COMMONWEALTH OMBUDSMAN

FOR CONSUMERS

State of the Health Funds Report

Relating to the financial year 2023–24

Report required by s 20D(c) of the *Ombudsman Act 1976*

March 2025

Foreword

I am pleased to present the 20th annual State of the Health Funds Report, relating to the financial year 2023–24. The Ombudsman Act 1976 requires that I, as the Private Health Insurance Ombudsman (PHIO), publish the report after the end of each financial year to provide comparative information on the performance and service delivery of all health insurers[1] during that financial year.

This report provides only a summary of the information about health insurers that is available on my Office's privatehealth.gov.au website, which is Australia's leading independent health insurance website. All 30 health insurers in Australia are required to keep their information on the website accurate and current.

I encourage consumers to visit the site to search and compare all health insurance policies available in Australia, including against their existing policy. The website also allows consumers to access other information – such as how many hospitals an insurer has agreements with in their state or local area – that may be relevant to their choice of insurer.

I thank the Australian Prudential Regulation Authority (APRA) for its assistance and advice to my Office in preparing this report. The information included in the report is based on data APRA collects as part of its role to monitor and report on the financial management of health insurers.

Iain Anderson
Private Health Insurance Ombudsman

[1] For the purposes of this report, "health insurers" refers to "health funds".

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About the data used in this report

The State of the Health Funds report

The State of the Health Funds Report (SOHFR) compares how health funds perform across the following criteria:

- service performance and financial management
- hospital benefits
- medical gap schemes
- general treatment (extras) benefits.

Consumers can use the information in this report to consider insurers' suitability for their circumstances or assess their current insurer's performance relative to others.

The range of indicators included in this report allow consumers to focus on the factors most important to them, noting that not all factors will be of equal value to every individual or family.

More information about specific indicators is provided in the explanations preceding each of the tables in this report.

Open and restricted membership health insurers

Membership of 'open' health insurers is available to everyone.

'Restricted membership' health insurers have certain membership criteria which mean they are not available to all consumers. For example, membership may be restricted to employees of certain companies, occupations or members of particular organisations.

Where applicable, open and restricted membership funds are listed separately in each of the tables in this report.

Data collection

Most data used in this report is collected by the industry regulator, the Australian Prudential Regulatory Authority (APRA). While insurers report to APRA for regulatory purposes, some of the information they provide is useful to consumers and is

reproduced in this report. However, it is important to read the text explaining the data in conjunction with the tables.

As funds differ in size, most of the statistical information is presented as percentages or dollar values per membership, for easier comparison. We have not weighted the importance of various indicators, as these are subjective judgements that consumers are better placed to make based on their individual circumstances, preferences and priorities. For the same reason, we have not consolidated or averaged insurers' scores across indicators to provide an overall performance or service delivery score.

The report provides consumers with information about the benefits each insurer paid over the last year. It also includes information about the extent of coverage insurers provided for hospital, medical and general treatment and the differences in each insurer's average policy coverage across Australia.[2] The indicators we used in this report are not intended to represent the full range of factors that consumers should consider when comparing insurers' performance. Rather, they reflect those for which there is reliable data which can reasonably be compared across all insurers.

[2] Consumers can also access this information, broken down by state, under each insurer's performance tab on privatehealth.gov.au.

Summary of the year 2023-24

High complaint numbers

In 2023–24, the Office received 4,241 complaints about private health insurance, a 23.7% increase compared to the number we received in 2022–23. Most complaints were about Australian private health insurers, but we also received complaints about overseas visitor and overseas student health cover providers, health insurance brokers, and healthcare providers.

The increase in complaints is mainly attributable to the large volume of complaints we received about Defence Health. As illustrated in Figure 1, complaints about Defence Health represented 31.6% of all complaints received about domestic cover offered by Australian registered insurers.

In July 2023, Defence Health undertook a major system transformation which caused issues with premium payments, claim processing and transfer certificates. We received several complaints about these issues, customer service and delays. As a result, there was a marked increase in service-related complaints, as shown in Figure 2.

