher MLS rate for high income earners was introduced in 2012.

Indexation of both the MLS and PHI Rebate income thresholds was paused in 2015. As incomes increased over time, this reduced the number of people eligible for higher levels of the Rebate but increased the number of people facing the MLS.

While, as noted above, the proportion of Australians with private hospital cover has stayed relatively stable for two decades since the introduction of LHC, over time the age profile of members has changed. The number of people in their 20s with private hospital cover has dropped, and this is balanced out by more people in their 70s picking it up (Duckett and Nemet, 2019).

Older people's views on private health insurance

Previous National Seniors research based on 2008 ABS survey data revealed that older people's primary reason for purchasing PHI was security or protection or peace of mind, with 53%-60% of survey respondents aged 50 or over selecting this reason (Temple and Adair, 2011). A much lower proportion of survey respondents under 50, just 27%, selected that reason.

Other predominant reasons older people selected for having PHI were choice of doctor, being treated as a private patient in hospital, and anticipating a shorter wait for treatment (Temple and Adair, 2011).

Affordability was by far the most prevalent reason for not purchasing PHI, selected by 65%-68% of people aged 50-79. For people aged 80 or over, affordability rated equally with having a pensioner, Veterans' Affairs or health

concession card, and therefore not needing PHI, as a reason for not purchasing it.

Multiple aspects of unaffordability were highlighted by COTA Australia (2017a, 2017b) in two government submissions from 2017. Drawing on their members' views, COTA's concerns included:

- the high cost of premiums, particularly compared to the benefits received;
- the rate of premium increases;
- out-of-pocket expenses over and above premiums;
- insurers' preferred providers not necessarily being the member's preferred provider;
- the complexity and challenges of shopping around for the best product, with confusing information; and
- limitations on coverage of some products that were not always clear upfront.

Their members' views about the benefits of PHI largely echoed the 2008 data.

More recent National Seniors research based on a 2023 survey of more than 5000 people aged 50 or over has highlighted a major problem with the healthcare system in Australia (National Seniors Australia, 2023). While in theory Medicare provides universal cover, in practice it does not cover everything. As a result, many of those surveyed reported going without healthcare when it was needed because they could not afford it.

Most strikingly, cost prevented 20% of respondents from accessing a dental checkup, 24% from accessing dental treatment, and 26% from attending a mental health appointment.

But even attending a GP appointment was too expensive for 7% of people. This was likely because of the increasing inclusion of an out-of-pocket payment in GP appointment fees – something numerous respondents commented on.

At the same time, the survey showed many older people will go to extraordinary lengths to keep their private health insurance (National Seniors Australia, 2024). Many sacrificed social activities, holidays, clothing, and leisure to pay for it; some even spent less on groceries to keep it.

For example, some of the many comments from respondents included:

> *"dropped visits to family because of increased private health insurance"*
>
> *"one prioritizes health insurance however it means cutting back on day-to-day items and outings"*

People shared these stories in the context of a cost-of-living crisis, in which 46.6% of those surveyed had noticed private health insurance had become 'a lot less affordable' in recent times.

Together these insights tell us that many older people cannot afford PHI, but among those who can afford it, it remains incredibly important.

About this report

This report is based on a 2024 survey of thousands of older Australians which included a module about private health insurance.

National Seniors Australia included the module in response to the insights gained from previous research and comments about PHI that the organisation routinely receives from members.

The report is an attempt to understand more fully older people's experiences with private health insurance – respondents' levels of coverage, their reasons for having it or not having it, the problems they have encountered with it, and their insights into what must change.

METHODS

The National Seniors Social Survey

National Seniors Australia is a member-based not-for-profit research and advocacy organisation representing all older Australians. Every year since 2012 – except 2020 when focused on COVID research – National Seniors has conducted a survey of older Australians' behaviours and views about topics relevant to lifestyle, health and wellbeing called the National Seniors Social Survey, or NSSS.

The 12th NSSS (NSSS-12) was conducted in February 2024. Anyone aged 50 years or over and living in Australia was eligible to participate. Invitations were distributed to older Australians via the National Seniors membership database and online networks, and further distribution to other older Australians was encouraged. Responses were collected online via Survey Monkey. Participants were encouraged and able to retain anonymity, but any potentially identifying information in comments was redacted prior to publication.

As for other National Seniors Social Surveys, we asked questions on multiple topics relevant to older people's lives, plus a range of demographic questions. This report draws on responses to questions about PHI in the 'Issues that affect you' module of the NSSS-12 (question wording in Appendix 1). In total, 4564 NSSS-12 respondents answered one or more of these questions. Specific numbers for each question are reported in the text.

The demographic characteristics of respondents who answered any of these questions are provided in Appendix 2. We use demographics to characterise the sample as our recruiting strategy was open rather than attempting to reflect group proportions in the broader population.

Quotes from survey respondents (in blue italic) were selected to illustrate some of the variety and prevalence of ideas expressed in a free-text question about older people's PHI decisions or experiences. When possible, we reproduce quotes verbatim, occasionally omitting or altering parts for clarity, anonymity, or to avoid mentioning the names of specific insurers or healthcare providers (indicated with square brackets []). Minor typos were corrected for readability (no brackets). All other phrasing idiosyncrasies were retained.

Analysis methods

The software package Stata v18 was used for all quantitative analysis. Chi-square tests evaluated differences between groups and multiple logistic regression models evaluated the relative contribution of relevant demographic factors to private health insurance outcomes.

We analysed text comments using the thematic analysis framework described by Braun and Clarke (2006). We identified themes via inductive analysis guided by a critical realist approach that aimed for accuracy and objectivity in interpreting respondents' views. We acknowledge the influence of our pre-existing knowledge and understandings on identified thematic categories.

The number of comments comprising any given theme was estimated to give a sense of its prominence. Comments could contribute to more than one theme.

WHO HAS PRIVATE HEALTH INSURANCE?

The survey showed that most NSSS-12 respondents had PHI, with two-thirds having a combined hospital and extras cover policy (Figure 1).

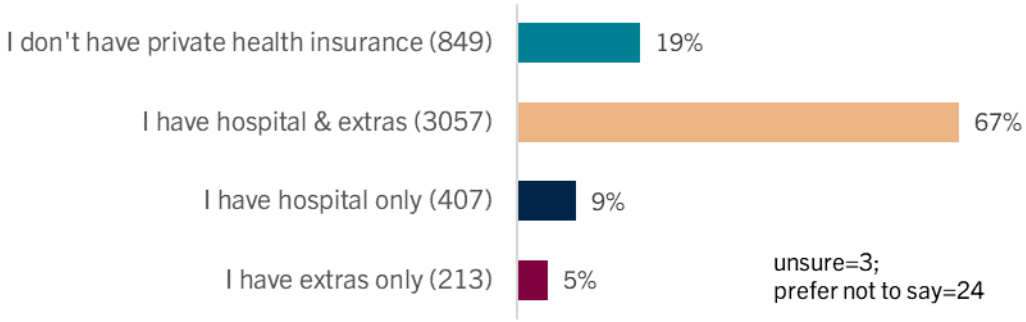

Figure 1. Private health insurance cover of NSSS-12 respondents (total n=4553)

The proportions of NSSS-12 respondents with PHI varied according to personal circumstances. The figures below show differences in private health cover across age groups and binary gender; partner status and self-rated health; income and wealth, including housing costs.

The proportion of people with combined hospital and extras cover rose from 63% in the under 65s to 68% and 69% in the older age groups. For those 85 and older, 83% had private hospital cover (combined or not) compared to 75% of 50-64-year-olds (Figure 2).

The same proportion of men and women had no PHI (19%), but higher proportions of men had hospital and extras combined (Figure 3), with lower proportions of men holding extras only cover.

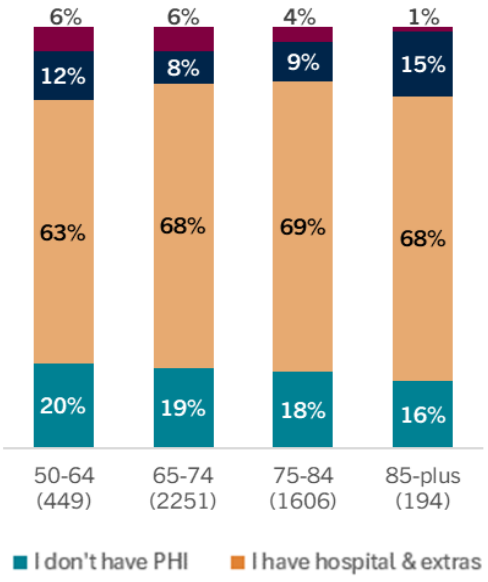

Figure 2. PHI according to age group; Chi-square=35.5, p<.001

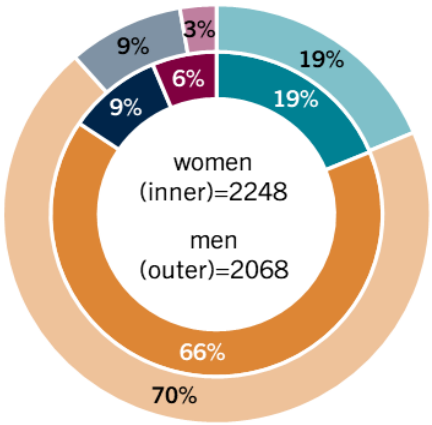

Figure 3. PHI according to binary gender; Chi-square=33.1, p<.001

Differences were more substantial between single and partnered people: 24% of singles did not have private cover compared to only 16% of couples (Figure 4).

Seventy percent of those who reported good or excellent health had hospital and extras cover combined compared to 56% of people whose health was poor or very poor. In this latter group, 30% had no PHI at all (Figure 5).

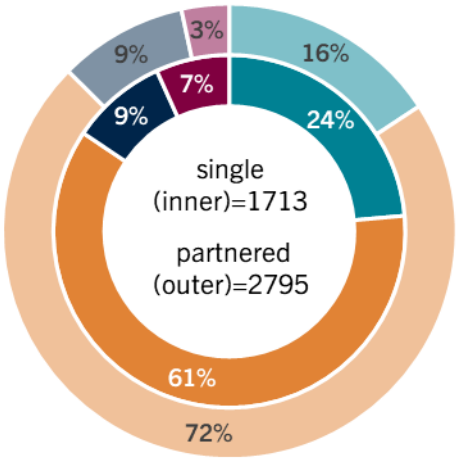

Figure 4. PHI according to partner status; Chi-square=79.41, p<.001

Figure 5. PHI according to health status; Chi-square=73.94, p<.001

Not surprisingly, there were marked differences in private heath coverage according to financial wellbeing.

Hospital cover was held by 92% of people with savings, investments, and/or superannuation of $750,000 or more compared to only 55% of those with up to $100,000 (Figure 6, over page). Among the 384 respondents with savings, investments, and/or super of under $10,000, half (52%) had no PHI, and just 40% had hospital cover with or without extras (not graphed).

For those whose source of income was the Age Pension only, nearly half (45%) did not have any type of private health cover. When income included sources in addition to, or other than the Age Pension, 80% had hospital cover at least (Figure 7, over page).

Housing costs, either from renting or paying a mortgage, were also relevant to PHI status. Only 51% of respondents with these housing costs had a combined hospital and extras policy compared to 73% of those who owned their home outright (Figure 8, over page).

A logistic regression model tested the relative strength of these sociodemographic associations with having any type of PHI. Financial status (savings level, income type and housing costs) had the strongest relationship with PHI status but the other factors (age, gender, partner status and health) also had independent effects on a respondent's likelihood of being covered. Appendix 4, Table S8 provides model results and output.