We engaged closely with Defence Health to monitor its complaints handling processes, and implemented temporary changes to our own processes to assist them with the increased volume. We also sought information about the resolution of ongoing issues and improvements made.

Complaints about Defence Health reduced over time as Defence Health took steps to rectify the issues, however the large number of complaints about Defence Health remains a very significant outlier in this financial year's statistics. We received far more complaints about Defence Health in 2023-2024 than we did about the Medibank data breach incident in 2022-23.

We previously released an issues paper regarding lessons learned from a major system transformation undertaken by an insurer, which had similar negative impacts on policyholders and consumers.

Enquiries

In 2023-24, we received 1,675 private health insurance enquiries. Enquiries are matters we resolve by providing general advice or information, or which involve matters outside our jurisdiction. Enquiries are recorded separately to complaints (see page 9 for further information).

Increased premiums for new Gold policies

Private health insurers can apply once a year to raise the premiums for their private health insurance policies. Each premium rise must be approved by the Minister for Health and Aged Care.

In February 2024, Choice Magazine reported[3] that some insurers were closing cheaper Gold-tier policies then releasing very similar Gold policies with higher premiums. Choice suggested that some insurers may be introducing new policies to circumvent the annual premium approval process for existing policies.

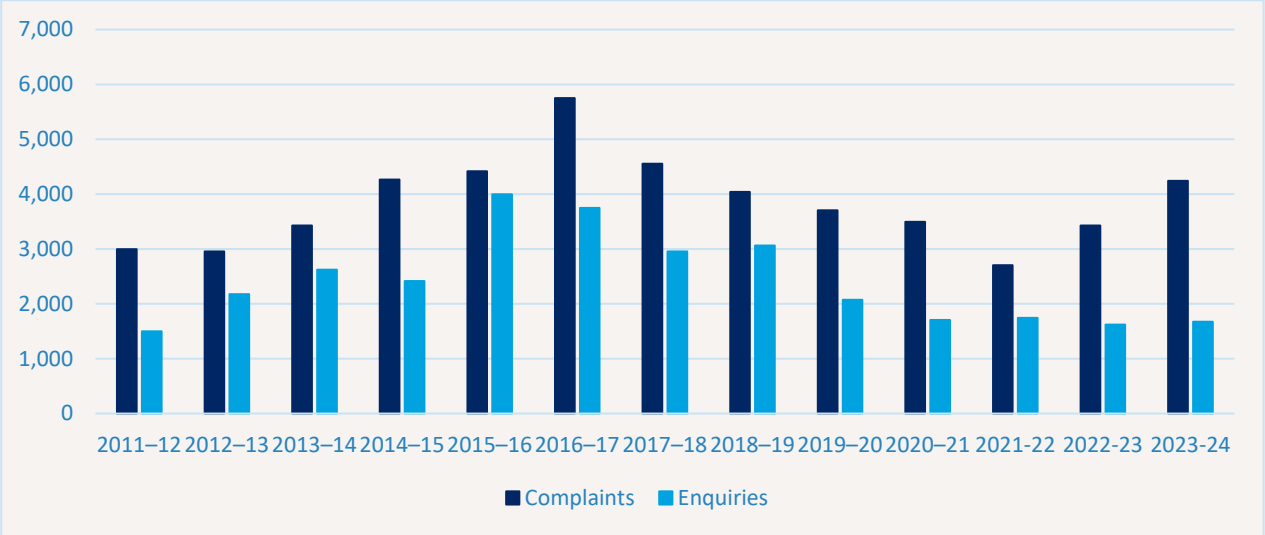
When the Office reviewed historical information from the past 3 years, the data indicated that some insurers had been closing policies, then shortly after opening almost identical new policies with significantly higher premiums, in some instances.

While insurers who may be engaging in this behaviour are not breaching any existing regulations, these practices restrict consumer choice because any new Gold policy a consumer may want to move to will have a much higher price than their existing Gold policy. Also, consumers who may otherwise be unhappy with their insurer may feel compelled to keep their existing policy because of the significant cost of change.