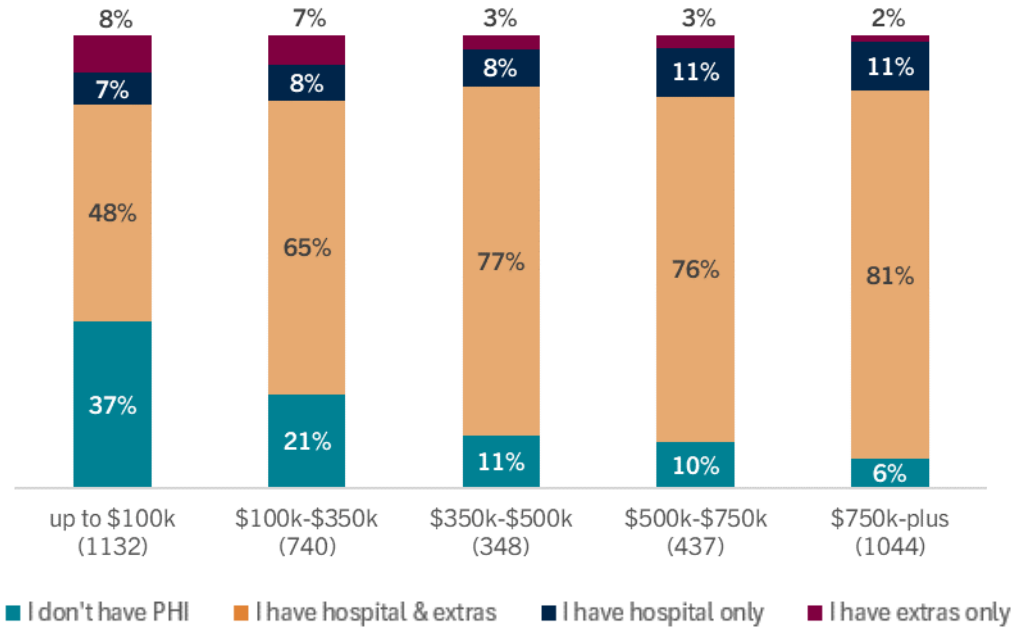

Figure 6. PHI according to savings, investments and superannuation level; Chi-square=476.8, p<.001

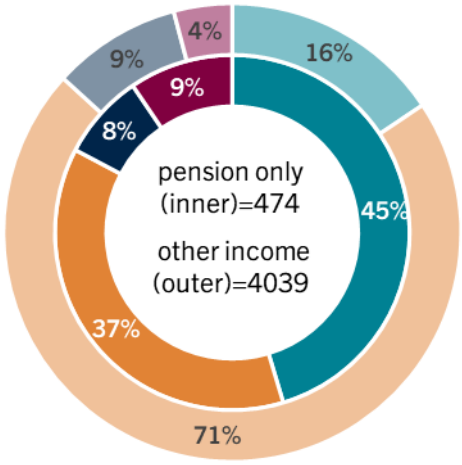

Figure 7. PHI according to Age Pension only as income source; Chi-square=298.50, p<.001

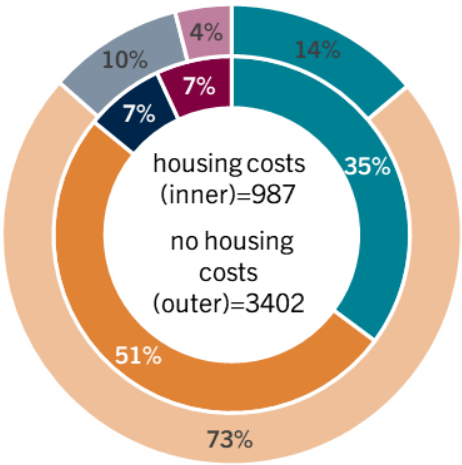

Figure 8. PHI according to housing costs (rent or mortgage payments) vs none (own home); Chi-square=259.36, p<.001

Levels of combined hospital and extras cover

Respondents with PHI were asked to identify their level(s) of hospital and extras cover.

Of those who had combined hospital and extras cover (n=3051) just over 50% had gold or gold-plus hospital cover and 35% had silver or silver-plus cover. Bronze/bronze-plus and basic/basic-plus cover were held by 7% of people with combined hospital and extras cover (see Appendix 3; supplementary tables S2 and S3). Very few people selected 'other' for this question, but their responses are tabled in Appendix 5. Table 1 below shows the proportions opting for the varying combinations of cover level across hospital and extras.

Table 1. Levels of cover for PHI policy holders with combined hospital and extras cover

Combined hospital and extras policy: levels of cover (n=2777)	number	percent
gold hospital & top extras	1276	45.9
gold hospital & medium extras	200	7.2
gold hospital & basic extras	70	2.5
silver hospital & top extras	393	14.1
silver hospital & medium extras	468	16.8
silver hospital & basic extras	163	5.9
bronze or basic hospital & top extras	22	0.8
bronze or basic hospital & medium extras	62	2.2
bronze or basic hospital & basic extras	123	4.4

Not surprisingly, levels of hospital and extras cover were closely aligned; people who elected to have gold level hospital cover combined it with top level extras while the small proportion with bronze or basic cover mainly had basic extras. For silver level hospital cover, the proportions electing top extras and medium extras were similar.

PHI policy holders who had hospital cover only (no extras) were split fairly evenly between having gold/gold-plus cover (36%) and silver/silver-plus cover (38%). Approximately 16% had bronze/bronze-plus or basic/basic-plus cover.

As shown in Figure 1 (page 8), just 214 respondents had extras only cover with 39% opting for basic extras, 26% for medium extras and 29% for top extras (see Appendix 3; supplementary tables S4 and S5).

For those who had PHI of any sort (n=3667), a logistic regression model tested the demographic factors associated with having a combined hospital and extras policy. Demographic effects were significant but not large. Older age, being a man, having a partner, higher savings, and having income source other than or in addition to the Age Pension were associated with being more likely to have combined cover. Savings showed the weakest relationship with having a combined policy. Health and housing status were not significant (see Appendix 4, Table S8).

REASONS TO HAVE PRIVATE HEALTH INSURANCE

All respondents were invited to write more about their decisions and experiences with PHI in a free text comment, and many of these gave insight into why older people have PHI.

Just under 2000 people wrote a comment for this question after indecipherable and irrelevant responses were removed. Over half of them commented on reasons they had PHI. Many of these commenters mentioned problems with PHI as well (discussed later), indicating a degree of mixed or ambivalent views.

Statistically, the group who commented were more likely than non-commenters to be in poorer health and less likely to believe they would maintain their current level of cover over the next 12 months. There were no other significant differences between commenters and non-commenters (see Appendix 4, tables S11.1 and S11.2).

From these comments we identified five kinds of reason for having PHI: to assist specific health situations; to reap other benefits of cover; to meet emotional needs; policy lock-in (discussed last below as it is also a problem); and miscellaneous other reasons.

Reasons to have PHI 1: To assist specific health situations

Just over 450 respondents framed their positive comments about PHI in terms of their health conditions, the life experiences that they associated with potential health problems, and the types of cover they had to help treat those issues.

Important as we age

Around 100 people commented on the importance of private health insurance for people who are getting older. All but one of these commenters had hospital cover.

"Private Health insurance is extremely important as we age."

"It's essential as you get older."

"Increasing using it to fix and repair my body in preparation for older years."

Some of these people gave specific reasons such as the higher likelihood of major health issues.

"I believe it is a good investment. I expect as I and my husband age we will require more hospitalisation. I've just had 3 months in hospital and I'm grateful for my health insurance."

"aging creates unbeknown/hidden ailments and /or diseases popping up their heads these include genetics ones also."

"Hip replacements, knee operations, cataracts, glasses etc, etc, are all on the horizon when you turn 80 plus"

"Imagine managing ageing health issues with out private health insurance and access to private medical treatment in hospitals"

Chronic health problems and frequent hospital trips

Around 120 people wrote about needing PHI because they have had, or continue to have, major and/or chronic health problems. All had hospital cover for this.

"We have wanted to keep private health insurance because my husband has multiple medical conditions but it is becoming very expensive - costs one of our pension payments per month."

"I have complex health needs, with some rare syndromes. As a result I rely on a team of medical professionals who understand my situation. I have had quite a few very negative experiences when in medical care with professionals who do not understand me needs. On several occasions this has been quite dangerous. A GP once quipped "You should keep your private health insurance even if you have to eat dog food". I would follow this. My local public hospital is not capable of meeting my needs."

"I keep the basic private health insurance that I have because I have a health condition that requires yearly surveillance with a gastroscopy. The public system is so overstretched I can't be guaranteed that I would get that."

"As i have type 1 diabetes (45 years plus), health care is expensive, and needs high level private insurance to cover insulin pump, etc."

Because of their health problems, some have required frequent or unplanned hospital attention for which PHI has been valuable.

"I have been so grateful that we have had health insurance over the past few years. My husband has had two knee replacements and 5 surgeries related to rectal cancer. I have had kidney and bladder cancer. It was such a relief to know that most of this treatment was covered by our health fund."

"I am 92 and for the last ten years have needed hospital care at least once a year and some years I have been hospitalised several times. I have been able to promptly assess private hospital care so I am very pleased I have had health insurance."

Importance of hospital cover

About 210 people wrote about valuing their hospital cover.

Many shared details of the beneficial hospital care and cover they have received.

"My wife was recently hospitalised for some weeks, incurring costs of some $80,000. We simply could not have coped without private health insurance."

"Invaluable. Required bypass surgery although never any symptoms. Cost was $44,000. I paid $3000 after Health Fund contribution."

"I have benefitted tremendously from Private Health Insurance both in terms of cost, timing and hospital experience. I have had 2 total knee replacements, one hip replacement, 2 rotator cuff repairs, 1 hernia repair."

"Very pleased I was in Rehab hospital 4 weeks and out patient 15 weeks no cost"

Knee replacements, hip replacements, and cancer treatment were the procedures most commonly highlighted, each warranting over 20 mentions.

Literal life saver

Sixteen people remarked that they or a loved one would likely (or could) have died had it not been for their private health insurance. All had hospital cover.

"I see friends who do not have private health insurance waiting for treatment for life threatening illnesses"

"My mother was diagnosed with bowel cancer at 90 given 3 to 6 months to live, --------- because she had full private health cover i was able to get a surgeon to operate on her, and she led a full active life till 105 Without private health cover they would have just let her die, so I pay my fund before anything else."

Importance of extras cover

While most of the above comments appear to have pertained to hospital cover, around 100 people said that extras was a reason (or the only reason) they had PHI.

Some said they got great value for money with it, some were satisfied with the partial reimbursement they received, and others simply mentioned that they had extras cover or had mixed views of it.

"I have taken Extras cover because I need massage, chiro and physio on a regular basis. I did my sums and figured that the extras cover was well worthwhile for me. It also covers a fair bit of dental."

"It helps me with dental and chiro appointments"

"increased my extras cover because I use many of them regularly - dental, physiotherapy, podiatry, hearing aids, optical."

Dental and optical were frequently mentioned extras that respondents used. Quite a few also mentioned some form of physical therapy including physio, chiro, osteo, or massage. Some commenters also mentioned devices such as hearing aids and insulin pumps, or other costs such as podiatry, ambulance, and gym fees.

Reasons to have PHI 2: Benefits of cover

Around 530 respondents wrote about PHI in terms of the benefits they received through their cover, including a greater sense of choice and good financial returns. This category also includes comments about their provider or PHI that were broadly favourable.

Choice of timing: no wait

Not having to wait long for surgery or other medical treatment was a benefit of PHI mentioned by almost 200 commenters.

Some people wrote about the benefits of being able to pay for immediate treatment.

"I have needed immediate hospital treatment and did not have to wait."

"having the top cover for hospital and extras is very important for all elderly people, and can give confidence about prompt treatment for illnesses and operations to preserve quality of life without a lot of expense. That is my experience."

"It pays for itself when you have need for medical treatments and don't want to wait. This is particularly the case for preventive treatments."

"I have cover with no excess. I believe this will cover any costs associated with treatments which may be required in the future. Being a smoker, I find this necessary given that I will be put to the back of waiting lists for any operations. I pay my way and expect returns on my investment in the future."

In other cases, it was more of a comparison to the long wait times on public health lists.

"Got to have it. Life's too short to wait years to fix something in public system."

"It is essential that we keep it as the waiting period for public systems is high"

"In the past 5 years I have had 2 hip replacements a cochlear implant and 2 cataract surgeries some of my neighbours have been on the waiting list for years and will probably die with chronic operable problems before they get to the top of the public hospital waiting list."

"I feel that I have to have private health insurance if I want timely surgery for things like cataracts, hip or knee problems i.e. anything that would be elective. The public hospital and Medicare system fails as - the waiting lists are too long, and too often priority is given to those who will sign to go private. Both of the above needs addressing especially the pressure to go to a public hospital as a private patient. It disadvantages the most vulnerable and those that cannot afford, it erodes the basic right to equality on health care. It also increases the cost of private health insurance and therefore reduces the participation. It is, on my opinion, an unconscionable practice by a lot of consultants who work in the public hospital system."

Choices in care: private rooms and health professionals

Approximately 90 people gave 'choice' as a reason for wanting PHI.

Having a private room, choosing one's doctor, and being able to attend a private hospital were the primary choices people said they wanted to exercise.

"I very much value the privacy of private hospital single accommodation."

"We have private health insurance so we can select the specialists"

"just recently signed up for private Health Insurance as I have been finding it increasingly difficult to access health practitioners in the public sphere"

"I would like to be able to have the specialist medical practitioners and hospital of my choice, although I have not needed any serious medical attention since my first pregnancy, more than 60 years ago now."

Financial benefits

Just under 80 people wrote about the financial benefits they had reaped by having PHI.

"After being covered by my parents for health cover, I joined me and my husband to health cover when we got married. This continued for 4 children until I left the marriage after almost 24 years. I continued my subscription as a single person, and would never discontinue my subscription. I had spinal surgery ten years ago, and my fund paid out over $100.000 and I never

received a bill. During our marriage, my husband had a multiple trauma car accident, and spent 6 months in hospital before signing himself out. We never got a bill!"

"[Provider] paid $80,000 for my wife's heart bypass op, and they have provided EXCELLENT service - We will stay with them as long as possible"

"I am so glad we have private health insurance as my husband was admitted to a private hospital over Christmas New Year with a life threatening illness. The level of care was fantastic and apart from the hospital excess, our costs have been limited to Pharmaceuticals. The room alone would have cost $9000+ per night."

Some said they had received more monetary value than they had paid in premiums.

"I am sure that i have received more from my health insurance than i have paid into it. With multiple stays of many weeks and big operations i feel that i am a winner."

"Based on the claims lodged during my former wife's mental illness. My pacemaker inserted during May 2020. I expect I'm in credit!!"

Others were grateful for more modest savings or returns.

"never pays the expenses but goes a long way. sometimes bonus for visits"

"very good organisation. costs kept to a minimum"

Great service or general good experience

About 240 people spoke positively about their PHI experience in general terms, simply using words such as 'excellent', 'good', 'all okay', 'has always been fine', and similar.

Others mentioned being satisfied with their specific PHI provider. A few shared some powerful stories of outstanding service.

"When my wife was incapacitated for 2 years from Motor Neuron Disease (ALS) and I was her primary carer, [fund] rang me out of the blue and asked how they could help. I said I was having to get up every 3 hours during the night to attend to my wife and the broken sleep was affecting my health and ability to tend to her. I asked if they could fund a night nurse two or three days per week to allow me to get a decent night's sleep. They allocated $10,000 for a fixed 6-month period for me to pay for a night nurse twice a week, on the basis that this was cheaper for them than having to admit either my wife or I or both into remedial or palliative care in the public hospital system. I was stunned that they had initiated the help process. Consequently I am now extremely loyal to [fund]."

"We are with [fund] top level and extremely happy with them. They are Australian Not for Profit, have covered every insulin pump I have needed. The first pump had not been legislated etc and was months from approval for Health funds to cover, but [fund] went that one step further and made it possible to cover 100% $19,000 worth of pump."

Reasons to have PHI 3: Emotional need

Some comments on the reasons for having PHI were primarily emotional in nature, with around 240 people describing it as reassuring, necessary, or extremely important to them. Almost all these commenters had hospital cover, not extras-only.

Peace of mind, security

Around 100 people wrote about the sense of security, reassurance, comfort, or peace of mind they felt from having PHI, or that they could not imagine going without it.

"peace of mind"

"Good safety net"

"We have had excellent assistance with private health cover, could not have managed without it."

For some this seemed a wholly positive emotion.

"I firmly believe that avoiding stress is a basic health benefit. Our health insurance is a major benefit in avoiding stress."

"In the past 5 years I have had two procedures, one major the other less so, and I felt relaxed. Both went extremely well. One happy, grateful patient."

For others it was related to a fear of not having it.

"I have had insurance all my adult life. My wife and I have discussed dropping but feel that while we haven't used it much, the minute we drop out something will go wrong."

"I maintain private health cover as I am afraid of what would happen if I didn't have it and I became sick"

The sense that 'you never know when you'll need it' was also present.

"Security if I need hospitalisation quickly"

"It gives me the advantage of getting treatment quickly if required. I feel in control knowing I have it"

Necessary, or a necessary evil

About 90 people had a slightly more pragmatic emotional frame for PHI as simply being necessary or essential.

"I think it is very important to keep private health insurance and will keep it until I cannot afford to."

"I need it to ensure I don't have long periods of time off work."

Many of these compared it favourably to the public health system or framed it as necessary despite its drawbacks such as being expensive.

"The public health system is broken so private health is necessary"

"It is too expensive but very necessary as the public health system often does not cope."

Seventeen people used the phrase 'necessary evil' to describe it.

"A Necessary evil!"

"I believe it is a necessary evil one that you can't afford to have but you also can't afford not to have especially as you get older."

Very important expense

Around 50 people simply asserted how important PHI is to them with strong language.

"I consider it my most important cost"

"I have had it since 1965 when I first started work and have continued with it and will continue."

"I will continue to purchase near top private health insurance until I die."

"Private health insurance enables me to enjoy a relatively high standard of health as I progress through my lifespan."

Some said they would rather go without other things to pay for it.

"Always had and always will have top private health insurance. Will budget and save on something else but never on health insurance"

"I will give up private health insurance just before food"

"I would use my housing loan drawback facility to maintain top health insurance if I had to."

Location

Seven people said that living in a regional, rural or remote area was the reason for having PHI (though other people said the opposite, see further section below).

"It's important as living in a rural setting and sometimes needing to travel to access specialist I feel I need the cover."

"Having private health insurance has been a lifesaver for us in recent years with the impact of living in an area without specialist services and health issues."

Reasons to have PHI 4: Other motivations

Approximately 30 respondents gave other reasons for having PHI.

Risk mitigation

Some commented on the fact that all insurance is about risk mitigation, so they were happy to pay for PHI in the hope that they never needed it.

"So far so good. Our claims have increased dramatically - from very few for years to rather a lot in the last few years. Although it is expensive, we are not hoping or expecting to get our money's worth any more than we hope our house will burn down just because it is insured."

"Insure to mitigate financial loss. Any insurance is taken out against risk."

Tax avoidance

Some of these respondents said they had PHI for tax purposes, presumably referring to the Medicare Levy Surcharge.

"I have to have private hospital cover otherwise I would pay more in income tax than I pay for health cover"

Individual responsibility

Others shared their belief in individual responsibility, not relying on the public purse.

"I am a person, who wishes for little to no input into my life from the government and would prefer to keep it this way. My sovereignty is important to me, including my heath insurance needs. I am my responsibility and not the government's and when or where possible it will remain this way."

"We like to maintain our independence. We are fully financed in our retirement and not on a government pension or payout except in rare circumstances where the government insists we take their payments. Nice!"

Pooling risk

A couple explained the principle of investing in a common pool so that whoever needed it would benefit from it.

"I have contributed in many years with very few claims, but lately, we have incurred some huge bills which would have wrecked our finances had we not had the insurance. So, I am very grateful that we can draw on the accumulated pool with a clear conscience, and get the treatment we want when we want it !"

"I have always thought of insurance as sharing the risk, and paying while you are young so someone will help you later when you need it. I don't like how have shifted to - I will only pay if I know I will get big benefits now."

Government PHI Rebate

Just one person mentioned the government Rebate on premium prices.

"Private health insurers are just thieves. The out of pocket costs are mind blowing. Just had a hernia op - the surgeon alone was around $3,700 out of pocket. The costs of private health insurance are just bloody sad. If not for the Govt rebate I would bail from such insurance."

Reasons to have PHI 5 (and also a problem): Policy lock-in

Just under 40 people said they kept their PHI because the legacy costs of dropping it would be too great.

This was either because they had an excellent policy that is no longer offered to new customers, or because of the threat of the Lifetime Health Cover (LHC) loading if they should leave and want to return later.

All these commenters had hospital cover.

"I have compared my private health cover and I am on a good wicket in comparison, plus I have gap saver which is fantastic and which is no longer available to new members."

"Private health insurance taken out many years ago has been maintained as the latest insurance agreements no longer have the range of coverage currently locked into the supporting contract."

"I am not a believer in private health insurance but was lured into it when the government used scare tactics in the past"

"I have paid for it all my life so I keep doing it. I'm scared to let it go but I would love to let it go"

"After stopping hospital cover in the past due to financial constraints, I would not do so again - the 10 year financial penalty (premium loading) is prohibitive."

PRIORITISING PRIVATE HEALTH INSURANCE

When asked how important it was to maintain their PHI, almost all respondents (96%) said it was important, with 76% saying it was very important to them and 20% saying it was somewhat important.

Almost all (95%) believed it was likely they would maintain their current level of PHI over the following 12 months. Supplementary figures S6 and S7 in Appendix 3 provide proportions across all response options.

This is consistent with the comments noted in the previous section in which some respondents said they would prioritise their PHI over almost any other costs.

Given current cost-of-living pressures, NSSS-12 respondents were also asked whether they were considering cost-saving strategies to enable them to maintain their private health cover.

Approximately 3500 people responded, with 47% (1,666) indicating they didn't need any strategies.

Figure 9 shows the proportions who were considering one or more cost-saving strategies. The 'other' reasons given by 86 respondents are presented in Appendix 5.

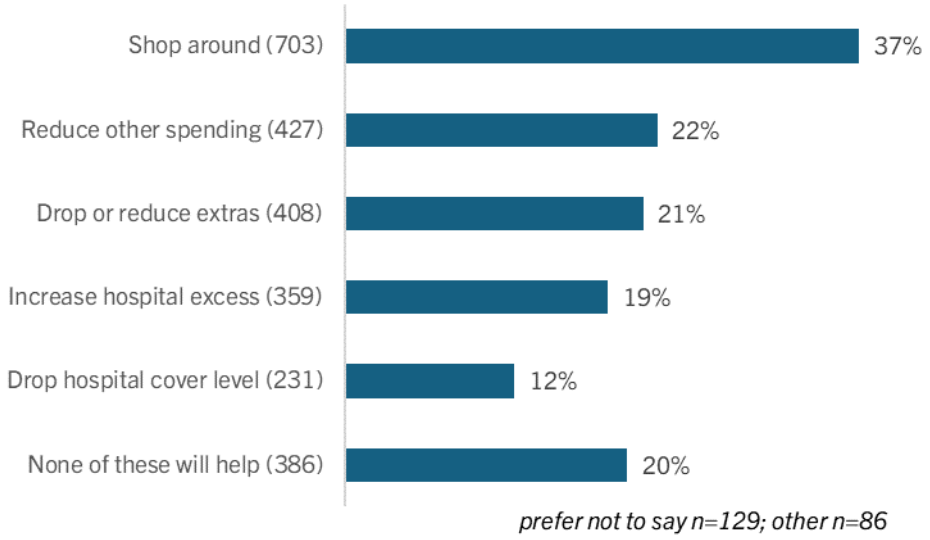

Figure 9. Cost-saving strategies respondents said they are considering to maintain their PHI (n=1912)

Logistic regression showed those considering strategies to assist with maintaining PHI were most likely to have the Age Pension as the sole source of income. Having poorer health, having a partner, being younger, being a woman, having lower savings, and ongoing rent or mortgage housing costs were also associated with the likelihood of considering strategies to maintain PHI (Appendix 4, Table S10).

PROBLEMS WITH PRIVATE HEALTH INSURANCE

As mentioned in a previous section, an open comments survey question elicited over 1000 positive comments about PHI that explained why people have it and why they value it. At the same time, over 1000 people wrote negative comments about PHI, highlighting problems with it. Again, many of these writers also mentioned positives, indicating feelings about private health insurance are quite mixed among older Australians.