The Minister for Health and Aged Care made a statement in December 2024 acknowledging these concerns, available here. Our statement is available here.

[3] Health insurers are increasing their top-level policy prices by over 30% | CHOICE

Figure 1: Total complaints and enquiries by year



Complaints

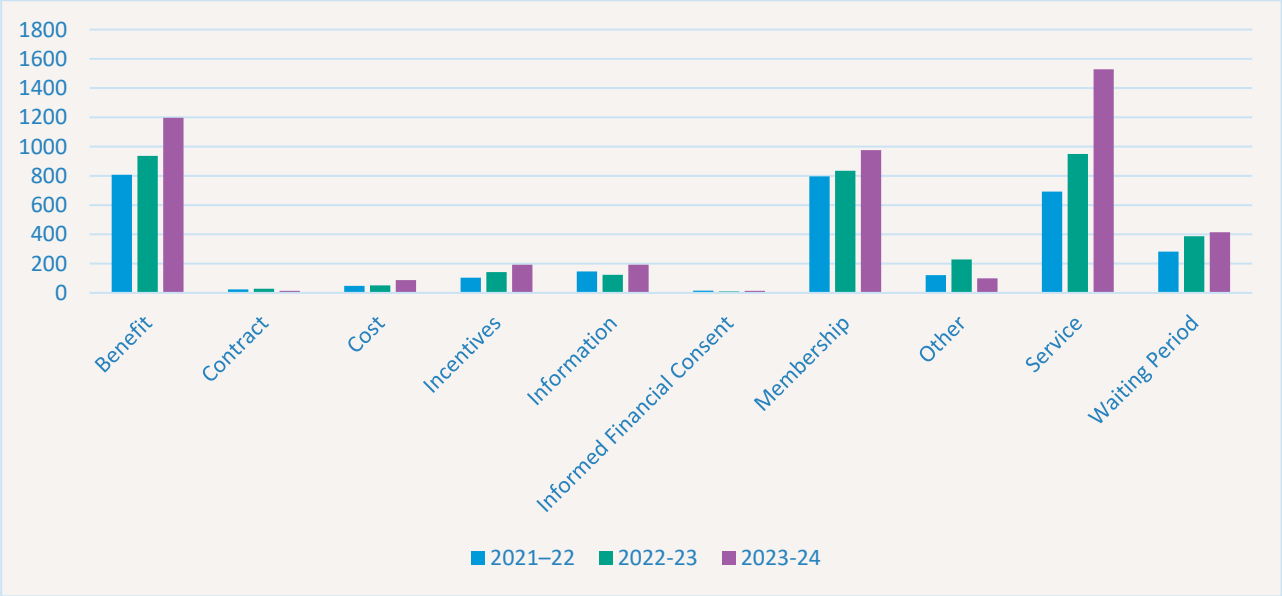
During 2023–24, the most common issues in consumer complaints related to service, benefits, and membership.

When consumers contact us about an insurer's service, it is rarely the sole reason for their complaint. In our experience, they usually flow from another issue which, when combined with poor customer service, cause policy holders to become increasingly dissatisfied. These additional service issues include inadequate responses, delayed responses and poor internal escalation processes. As mentioned in the summary, this financial year saw a significant increase in service-related complaints, primarily in relation to Defence Health.

Complaints about benefits include those about general treatment (extras/ancillary) benefits and unexpected hospital policy exclusions and restrictions. These complaints are typically about the amount the insurer paid for the service or the time it took to process a claim.

In most instances, complaints about membership relate to membership cancellation. These complaints generally reflect problems and delays in insurers processing requests to cancel memberships and handling associated payments or refunds. In most cases, consumers are transferring from one insurer to another, rather than leaving private health insurance altogether.

Figure 2: Complaint issues over past 3 years



Enquiries

Most enquiries the Office received during 2023–24 were about how private health insurance works and Lifetime Health Cover (LHC).

In 2023-24, 34% of enquiries were about LHC. LHC is a policy designed to encourage people to take out hospital insurance earlier in life and maintain their cover as they age. It imposes a loading on membership premiums for every year the member is aged over 30 when taking out cover, which is removed once the member reaches 10 years of continuous coverage.