Drawing on these comments, we identified six kinds of problem with PHI : the cost of buying it; out-of-pocket costs; inadequate coverage, confusion, and complexity; poor service; not receiving anticipated benefits; and miscellaneous other problems.

Problems with PHI 1: Cost of buying insurance

As might be expected, the single biggest complaint respondents had about PHI was its cost. Over 700 people mentioned the cost of PHI itself as a drawback in one way or another.

Too expensive

Around 370 people spoke about cost in general terms, remarking on PHI being expensive or similar. For some people it was simply unaffordable or had become so when they experienced a life change such as retirement, divorce, or unemployment.

"Ridiculously expensive"

"Paying such expensive premiums when we no longer have an income are worrying."

"Pension insufficient, rent is too high, no spare funds"

"We had top level private health insurance for some 30-40 years cannot afford it now."

High premiums and the lifetime health cover loading

Other commenters detailed specific aspects of the cost problem.

High premiums, and especially regular rises in premium levels, were specifically mentioned by around 220 commenters.

"After retiring we could not afford the monthly payments - living on the age pension means money is tight."

"Premiums are increasing faster than income, making maintaining cover more difficult"

"Premiums keep going up every year and has become unaffordable"

"The costs that go up every year with everything else going up and not getting enough money to keep up"

More than 30 of those who commented on premiums noted the impact of the LHC loading on them, in making it difficult or impossible for them to have PHI.

"I find it totally unacceptable that, because I was poor decades ago and could not afford health insurance, that there is a surcharge if I take it up now."

"Too expensive. Too little benefit. The loading for being over the age of 35(?) is discriminatory for older people and those with lower incomes particularly women who mostly have lower incomes or casual work."

"as my partner let her health insurance lapse we now have to pay a 10 year loading we make our premium 602 per month it is at the stage where we will have to let it go 10 years is so over the top"

"Following divorce I raised 3 children. My ex husband, their father, managed to dodge financial contribution to their upbringing. He was self-employed, had a good accountant and worked for cash much of the time so fell below the income figure required to be forced to pay anything more than a few hundred dollars a year. I worked full-time but could not afford hospital cover. As years went by the penalty of being older made it impossible for me to take up hospital cover. We need some sort of moratorium so that older people can obtain hospital insurance."

Put more in than get out

For around 170 people a focus was the cost-benefit ratio, with people unhappy that they had spent much more than they had gained via the fund covering health expenses.

"It costs my wife and me over $400 pm. Most years we would not claim more than about $3000."

"Pay way more than we get back."

"Always seem to be paying in more than ever getting back. All our big ticket items to date have been covered by Medicare. My wife has an incurable but treatable cancer and I had emergency surgery in the last 12 months. Private health cover has been irrelevant for those two treatments."

In some cases, the disappointing cost-benefit ratio was because the fund's maximum allowable refunds for the health services the customer used added up to less than the cost of the premium they paid. Many noted that although premiums regularly increased, the returns did not.

"Pay way too much and not much in return. Should refund more for classes that maintain health.eg I paid $280 for 10 week osteoporosis class and got $55 back."

"I am currently measuring the cost of dental, optical and Physio, comparing the cost if insurance and the gap, against the full cost of these services. I am still unsure."

"Annual fee increase without increase of benefits... year in, year out !"

"Cost goes up, but rebates on extras never increase."

In many other cases, it was because the customer had not had cause to claim back very much over time.

"I am about to cancel my husbands gold level insurance. I worked out that he has spent approx $60,000 over 20 years and gets a discount on pair of glasses every couple of years and an annual dental check up!!!"

"I had private health insurance for about 20 years and used it only 2-3 times. I haven't had it for the past 20-odd years and haven't wished that I'd kept it up."

"I rarely drew on the insurance as my wife and I had generally good health."

As a part of this general sentiment, about 10 people observed that PHI used to be much better, and that its cost effectiveness has reduced over time, perhaps making it no longer worthwhile.

"I feel the insurance is covering less than it used to. Not sure if providers are charging more, or insurer is contributing less"

"In the beginning it was very beneficial. Over the years the benefits gradually declined whilst the proviso's and premiums rose."

"it is less useful than it used to be, I used to get the premium back in health treatment each year for my family. These days this does not occur. Some people save the money and invest it to use if they need treatment later on. Food for thought."

Save cash in the bank instead

Just like the previous comment, over 40 commenters noted that they had been better off (or would have been better off) cancelling their PHI and instead paying for private healthcare with their own funds, with the money they had saved by not paying the premiums.

"Over the years I have considered cancelling my health insurance but as I have got older I realise that I need cover more than in years gone by. Also I have paid such a huge amount of money for health insurance over the years I would be silly to cancel it now. I only wish I had set up a medical bank account and regularly deposited money into it over the years which would cover my medical expenses as well as earning interest."

"We have rarely been able to claim anything from Private Health Insurance in the past 20 years but have paid into it approximately over $70,000. Now as we are getting older the risk of needing it is higher but having our lives to live all over again we would have self insured."

Problems with PHI 2: out-of-pocket costs

The gap between what health providers charge and what the PHI provider refunds was the subject of almost 350 comments.

For most of these commenters it was the out-of-pocket costs beyond the premium excess that mattered. Some of these 'gap' payments ran into five figures.

"Partner had insurance supposed to cover everything. After a operation we were billed an extra 12000. Not worth anything"

"Costing $14,000 out of gap fees for Surgeon fees ,hospital admission fee within the financial year and anaesthetist fees."

"We have had two major health insurance claims this year. One involved out of pocket costs in excess of $18,000."

"I have had two spinal surgeries, in both cases I paid thousands of dollars cash in gaps (20,000 in total). I only keep insurance because the public system is impossible to negotiate and ensures prompt attention, but I worry about having sufficient money for any future gap."

Many such commenters felt hard done by that they had to pay large sums of cash when already investing in expensive PHI.

"From my perspective, I have two main concerns about private health insurance. First, the monthly cost, which keeps increasing. Second, despite having Gold Hospital Cover, I have had to pay a gap when myself or my wife have had to use this service. In some instances, such as when I had a radical prostatectomy for prostate cancer, I had to pay a gap of several thousand dollars."

"I am very frustrated at the out of pocket expenses for any type of treatment, hospital or extras, despite having top cover and paying for Medicare through my taxes. The gap expenses seem to be applied by all the service providers just so the needy public part with more of their much needed retirement funds."

"my knee replacement (both) cost me $14000 in spite of our top health cover."

This feeling of frustration was made still more acute when noticing that public patients – including themselves when seeking treatment at a public hospital – received care for free.

"You take out health insurance pay excesses and out of pocket expenses whereas public patients pay absolutely nothing Doesn't seem too fair of a system"

"We have recently switched from going directly to a Private Hospital in emergency situations to going to a Public Hospital due to the enormous gap we always needed to pay even though we had top hospital and extras cover, which in itself is a very expensive account to pay every year. Neither me nor my husband have ever been without top health insurance cover our whole lives."

"I paid for top hospital and extras private health insurance for over 40 years. I still got a $6000 bill for a hospital admission gap in a public hospital just BECAUSE I had private health insurance. The treatment would have been FREE if I had been uninsured."

People did not necessarily blame the PHI company for this problem. Many instead blamed the health providers themselves.

"Very concerned about the wide range of doctors "gap" fees - even with "gold" insurance cover. They are not transparent or publicly advertised. Eg knee replacement gap fee ranges form $300 to $5000 depending on doctor. I would like these fees to be publicly available on the internet so I can choose a doctor based on these fees rather than having to get a new referral from my GP, which is expensive and wastes time."

"The annoying thing is that when you have day procedures not only does your health insurance not cover certain things, but the specialists each charge a non-claimable fee. This is ridiculous that they can organize their holiday savings this way!"

For a few commenters, the hospital excess cost built into the agreed premium contract (rather than the gap payment added by the healthcare provider) was the problem.

"Not impressed with having to pay same excess for day surgery as overnight admission"

"excess a bit rich & paying for first night expensive."

The issue of out-of-pocket costs was not just relevant to hospital treatment. The low – and seemingly diminishing – refunds for extras services were also a source of frustration to people with PHI.

"Paying an awful lot of money and don't get much back. Dental is my bug bear. Husband can claim $400 a year because he still has most of his own teeth. I've had dentures for 60 years and I can only get $250 on a set of dentures, which usually last 13-15years, depending on quality. Over 15 years, he can claim $6000. I can claim $250 every 15 years. That would pay for a set of dentures. This should be changed, but they are making millions out of it."

"Mainly need dental. My cover is inadequate and doesn't give much back. My teeth are getting progressively worse."

"So far my only complaint is I need weekly physio appointments which keep me somewhat healthier lungs on which I only get a return of $29.00 for a $100.00 visit."

Problems with PHI 3: Coverage, confusion, and complexity

Just under 200 people commented on problems with what PHI policies covered, gaining clarity on what was covered, and obstacles to changing policies if coverage was inadequate.

Unable to tailor coverage

A prominent problem, mentioned by nearly 80 people, was the inability to tailor hospital or extras packages to simultaneously reduce costs and increase relevance of items.

Numerous respondents complained that they were paying for things they would never need (with obstetrics being the most common example) because those items were coupled with things they do need.

"Most areas in private health insurance have obstacles [for] example pregnancy and knee replacements are in the same category. So if you want to lessen the amount of the policy by not having pregnancy you would have to forgo knee replacements also. "Very shifty"."

"it's very expensive and it's not possible to have the things we need unless we are on the top level, and we don't need obstetrics etc. I'm fed up paying for things I don't need but knowing that I'll probably end up on the public system for the things I do need in the future e.g. joint replacement!"

"We are covered by all these extras not wanted makes the health insurance look good but the main thing wanted is a better optical and dental payout"

Insufficient coverage

An additional problem was the insufficiency of coverage. Some commenters noted private health insurance did not cover a specific health condition or treatment at all.

"It is very expensive and I do get frustrated by the number of preventative medical items that are not covered. An example is I have to do a heart stress test and it is not covered by Medicare or [private fund]"

"I have maintain a hormone replacement therapy as this helps me stay healthy and keeps my brain ticking along nicely. Part of this treatment is a combination hormone implant which is expensive. No private health organisation will help pay for the expensive part of my treatment because it is a combination drug. If it were separated, they would all contribute towards the cost of the implant."

"Whatever policy I have doesn't seem to cover my problem. For example, I switched for better dental coverage only later to need an iron transfusion that my previous policy would have covered but not this one, but the previous had been hopeless on dental, which had been my main concern then."

Items that people said were not covered by their policy, but should be, included: some scans, prescription medication, dermatology, urology, dentures, podiatry, mammograms, exercise classes, alternative medicine, post-hospital community packages, a radical robot prostatectomy, and seeing specialists in their rooms.

In other cases, commenters said their coverage was too limited to address a health issue adequately.

"the limits on payments totals is frustrating as they always seem to be reached e.g. glasses and pharmaceuticals and physiotherapy, quite early"

"Insurance cover even though I have highest extra cover but still can't get enough support for keeping my teeth in good. condition only can get one crown a year. As we age your teeth wear out !!"

"I would prefer extras to be a lump sum not allocations to different sectors eg I need regular physio not maternity or a massage. I can only see a periodontist twice a year tho my health requires more but I can get a refund for an extraction."

Policy complexity and confusion

Another problem was the complexity of policies, especially their fine print. Many commenters found it difficult to understand what was covered and what wasn't, and therefore what was claimable.

"Health insurance [list of providers] was worse than home, contents and car comprehensive insurances for providing an easily understood explanation of what the cover actually was. Claims were always a surprise."

"I found their policies were deliberately misleading and confusing. They claimed to cover for certain things but dodged and weaved when it came to claiming and only paid a fraction of the cost. In short, a very dishonest industry, only interested in profit."

Hard to change

For many commenters the complexity made changing policies or providers prohibitive, which meant they felt stuck with a situation they were unhappy about.

"The choice process for private health insurance is overly complex. The funds should have a legal obligation to advise when they have another product that is similar but cheaper."

"We have found that trying to make comparisons between companies is very difficult, especially for extras, as not the same information is revealed about particular types of therapies etc. One had to know exactly what item you want to compare to get the information, usually by phone after a long wait. So, basically given up!"

Nevertheless, some commenters said it was necessary to shop around regularly to get the most appropriate and affordable cover.

"I have moved our policies regularly in an attempt to mitigate the annual premium increases and ensure we have the right cover."

"Comparing policies is still time consuming, making shopping around a lengthy process. Loyalty to one insurer counts for nothing. Shopping around for all insurances is essential to keep insurance costs manageable."

Aside from the complexity, there were other reasons people could not or would not change, leaving them with a policy they do not want. These include wait periods imposed after a change, concern that a change would inadvertently result in no coverage at an urgent time, and the disruption it would entail.

"when changing insurers nothing was said about it being an effective upgrade and therefore involved a waiting period before we could claim on hearing aids at the level we had claimed previously."

"As I have had cancer, I'm not confident changing providers. I am concerned with cost ongoing."

"My husband has found [changing providers] difficult due to his dementia and so I won't be changing anymore."

Problems with PHI 4: Poor service

Around 100 commenters expressed dissatisfaction about other aspects of PHI providers' business models.

Communications and data

Just over 20 people wrote about adverse communication and data issues, such as face-to-face branches closing, poor phone or online communication services, or data breaches that had affected them badly.

"With [fund] which has been good, however they are closing their local office."

"Current private health insurer has abysmal service levels - on hold for at least an hour, often two hours, is the usual for calling them. There is an option to use messaging on their website, but messages are never answered. The website itself is terrible: information is incorrect; online claims for particular items are not available; and reports on claims history are no longer available. And yet premiums go up regardless of their incompetence."

"What can I say, Medibank! Confidentiality breeches. Now in a not for profit fund. Still expensive"

No loyalty discounts or no claims bonuses

Over 20 people felt disappointed that long standing customers did not receive a loyalty discount, especially when new members sometimes did receive one for joining.

"I do not agree with larger companies advertising that if you come and join them you will get first 8 weeks for free. what about the loyal customers who are not moving around from one fund to another - what do they get - no 8 weeks for free."

"gap should not exist for members who have paid for so many years"

"I'm very loyal to my health insurance provider. I'd LOVE to be reminded come renewal period the $ value of savings I'm being given for the years of membership. Because I can't be sure I'm being given a discount each year. So they should SEPARATELY ITEMISE the savings within the bill itself. Can you ask insurance companies to do this? Pretty please?! :-) "

In addition, over 20 people felt it would be appropriate to provide healthy members with a 'no claims' bonus, discount, or rollover.

"WHY cannot health funds give their customers a No Claims Bonus the same as car insurance, of say 10% discount on premiums in the case where the client has made no claims. I have made no claims in ten years but the cost keeps rising. I have asked my health fund [name] and they more or less scoffed at the suggestion. I also said it may stop them losing so many customers who can no longer afford health insurance."

"with the extra covers you should be able to roll over your unused claims i.e. I don't need new glasses every year so I should be able to roll over the unclaimed benefit for when I do need a new pair of glasses."

"I believe I should be rewarded for maintaining my good health generally because I never incur Hospital stays for ongoing medical conditions/diseases etc from year to year. I have not spent time in Hospital since 1977."

Unhelpful rules and useless bonus items

Around 20 people objected to other aspects of how policies are set up, including:

- how couples vs singles vs families are treated in policies;
- the 'penalties' for a member using their own healthcare providers rather than the fund's preferred providers;
- gimmicky items that seem a waste of premium dollars;
- that people can jump into membership to claim big costs then jump out again.

"I resent my single contributions being half of a married couple's, when their children have also benefited (with maternity/dental/medical etc). Married couples should pay more per child."

"Insured as a couple - annual limits should be couple based limits not per person"

"The rebates on extras is very poor unless you use the insurer's preferred suppliers. I have complained about this as my suppliers have all my medical history"

"There seems to be wastage or high level of benefits being paid out by funds on claims which are based on needs that are not justified. e.g. new spectacles/sunglasses every year. there are comparatively small benefits paid on more essential items e.g. hearing aids, CPAP machines and dentures."

"long term members do not get any more than those which join just before a procedure, do the mandatory waiting period, get the procedure done, get paid the benefit and then pull out of the fund. They then do the same the next time one of their family needs a procedure done. This type of activity increases the premium of those who are in the fund for the "long haul" and is totally unfair."

Other instances of poor service

Almost 30 people made more general comments about the level of service they have received (e.g. *"Most unsatisfactory"*, *"Over priced and under delivered"*), or gave specific examples of poor service.

"Had private health cover whole married with children. When I divorced, our health fund wouldn't give me the same cover/history for the price I had paid while married. I had to start all over as a new customer, so I more or less told them where to go. My ex husband was to continue the cover. Not very fair"

"Appalling. Phone contact staff have a "staff briefing sheet" like all insurance companies. Say no/deny all claims. Recent rejection of potential/possible claim by a clerical reception staff member based on an ambiguous company proforma on whether a possible diagnosis was to be claimed as a "Pre-existing medical condition" before the health cover was upgraded - 12 month waiting period. Additional Medical Certificate issued by the medical specialist - resubmitted, clerical decision then overturned and approved by the health insurance medical specialist. The structure and sequencing of the questions on the proforma was poorly constructed and was knowingly deceitful by the company. Many aged applicants would have given up and accepted the initial rejection by the first port of call by phone - insurance companies don't pay many legitimate claims [without] intervention"

"I have had moderate support through major events. I am concerned about the regular changes in cover which means I may not get this in future without cost increase that will not be sustainable"

Problems with PHI 5: Didn't get the expected benefit

One downside of PHI was when it did not produce an expected benefit at all.

Private cover not a guarantee

Over 30 people commented that despite their cover, they did not receive the benefits they thought they were paying for and expected to receive with PHI.

This included access to specialists (or priority access compared to public patients):

"found it hard to get into hospital or specialist even with private"

"the worst case scenario, if life or death the public medical system will accept you, and in some cases you'll get the top specialist or surgeon anyhow"

It included access to private rooms or private hospitals:

"Even though we have top cover, for one operation I was put into a shared room, when I was entitled to a private room. Was not happy about it."

"disappointed that certain private hospitals do not always have private beds available"

It applied to waiting times:

"essential in canberra as public hospital and public care have long waiting times. However even with private cover some specialists have long waiting time"

"The idea of easy access to private professionals due to health insurance is not that valid. I have had to wait months to access to a specialist for items needing 30 day attention."

It applied to the expectation of receiving better quality healthcare through the private system:

"When I needed a laminectomey, the Specialist insisted it could only be done in a private hospital; cost me $20,000; I would never recommend that hospital to anyone. [Staff issues], it was dirty, I had to fight to get my medicine, and there was no aftercare. By contrast, I had my hip replacement in [public hospital], no charge, brilliant staff, straight to aftercare hospital. My husband had Pulmonory Fibrosis. Private specialist was useless. Transferred to [public clinic], where the service and support was excellent right up until his death. Again, no charge"

"Paying out of pocket after having top cover, it is probably better to just go public. The care is just as good and sometimes better."

It also applied to care they hoped was covered but was not:

"People join hospital funds for the surgery, wait the required time (usually a year) and then find fees have increased and it's unaffordable to continue."

"Public health provides everything. Private health will not."

Location issues

For 10 people who lived in regional, rural or remote areas there was no point in getting PHI (or it was not value for money) because they would have access to the same health facilities and personnel as public patients and no options to access some benefits at all.

"Living in rural NSW, discussed Health Insurance with my GP who said it was a waste of money because we would be taken to a Base Hospital where we would get that same care and Doctors as those with cover."

"When you live in a rural area and you are sick or injured, you don't have a choice of doctors - you get who is available. You are treated in the same rooms, exactly the same as a 100% publicly funded patient. There are very few service providers that supply access to the "extras". Drs and Medical providers advise you not to use your Private Health care card as it will cost you more in out-of-pocket expenses on top of your annual insurance fee."

"[PHI fund] promotes their [program] so customers can reduce their costs. But [program] is not available everywhere, certainly not in regional areas."

Interestingly, some of these regions were identical to those from commenters who said PHI was essential for their region (as noted in a previous section above), for example north Queensland. This perhaps suggests PHI is necessary but poorly serviced in such places.

"[PHI FUND] IS VERY IMPORTANT LIVING IN FAR NORTH QLD."

"For the benefits received in Nth QLD, private health insurance is too damned expensive."

Problems with PHI 6: General gripes and principled objections

Finally, over 110 commenters expressed general dissatisfaction with the PHI industry.

General disgruntlement

Most of these people expressed unhappiness about PHI businesses. This number includes many who simply used colourful language to describe PHI providers, using phrases such as 'theft' or 'a con'. Sixteen people used the phrase 'rip off'.

"Private health insurance is legal money laundering by white collar criminals"

"Nothing else to say other than they are thieves"

"It's a government organised rip off which steals massive amounts of wasted bureaucratic money from healthcare."

"Rip off merchants 101."

Others questioned if PHI was still worthwhile. Some simply did not need it.

"I just didn't need to be paying for insurance when I don't go to doctors or have any big needs to cover"

"Had private health cover for most of my life until about 18 months ago - not worth it anymore!"

"Too many people are opting out making it harder and harder to keep private hospital cover"

"Can't trust this Government to not change the rules"

Public not private

Some of these commenters expressed their objection to the concept of PHI and reiterated their support for public healthcare, or at least not-for-profit PHI funds. Profit as a motivator in the PHI industry was a reason for dissatisfaction.

"Private health insurance is too expensive and I don't think we should need it in Australia. I'd rather the money that the government gives to private health funds went into the public system that services all people!"

"I fail to see the point of private, for profit, insurance companies. Insurance is the best example of a legalised Ponzi scheme. The not for profits are constantly squeezed by large private insurers, In an attempt to drive the NFP's out. Health is not optional or for sale."

DROPPING PRIVATE HEALTH INSURANCE

NSSS-12 respondents who did not have PHI currently (n=849) were asked whether they had PHI previously, and 72% of them did have it at some point. There were no significant demographic differences between those who did and who did not have PHI in the past.

Those who did have PHI at some point were asked to select one or more reasons for dropping PHI. The proportions selecting each option are presented in Figure 10. The text responses provided for 'other reason' are presented in Appendix 5.

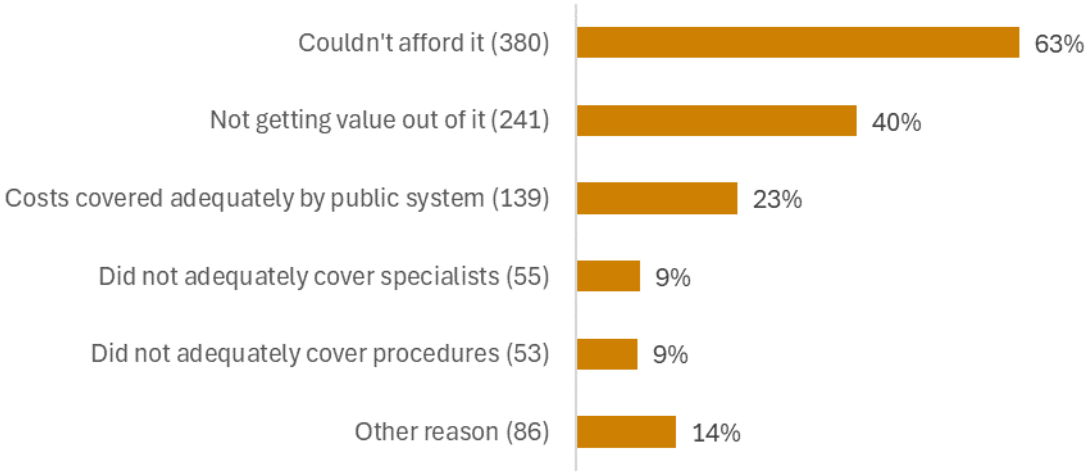

Figure 10. Reasons for dropping PHI (n=602)

Comments about dropping PHI

Almost 250 of those who used to have PHI but dropped it wrote a comment in the open-ended question about PHI.