27% of enquiries were general enquires about private health insurance. Although the Office does not recommend particular insurers or policies, we can provide general information to consumers about what factors they should consider when selecting a policy.

Enquiries about Overseas Visitors Health Cover were our third most common enquiry topic, representing 18% of enquiries. In last year's report, we observed a greater proportion of inquiries in 2022-23 about Overseas Visitor Health Cover, making up 21% of all enquiries compared to 16% of enquiries in 2021–22. This return to 18% likely reflects a return to more usual volumes of international travel and tourism following the removal of COVID-19 restrictions.

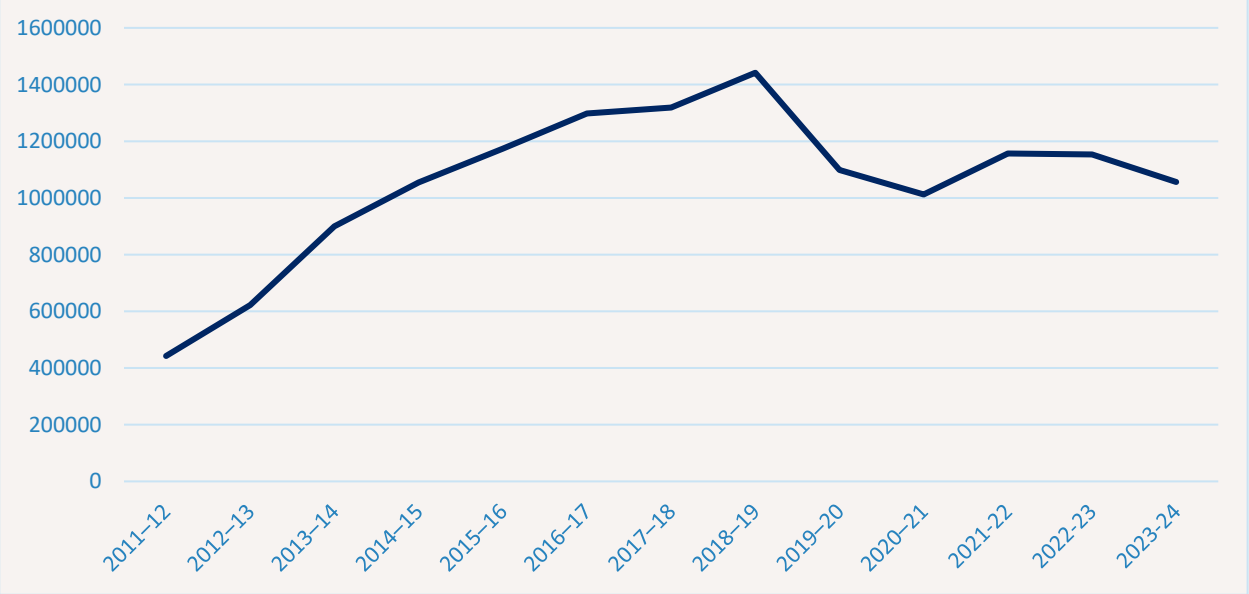
Consumers also contacted our Office to seek:

- information about government incentives such as the government rebate and Medicare levy surcharge
- information about health insurance for overseas students studying in Australia
- information about the role of the Private Health Insurance Ombudsman
- general advice about Australia's healthcare system.

Consumer website privatehealth.gov.au

During 2023-24, visits to the website saw a slight decrease compared to the previous year, with 1,056,477 visitors compared to 1,153,195 visitors in 2022-23. The website largely relies on organic growth, with most visitors discovering the website through search engines.

Figure 3: privatehealth.gov.au visitors per year



Service Performance and Finances

Member retention

The member retention indicator is used as one measure of the comparative effectiveness of health insurers and their level of member satisfaction. This indicator measures what percentage of members (hospital memberships only) have remained with the insurer for 2 years or more.