Examining the major themes of their comments gives us some further insight into the reasons why. Compared to 'keepers', 'droppers' were strongly over-represented in comments about:

- Out of pocket expenses
- General disgruntlement about PHI
- Not needing PHI
- The cost of premiums
- Not receiving expected benefits.

Note, however, that it was often not clear when the respondent had dropped their PHI. Some commenters mentioned dropping it when Medibank was created in 1975, others in 2024, and still others at various points during the half century in between. Because the drop date is often unknown or occurred decades ago, caution must be exercised when interpreting the significance of dropping PHI for the current policy landscape.

Examples of comments from people who have dropped their PHI are reproduced next pages. Their sentiments do not differ markedly from other complaints about PHI.

Dropped because of out-of-pocket expenses

"I was a continuous Health Fund member at the top levels from 1966 to I stopped in 2024. Over the years my claims were negligible. I did make an inquiry on what I would get back for a knee replacement and to my horror found that despite having top cover for that, my known out of pocket expenses would exceed $10,000. So I wondered why it was worth even being in the Fund. I also found that the 'extras' were a waste of premiums. You never ever got back what you paid in premiums in any year. When you did claim, the rebate was capped and you were miles out of pocket."

"After my husband and son both had a day surgery procedure 30 years ago I got a bill to pay asap gap payment of $1800. I could not afford that so we ceased private insurance, which was already a struggle to pay for."

"When we had it we had to pay big for an op that they had not showed us as we were under insured. Stopped after that."

Dropped with general disgruntlement

"Blood from a stone!"

"It's a scam. Pay an extra 200 to cover a possible $230 extra in claims."

Dropped because did not need PHI

"I was 30 when I dropped out of PHI. If I need glass's or dentist, I just pay for it as needed. I wouldn't have got the value out of PHI. That money went towards paying my home off."

"I had Private Health until I was about 50. As I have Refractory Coeliac Disease, I was going to a Public Hospital."

"My local public hospital is well-staffed with good doctors and nurses; if I need private hospitalization I have enough money set aside to pay for it."

Dropped because of the cost of premiums

"a 6 month period of unemployment meant dropping health insurance"

"Once I stopped working full time and became a pensioner private health insurance became unaffordable"

"I gave up work to look after my parents. On returning to the workforce I would have had to pay a lot extra because of my age even though I saved the government thousands of dollars looking after my parents."

"Private health insurance is too expensive and when i used it incurred a gap fee that could considerable strain on my financial situation, so we dropped it. It was a bill at the time when we had children, extensive bills eg house (interest rates were very high), food, supposedly free education. Raising children was very expensive. So there was no room for health insurance. And when we could finally consider it, we were told we had to pay more because we were over 30 years of age. Go figure, how is this helpful?"

Dropped because did not receive expected benefits

"My late wife needed hospitalisation but the local private hospital would not take a non-ambulant patient [. . .] I was disgusted and did not renew the policy."

"Private health care is a rip off because no matter how much u pay they don't cover a lot of things & it doesn't guarantee a bed if there isn't one available"

"I opted out of health insurance after a diagnosis of two problems led to surgery in a private hospital that imposed a $14000 excess and only addressed one problem. When the diagnosing specialist remarked that she considered the surgeon negligent, she offered to arrange surgery as a public patient. I expressed concern about waiting times which she advised were 6-8 weeks. I had waited 4 months for private treatment. The care in the private hospital and by the surgeon was of an appallingly poor standard and there was no aftercare. I subsequently had surgery as a public patient and the care was first-class in every way, including diligent aftercare. I withdrew from private health insurance concluding it was of no value. I would like to have insurance now but the government policy of imposing higher costs for folk who went without it for a period makes the cost prohibitive."

"Dropped private health insurance about 45 years ago, and started saving the funds into a bank account rather than giving it to an insurer so they could make a profit. We kept good health as a family, and my wife and I still do so now. The bank account has over 38,000 dollars in it, and we stopped paying into it when it started to adversely affect our entitlement to a part-pension from our illustrious government !!"

DISCUSSION

There is support for PHI

Our study found that a majority of older people in the survey have PHI, with only 19% having no cover at all.

Seventy-six percent of respondents had hospital cover which is a much higher proportion than the 53% for the 50+ age group estimated using data from APRA and the ABS (APRA 2024, ABS 2023). Given our survey shows clearly that income and wealth are strongly associated with PHI cover, we assume our survey population skews towards a wealthier older cohort more able to afford PHI.

Regardless, even among respondents with limited means, PHI was highly valued.

Our survey respondents are more likely to hold hospital cover at the gold or silver level. These are more expensive and provide stronger cover than bronze or basic level options.

Our respondents are also more likely to hold gold or silver extras cover, with many holding higher levels of cover (gold or silver) for both.

Commitment to maintaining cover, but at a price

It is clear older people value private health given that 96% of respondents said they believed it was important to maintain.

However, with half of the respondents saying they may need cost-saving strategies to keep it, it is also clear this is not a *fait accompli* for older people.

Notably, those dependent on the Age Pension as their sole income source were more likely than others to consider cost-saving strategies to assist with maintaining PHI. Given this, it is clear that full pensioners should be a target for assistance to maintain adequate PHI cover.

Government and insurers should be concerned that people feel they must drop their level of cover simply to maintain it. This reduces the revenue pool and means worse outcomes for policy holders and hence for public health. If reducing cover forces people into the public system this could put further strain on the public purse.

It should also not be assumed that people will be able to foot the bill when facing higher out-of-pocket expenses in private because their cover has been downgraded.

Equally we should be concerned if older people are forgoing other essentials just to maintain PHI cover.

Many respondents noted that premiums routinely increase each year while the expenses that are covered by PHI stay level or even reduce.

This not only makes premiums less and less affordable. It also increases the out-of-pocket costs, for both extras and hospital care.

Out-of-pocket costs were not just a concern for people who had reduced cover levels either. Some respondents with top cover also complained about the huge dollar amounts they had to pay for aspects of their healthcare not covered by their PHI.

In some cases, people's out-of-pocket expenses have run into five figures for hospital procedures. This is affordable only by a select few.

Associations with age, partner status, income, housing and health

Older people appear to be less likely to have extras-only cover at older ages. In addition, the balance of hospital-only cover increases with age relative to combined hospital and extras. This implies that people prioritise hospital cover as they age and see less value in covering non-hospital medical costs. Again, given the survey population skews towards a wealthier cohort we have to be careful with generalising these assertions to the wider older Australian population.

Lower proportions of single older people had any PHI cover at all than older couples. This may simply be a matter of affordability, with singles having less access to financial resources. Alternatively, it may be that single older people are more likely to take their chances with the public hospital system while couples want to look out for each other's wellbeing. In support of the latter interpretation, some comments revealed that hospital cover was primarily for a respondent's spouse because of their health status.

The results show that wealth in the form of income, savings, and home ownership strongly impacts on whether a person has or doesn't have PHI. As we might expect, and consistent with previous research (e.g., COTA 2017a, 2017b; Temple and Adair, 2011) as well as many of the NSSS-12 comments, this implies that cost and value issues are of paramount importance in determining PHI coverage.

However, one other factor – self-reported health status – also showed a very strong association, with those reporting being in good health much more likely to have PHI than those in poor health. This could imply that people in poorer health do not see value in PHI given their situation. This interpretation is supported by some comments from people with poor health who were dependent on public sector healthcare, and also by comments indicating some conditions and treatments are not covered by PHI at all.

Alternatively, the association between poor health and less likelihood of having PHI may be one of reverse causation where long term lack of PHI has led to poorer health outcomes, for example because of long waiting times.

A valuable necessity for some

It was clear from the free text responses that there are many reasons why older people value their PHI.

For example, respondents told us they value PHI because it helps them to address a specific health condition, or the increasing health risks associated with ageing; because it delivers desirable benefits such as choice of doctor or private rooms; because it meets emotional needs such as peace of mind; or for other practical or philosophical reasons.

While the reasons for having PHI were sometimes framed in negative terms like 'a necessary evil' or were related to the push-pull pressures of a policy lock-in, it is obvious that having PHI is desirable for many older Australians.

Negative experiences for others

However, not everyone felt positively about PHI. Around the same number of commenters made negative remarks as positive, and many expressed both sentiments in their comments, indicating very mixed views.

Many respondents who do have private health are aggrieved by it.

At the top of the list of complaints, not unexpectedly, were premium costs and the (sometimes large) out-of-pocket expenses associated with PHI.

Related to this were complaints from people who did not get the benefits they expected from their cover. Many were understandably frustrated by this and left wondering why they had PHI.

Others were angry at the poor coverage, complexity, or confusing nature of their policies.

Again, these priorities are consistent with previous research into older Australians' grievances with PHI (COTA 2017a, 2017b; Temple and Adair, 2011).

At the same time, some older people who do not have PHI have negative feelings towards it. A large proportion of these used to have it and dropped it. Drilling into the comments of 'droppers' and those who have never had PHI, we can see that some people simply believe PHI's cost is not worth the return, or that it is not a desirable way of achieving public health outcomes, and therefore they do not have it.

However, dropping it (or not having it) was not a choice for everyone as the comments show. Some respondents said they would like to have PHI but cannot afford it, whether because of premiums, out-of-pocket costs, the LHC loading, or all of the above.

Older people and the LHC loading

With respect to the LHC loading, numerous comments described scenarios in which respondents could afford to pay standard PHI premiums now, but the additional cost of the LHC loading now makes the premiums unaffordable. The loading is on average higher the older one gets, and is imposed for a ten-year period, so poses a significant cost for older people. Several of the respondents commenting on it were people who would have purchased PHI earlier in life if they could have (consistent with the policy's intention), but they could not afford it then because of high mortgage rates, dropping work to pursue caring responsibilities, unemployment, single parent status, migrating to Australia later in life, or other understandable reasons.

LHC is potentially problematic for people who were not financially well-off earlier in life, even if they have more now.

A 2023 government-sponsored review of aspects of the PHI system, which included LHC within its scope, seems to have agreed with this point. It argued LHC (or something like it) is important to disincentivise people from only taking out PHI when their likelihood of needing expensive healthcare is higher. But the review also recognised the dilemma faced by people whose means had changed dramatically across their life course. The reviewers wrote:

> There are sound reasons for the incentive to vary according to age of entry, and to have a maximum loading, to maintain access at all ages. *It is also necessary to have special rules in cases where people might reasonably take out cover at other ages, for example, due to migration.* Options which remove any of these features are simpler, but *test poorly against other criteria such as equity.* (Finity Consulting, 2023, p5, our emphasis)

Despite this point, the review did not recommend any changes to LHC. However, its methods did not incorporate an investigation of older people's life experiences to highlight equity issues with the current policy.

Future reviews might do so to ensure equity questions are explored thoroughly.

Increasing the PHI Rebate for lower-income older people

In lieu of any change to LHC, one policy strategy that would help make PHI affordable for a greater number of older people is to enact select increases to the PHI Rebate.

This short-term change could also help existing policy holders to retain their membership.

As mentioned above, the Department of Health and Aged Care has recently been investigating aspects of private health insurance, specifically the effectiveness of the regulatory settings for the Medicare Levy Surcharge (MLS), the PHI Rebate, and LHC (DHAC, 2023).

One of the specific findings of the review was that PHI Rebates for older people provide value for government (Finity Consulting, 2023).

It recommended that the PHI Rebate could be increased for lower-income older people as an effective way to maintain coverage.

Given our survey showed that low-income and low-wealth seniors are less likely to have private health insurance and more likely to consider downgrading or dropping their cover, this policy change may be beneficial – if targeted correctly.

The need for reform of the private health system

As the survey results show, a large proportion of older people clearly value PHI, but many are dismayed by its apparent lack of value. This suggests the need for bigger, longer-term changes.

In some cases, the cost and lack of value are driving older people to drop their cover, or to modify their cover or other spending simply to hold onto it. None of these strategies are desirable as they impact on health and wellbeing at an increasingly vulnerable time in life.

In addition, if older people exit the private health system this could have negative impacts on the sustainability of both the private and public health systems. As we noted in the Background section, the proportion of Australians with hospital cover has only been maintained in recent years because of an increase in older people purchasing it, since younger people are dropping it in large numbers (Duckett and Nemet, 2019). Older people exiting would therefore be a disaster for the system as it stands.

Clearly there is a need for ongoing reform of private health, which can only happen if attention is focused on the system as a whole.

Debates about the operation of the private health system, including the efficiency and cost of private health insurance, are ongoing.

The Productivity Commission (through its precursor organisation) last undertook a full review of private health insurance in the late 1990s (Industry Commission, 1997). There have been several government and industry reviews and processes since, including:

- The ACCC's annual reports to the Australian Senate over 25 years analysing key competition and consumer developments and trends in the private health insurance industry that may have affected consumers' health cover and out-of-pocket expenses;
- Reports of the Private Health Insurance Ombudsman;

- The Private Health Ministerial Advisory Committee (2016 – 2018), charged with reviewing all aspects of private health insurance and providing advice to government on reform; and
- A 2017 Senate inquiry into the value and affordability of private health insurance and out-of-pocket costs (The Senate, 2017).

With consumer confidence in the private health system low and the risk of diminishing value to consumers undermining coverage, it is important that governments seek to ensure ongoing reform and innovation in the sector.

Prior to the federal election in 2018, Federal Labor proposed that the Productivity Commission would conduct a full review of the private health insurance system. However, this policy was not part of the Labor platform during the 2022 election when it won office.

A full Productivity Commission review of the private health system – not just insurance but medical and hospital fees and charges – would help to understand what policy options could be enacted to improve the system.

The health of us all depends on it.

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APPENDICES

Appendix 1: Survey questions analysed in this report

The NSSS-12 contained a set of questions addressing private health insurance which provided core data for this report.

Question 1

Do you currently have private health insurance?
Please select the response that best describes your circumstances

- No, I don't have any form of private health insurance [skip to Q7]
- Yes, I have hospital cover and extras
- Yes, I have hospital cover only
- Yes, I have extras cover only
- Unsure [skip to Q9]
- Prefer not to say [skip to Q9]

Question 2 (for those with hospital cover)

What level of hospital cover do you have?

- Gold or Gold-plus
- Silver or Silver-plus
- Bronze or Bronze-plus
- Basic or Basic-plus
- Unsure
- Prefer not to say
- Other (please specify)

Question 3 (for those with extras cover)

What level of extras cover do you have?

- Top level extras
- Medium extras cover
- Basic extras cover
- Ambulance only cover
- Unsure
- Prefer not to say
- Other (please specify)

Question 4 (for all respondents with private health insurance)

How important is it for you to maintain your private health insurance?

- Very important
- Somewhat important
- Not so important
- Not at all important
- Unsure
- Prefer not to say

Question 5

How likely are you to maintain your current level of private health insurance over the next 12 months?

- **Very likely** to maintain my current level of private health insurance over the next 12 months
- **Somewhat likely** to maintain my current level of private health insurance over the next 12 months
- **Somewhat unlikely** to maintain my current level of private health insurance over the next 12 months
- **Very unlikely** to maintain my current level of private health insurance over the next 12 months
- **Unsure** about maintaining my current level of private health insurance over the next 12 months
- **Prefer not to say**

Question 6

Are you considering any of the following cost-saving strategies to maintain private health insurance? *Please select all that apply*.

- I don't need any cost-saving strategies to maintain private health insurance
- Increasing my hospital excess to reduce premiums
- Dropping my level of hospital cover (for example from silver to bronze cover)
- Dropping or reducing extras cover
- Shopping around for a cheaper premium
- Reducing spending on other living costs (for example on transport, groceries, entertainment, etc.)
- None of these options will help me
- Prefer not to say
- Other (please specify)

Question 7 (only for those who indicated they do not have private health insurance in Q1)

Have you ever had private health insurance?

- Yes
- No
- Unsure
- Prefer not to say

Question 8 (only for those who used to have private health insurance but do not now)

Why did you drop your private health insurance? *Please select all that apply*.

- I was not getting the value out of it
- I couldn't afford the premiums
- I believe my medical costs will be adequately covered by the public system
- My policy did not adequately cover specialist consultations
- My policy did not adequately cover medical procedures such as scans
- Other (please specify)

Question 9 (for all respondents)

Please use the box below to tell us more about your decisions and experiences with private health insurance if you would like to.
[Free text response box]

Appendix 2: Survey sample demographics

This table presents sociodemographic information about the 4564 NSSS-12 participants who responded to at least one question analysed in this report.

Table S1. Demographic traits of private health questions respondents

Respondent characteristics (n=4564)	Number	Percent of total n*
Age group		
50-64	453	9.9
65-74	2269	49.7
75-84	1614	35.4
85-plus (oldest respondent 99 years)	200	4.4
Gender		
Women	2444	53.5
Men	2089	45.8
Non-binary or other or prefer not to say	15	0.3
Education level		
Schooling to year 10	626	13.7
Schooling to year 12 and/or other certificate or diploma	1834	40.2
Bachelor's degree or higher	1914	41.9
Self-rated health		
Excellent	571	12.5
Good	2512	55.0
Fair	1154	25.3
Poor or very poor	296	6.5
Savings (including superannuation)		
<$10k	386	8.5
$10k-$50k	427	9.4
$50k-$100k	326	7.1
$100k-$200k	362	7.9
$200k-$350k	384	8.4
$350k-$500k	349	7.6
$500k-$750k	440	9.6
$750k-$1.5M	602	13.2
> $1.5M	445	9.8
Unsure/prefer not to say	817	17.9
Fully retired	3896	85.4
Age Pension only as income	478	10.5
Partnered and living together	2814	61.9
Housing tenure		
Own outright	3423	77.5
Own with mortgage	420	9.5
Renting or other	575	13.0
Membership of one or more diversity groups**	976	21.4

* Percentages do not add up to 100% because respondents did not have to answer all questions.
**Diversity groups included: Aboriginal, Torres Strait Islander & First Nations people; LGBTI (lesbian, gay, bi, trans, gender diverse & intersex) people; people from a CALD (culturally & linguistically diverse) background; people living in a remote or rural area; people living with disability & disabled people; veterans. The survey also asked respondents whether they lived in a regional area, and 1229 (28.5%) did so. They are not included in the diversity numbers above unless they belonged to a diversity group listed above as well.

Appendix 3: Supplementary tables

3.1 Levels of hospital and extras cover

Those with private health insurance were asked to identify their level of hospital and/or extras cover.

Table S2. Levels of cover in group with hospital AND extras cover (n=3051)

LEVEL HOSPITAL COVER		
gold or gold plus	51.7	1,580
silver or silver plus	35.1	1,072
bronze or bronze plus	3.6	110
basic or basic plus	3.5	106
unsure	4.6	142
prefer not to say	0.7	22
other	0.9	26

LEVEL EXTRAS COVER		
top	57.4	1,750
medium	24.8	755
basic	12.5	380
ambulance only	0.2	6
unsure	3.8	117
prefer not to say	0.8	23
other	0.7	26

Table S3 shows the proportions of respondents with each cover level for combined hospital and extras.

Table S3. Hospital and extras combination proportions

HOSPITAL & EXTRAS COMBINATION		
gold hospital & top extras	45.9	1,276
gold hospital & medium extras	7.2	200
gold hospital & basic extras	2.5	70
silver hospital & top extras	14.1	393
silver hospital & medium extras	16.8	468
silver hospital & basic extras	5.9	163
bronze or basic hospital & top extras	0.8	22
bronze or basic hospital & medium extras	2.2	62
bronze or basic hospital & basic extras	4.4	123

Proportions for those with only hospital cover or only extras cover are presented in tables S4 and S5.

Table S4. Levels of cover in group with hospital cover only (n=401)

LEVEL HOSPITAL COVER		
gold or gold plus	36.1	146
silver or silver plus	38.2	154
bronze or bronze plus	6.2	25
basic or basic plus	10.1	41
unsure	7.7	31
prefer not to say	0.2	1
other	1.5	6

Table S5. Levels of cover in group with extras cover only (n=214)

LEVEL EXTRAS COVER		
top	29.4	63
medium	26.6	57
basic	38.8	83
ambulance only	0.9	2
unsure	2.3	5
prefer not to say	0.9	2
other	0.9	2

3.2 Priority of private health insurance

Table S6. Importance of maintaining private health insurance

RESPONDENTS n=3676		
very important	76%	2,786
somewhat important	20%	733
not so important	2%	75
not at all important	1%	24
unsure	1%	49
prefer not to say	-	3

Table S7. Likelihood of maintaining current level of private health insurance over next 12-months

RESPONDENTS n=3676		
very likely	84%	3,088
somewhat likely	11%	420
somewhat unlikely	2%	80
very unlikely	1%	25
unsure	2%	56
prefer not to say	0%	7

Appendix 4. Multiple logistic regression models

Chi-square tests determined the selection of variables included in multiple logistic regression models. A relevant sociodemographic variable was included if the differences between groups for the binary outcome variable was significant at p<.05.

All variables in analyses were ordinal or categorical. 'Don't know or prefer not to say' responses were coded as missing for all tests of difference or association between variables.

Table S8. Associations between NSSS-12 respondents' sociodemographic characteristics and having any PHI

PHI vs no PHI	Odds ratio	Std. err.	z	p-value	95% confidence Interval of OR	
age group	1.27	0.09	3.57	0.000	1.11	1.45
binary gender	0.68	0.07	-3.93	0.000	0.56	0.82
partnered	1.34	0.13	2.91	0.004	1.10	1.62
Age Pension as sole income	0.48	0.06	-5.79	0.000	0.38	0.62
savings	1.52	0.06	11.43	0.000	1.42	1.64
health	0.85	0.06	-2.24	0.025	0.74	0.98
housing cost	0.51	0.05	-6.81	0.000	0.42	0.62
constant	2.19	0.55	3.13	0.002	1.34	3.59

PHI is 27% more likely in older than younger age groups; 32% less likely in women than men; 34% more likely for partnered than unpartnered people; 52% less likely for those with Age Pension as sole income;52% more likely for those with higher savings; 15% less likely for those in poor or very poor health; 49% less likely for people with ongoing housing costs (rent or mortgage).

Outcome variable
Private health insurance (PHI) : 0=no PHI; 1=have PHI

Demographic variables
age group: 1=50-64; 2=65-74; 3=75-84; 4=85-plus
binary gender: 1=women, 2=men;
partnered: 0 not partnered,1 partnered;
AP (Age Pension) as sole income: 0= other income/AP-plus other income, 1=AP sole source of income
savings: 1=up to $100k, 2=$100k-$350k, 3=$350-$500k, 4=$500k-$750k, 5=$750k-plus;
health: 1= good or excellent health, 2=fair, 3=poor/very poor
housing cost 0= home owned outright; 1=housing costs (rent or mortgage payments)

Table S9. Associations between NSSS-12 respondents' sociodemographic characteristics and having combined hospital & extras cover

Combined cover vs hospital OR extras cover only	Odds ratio	Std. err.	z	p-value	95% confidence Interval of OR	
age group	1.20	0.09	2.41	0.016	1.03	1.39
binary gender	1.25	0.14	2.04	0.041	1.01	1.55
partnered	1.25	0.14	2.02	0.043	1.01	1.56
Age Pension as sole income	0.58	0.10	-3.17	0.002	0.41	0.81
savings	1.13	0.04	3.43	0.001	1.05	1.21
health	1.10	0.10	1.05	0.295	0.92	1.31
housing cost	0.85	0.11	-1.26	0.208	0.67	1.09
constant	1.35	0.37	1.1	0.272	0.79	2.33

Combined cover is 20% more likely in older than younger age groups; 25% more likely in men than women; 25% more likely for partnered than unpartnered people; 42% less likely for those with Age Pension as sole income; 13% more likely for those with higher savings. Health status and having housing costs were not significantly associated with having combined hospital & extras cover.

Outcome variable
Having combined hospital and extras cover : 0=no combined cover; 1=combined cover

Demographic variables
age group: 1=50-64; 2=65-74; 3=75-84; 4=85-plus
binary gender: 1=women, 2=men;
partnered: 0 not partnered,1 partnered;
AP (Age Pension) as sole income: 0= other income/AP-plus other income**,** 1=AP sole source of income
savings: 1=up to $100k, 2=$100k-$350k, 3=$350-$500k, 4=$500k-$750k, 5=$750k-plus;
health: 1= good or excellent health, 2=fair, 3=poor/very poor
housing cost: 0= home owned outright; 1=housing costs (rent or mortgage payments)

Table S10. Associations between NSSS-12 respondents' sociodemographic characteristics and considering strategies to maintain PHI

Maintaining PHI over next 12-months	Odds ratio	Std. err.	z	p-value	95% confidence Interval of OR	
age group	0.62	0.04	-7.97	0.000	0.55	0.70
binary gender	0.73	0.06	-3.66	0.000	0.62	0.86
partnered	1.46	0.13	4.09	0.000	1.22	1.74
Age Pension as sole income	1.78	0.33	3.15	0.002	1.24	2.56
savings	0.75	0.02	-10.17	0.000	0.71	0.79
health	1.47	0.11	5.24	0.000	1.28	1.70
housing cost	1.51	0.17	3.69	0.000	1.21	1.87
constant	0.62	0.04	-7.97	0.000	0.55	0.70

Considering cost saving strategies to maintain cover is 38% less likely older age groups; 27% less likely in men than women; 46% more likely for partnered than unpartnered people; 78% more likely for those with Age Pension as sole income; 25% less likely for those with higher savings; 47% more likely for those with poor or very poor health; 51% more likely for people with with ongoing housing costs (rent or mortgage).

Outcome variable
Having strategies to maintain PHI over 12-months : 0=no PHI; 1=have PHI

Demographic variables
age group: 50-64; 65-74; 75-84; 85+;
binary gender: 1=women, 2=men;
partnered: 0 not partnered,1 partnered;
AP (Age Pension) as sole income: 0= other income/AP-plus other income**,** 1=AP sole source of income
savings: 1=up to $100k, 2=$100k-$350k, 3=$350-$500k, 4=$500k-$750k, 5=$750k-plus;
health: 1= good or excellent health, 2=fair, 3=poor/very poor
housing cost: 0=home owned outright; 1=housing costs (rent or mortgage payments)

Table S11.1 Associations between NSSS-12 respondents' sociodemographic characteristics and likelihood of providing comment as text response (only respondents who have PHI)

Commenters vs non-commenters	Odds ratio	Std. err.	z	p-value	95% confidence Interval of OR	
age group	0.96	0.05	-0.75	0.453	0.86	1.07
binary gender	0.85	0.07	-1.97	0.049	0.72	1.00
partnered	1.05	0.09	0.57	0.569	0.89	1.24
Age Pension as sole income	1.02	0.16	0.14	0.886	0.75	1.39
savings	0.98	0.03	-0.86	0.389	0.93	1.03
health	1.37	0.09	4.67	0.000	1.20	1.57
housing costs	0.96	0.10	-0.45	0.654	0.78	1.17
Intention to maintain PHI	0.48	0.11	-3.13	0.002	0.31	0.76
constant	1.85	0.55	2.06	0.040	1.03	3.33

Commenters were 37% more likely than non-commenters to be in poorer health and 52% less likely to intend maintaining their PHI at current levels for the next 12 months.

Outcome variable
Commenters vs non-commenters : 0=no PHI comment; 1=provided PHI

Demographic variables
age group: 1=50-64; 2=65-74; 3=75-4=84;5= 85+;
binary gender: 1=women, 2=men;
partnered: 0 not partnered,1 partnered;
AP (Age Pension) as sole income: 0= other income/AP-plus other income**,** 1=AP sole source of income
savings: 1=up to $100k, 2=$100k-$350k, 3=$350-$500k, 4=$500k-$750k, 5=$750k-plus;
health: 1= good or excellent health, 2=fair, 3=poor/very poor
housing cost: 0= home owned outright; 1=housing costs (rent or mortgage payments)
intention to maintain PHI: 0= not maintaining PHI, maintaining PHI over next 12-months

Table S11.2 Associations between NSSS-12 respondents' sociodemographic characteristics and likelihood of providing comment as text response (all respondents)

Commenters vs non-commenters	Odds ratio	Std. err.	z	p-value	95% confidence Interval of OR	
age group	0.83	0.10	-1.62	0.11	0.66	1.04
binary gender	1.28	0.21	1.51	0.13	0.93	1.77
partnered	0.90	0.15	-0.61	0.54	0.65	1.25
Age Pension as sole income	0.90	0.18	-0.53	0.60	0.61	1.32
savings	1.12	0.08	1.63	0.10	0.98	1.28
health	0.99	0.12	-0.08	0.93	0.78	1.25
housing costs	0.99	0.17	-0.08	0.94	0.71	1.38
had PHI in the past	1.35	0.24	1.68	0.09	0.95	1.91
constant	0.58	0.27	-1.18	0.24	0.24	1.43

When sociodemographic factors were accounted for, there were no significant associations between providing a text response and having dropped PHI.

Outcome variable
Commenters vs non-commenters : 0=no PHI comment; 1= provided PHI comment

Demographic variables
age group: 1=50-64; 2=65-74; 3=75-84; 4=85+;
binary gender: 1=women, 2=men;
partnered: 0 not partnered,1 partnered;
AP (Age Pension) as sole income: 0= other income/AP-plus other income**,** 1=AP sole source of income
savings: 1=up to $100k, 2=$100k-$350k, 3=$350-$500k, 4=$500k-$750k, 5=$750k-plus;
health: 1= good or excellent health, 2=fair, 3=poor/very poor
housing cost: 0= home owned outright; 1=housing costs (rent or mortgage payments)
had PHI in the past: 0=currently have PHI, 1= had PHI in the past

Appendix 5. Text responses to the 'other' options

Four survey questions allowed respondents to tick an 'other' option from a set list and then invited them to specify details.

1. Cover level – 'other' comments

Questions 2 and 3 about hospital and extras cover levels both had the option of an 'other' response with a comment box.

Forty-seven people used the comment box for one or both of these questions. However, the comments themselves were mostly not informative.

A lot of comments simply conveyed the respondent's uncertainty about their level of cover in a technical sense, or mentioned a level or specific product line that is different from our set options (e.g. *"either medium or top"*). The lack of clarity on these, and the diversity of products in the market that respondents could be referring to, makes it risky to attempt to recode responses to fit our preset options. In addition, the diversity of these responses means it is not meaningful to summarise across the commenters.

A few commenters wrote general remarks on PHI, but this topic is more meaningfully covered in the analysis of comments written in response to Question 9.

Some respondents specified that they had a DVA gold card, suggesting they did not have PHI at all, but that is unclear too.

Overall, the eclectic and ambiguous nature of these 'other' comments led to the decision not to conduct any formal analysis of them.

2. Cost-saving strategies – 'other' comments

Question 6 asked respondents if they were considering any strategies to save on costs for PHI. They were given options in a set list, and also a free text 'other' option.

There were 80 meaningful comments written in response to this question.

In almost half of these comments, commenters discussed cost-saving strategies already listed among the set answer options.

Cost-saving strategy set option	Comments
Increase hospital excess to reduce premiums	5
Drop level of hospital cover	15
Drop or reduce extras cover	15
Shop around for a cheaper premium	8
Reduce spending on other living costs	2
None of these will help	1

Some of the comments of this nature revealed the respondent had already taken the action, e.g. already increased their excess, dropped hospital cover entirely, reduced the extras to those they really need, or recently switched providers. Others suggested they were considering one or more of these options.

No other cost-saving strategies were suggested by respondents, beyond a call to increase pensions or other income, and suggestions to pay premiums annually or to apply for

Veterans Affairs cover. One respondent urged governments to force insurance companies to remove coverage for conditions such as pregnancy for older customers, a suggestion dealt with in more depth in the analysis of Q9 comments.

All the other comments fell into one of three categories:

Other comments	Comments
I need PHI, must find a way to keep it	12
PHI is expensive, doesn't cover enough, gap costs are a problem	11
Legacy costs are high and keep me in my current policy	5

The legacy costs alluded to by commenters likely include the lifetime health cover loading, the Medicare levy surcharge, waiting periods for existing conditions, and being on a policy that is good value but no longer offered to new customers. Again these remarks are covered more fully in the Question 9 analysis.

3. Reasons for dropping PHI – 'other' comments

Question 8 asked people who had dropped their PHI about the reasons for this, again with a set list of options plus an 'other' comment box.

There were 83 meaningful comments in response to this question, including comments from people who selected one of the set responses and wanted to elaborate on it. In addition, even among those who had not selected a set response there were a few comments that seemed to fit a set option.

There were other comments though. The following table summarises the 'other' reasons why the 83 dropped their PHI:

'Other' reason	Comments
Covered by DVA Gold Card or similar	25
Family or living situation changed	14
Out of pocket costs too high	13
PHI did not adequately cover needs	9
Didn't need or didn't want insurance	8
Dropped PHI when Medicare started	4
Workplace covered insurance for a time	4
Lifetime health cover loading too high	2
Believe in principle of public healthcare	2
Total comments on money issues of any kind	36

- **DVA Gold Card or similar.** A few commenters simply mentioned the DVA rather than specifying the Gold Card, so it is uncertain if they have a Gold Card or not but most of the 25 commenters in this response category did specify it.
- **Family or living situation.** Five commenters ended their PHI when they got divorced, some specifying they could no longer afford it. Three ended it when their children came of age. Another five mentioned other life disruptions such as losing a job, retiring, building a house, or moving overseas, leading to cancellation of PHI.

One commenter was removed from PHI coverage by her husband without her knowledge because he felt they couldn't afford it.

- **Out of pocket costs.** Commenters mentioned several aspects of out-of-pocket costs that resulted in them dropping PHI. The most obvious was gap fees which some described as *"huge"* and *"getting bigger"*, with specific examples of surgery costing $10,000, $12,000, or $20,000 out of pocket. For those concerned about gap fees it was often a matter of PHI being poor value for money, especially for people who had paid PHI premiums for many years prior. One person wrote, *"I was in a health fund since 1966 until 2022. During that time I rarely made a claim. But when I looked at getting a knee replacement I found that despite having top cover, my out of pocket expenses would be well over $10,000. Under the public system the out of pocket expenses are no where near this level."* Travel costs were also mentioned (perhaps because of PHI preferred provider limitations requiring longer distances to travel?).
- **PHI did not cover needs.** Some of the people who mentioned this issue also mentioned gap fees. For example, a gap fee resulted because their insurer did not cover all aspects of treatment. But others spoke about different issues associated with insufficient coverage, such as the limitations of living in remote or rural areas, where patients have to take any doctor they can get, implying that this made PHI not worthwhile. The comment reproduced in the main text about a private hospital not taking non-ambulant patients was written in response to this question then reiterated by the respondent in the free comment question.
- **Didn't need insurance.** Some commenters simply said they didn't need, use, or want their PHI so dropped it. One specified that they were healthy enough, another that they hoped they would be covered by the public system, and a third that they could afford to top up any expenditure without insurance.
- **Medicare.** Four people wrote about having had PHI decades ago, before the introduction of the Medicare system (or in one case, its predecessor Medibank).
- **Workplace.** Three commenters wrote that when working overseas their healthcare was covered by their workplace. A fourth did not specify overseas but said their PHI was with their work. Three of these commenters said they could not afford the premiums once their workplace stopped covering them.
- **Lifetime health cover loading.** Two people discussed not having PHI in their younger years: one worked overseas and the other worked casually so could not afford PHI. Both eventually did take up PHI but dropped it because of the 50% or 60% loading for joining at an older age.
- **Principle.** Finally, two people articulated their opposition to the idea of PHI, writing, *"I believe in universal coverage"* and *"It was a con and a waste of money pushed by the Liberal Party."*

Money was of course a dominant thread throughout many of these reasons for dropping PHI, with remarks on it appearing in 43% of comments. This number includes comments from people whose reasons for dropping PHI were listed in the set options. People generally commented that PHI is too expensive, that premiums have increased drastically, and that people on pensions and other low incomes cannot afford it. Some described PHI as *"money for jam"* or a *"total rip-off"*. One person undoubtedly spoke for others when they wrote, *"Private health cover is far too expensive, complicated and will always be unaffordable for the average Aussie. The cost increases significantly each year."*

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