This figure is calculated on the total gain or loss of members over the last 2 years (at 30 June 2024). The data considers consumers who take up membership and leave within that 2 year period. Figures are not adjusted for policies that lapse when a member dies, as these are not reported to APRA.

Most restricted membership insurers rate well on this measure compared to open membership insurers. This may be due to features particular to restricted membership insurers, especially their links with employment. The difference between restricted membership and open membership insurers is explained on pages 4 and 21 of this report.

Ombudsman complaints in context

The number of complaints we receive is generally very small compared to insurer membership.

There are several factors (other than performance) that can influence the level of complaints we receive about an insurer. These include the information the insurer and the media provide to members about the Ombudsman and the effectiveness of the insurer's own complaint handling process.

Complaints percentage compared to market share percentage

Table 1 shows each insurer's market share (at 30 June 2024) in the **Market share** column. Subsequent columns show the complaints we received about each insurer, as a percentage of the total complaints we received about all domestic insurers. These percentages should be compared with insurers' market share figures. Where an insurer's share of complaints was higher than its market share, this indicates that members of that insurer were more likely to complain than those of other similar sized insurers. This may also suggest that internal complaint processes at that insurer could be improved.

The table also indicates the percentage of complaints we received about each insurer. Note that these figures exclude complaints the Office received about overseas visitor and overseas student health cover providers, brokers, and healthcare providers.

The **All complaints** column reflects all complaints the Office received about the insurer. It includes complaints we investigated as well as complaints we finalised without the need for investigation. It excludes complaints about overseas visitor and overseas student health cover.

Due to Defence Health's significantly higher than usual complaint numbers, other insurers will have proportionally lower percentages of received complaints and this should be taken into account when making any comparison.

The **Complaints investigated**[4] column reflects complaints about the insurer that required a higher level of intervention by the Office, as a percentage of all complaints we investigated about all insurers. We can finalise most complaints to us by providing information to the complainant or referring the matter to insurer staff to resolve. Where insurer staff do not resolve a complaint to a member's satisfaction, we will investigate. As such, the rating for complaints investigated is an indicator of the effectiveness of an insurer's internal complaint handling arrangements.

[4] Complaints investigated were referred to as "disputes" in previous versions of this report.

Finances and costs

All health insurers are required to meet financial management standards, to ensure members' contributions are protected. Generally, insurers aim to set premium levels so their income from contributions covers the expected cost of benefits plus the insurer's administration costs.

The regulation of health insurer finances

The *Private Health Insurance Act 2007* (Cth) (the Act) specifies the standards that insurers must meet to ensure they remain financially sound and sets out financial management and reporting requirements for all insurers.

APRA produces an annual publication with financial and operational statistics for all insurers for each financial year.[5] Information included in the **Benefits as a % of Contributions** and **Management Expenses** columns is drawn from data APRA collect.

Benefits as a percentage of contributions

This column shows the percentage of total contributions the insurer received that it returned to contributors in benefits. Insurers will generally aim to set premium levels so that contribution income covers the expected costs of benefits plus the insurer's administration costs.

Management expenses

Management expenses are the insurer's administration costs. They include items such as staff salaries, operating overheads, and marketing costs.

As a percentage of contribution income: This figure is regarded as a key measure of insurer efficiency. In this table, management expenses are shown as a proportion of total insurer contributions.

[5] The 'Operations of the Private Health Insurers' report is available on the APRA website: apra.gov.au

Note that because givebacks to members are classified by APRA as a management expense, this may result in a higher management expense % than usual for insurers that provided their members with givebacks during the financial year.

Per average policy (no longer included): In previous reports, this figure provided a comparison of the relative amount each insurer spends on administration costs. The figure showed management expenses per policy. As APRA no longer reports on this figure, it is not included in this report.

Table 1: Service performance and finances

Insurer name (abbreviated)	Member retention (hospital	Market share	All complaints %	Complaints investigated %	Benefits as % of contributions	Management expenses as % of contribution income[7]
Open membership insurers						
AIA Health	68.3%	0.5%	1.5%	3.8%	88.0%	11.6%
Australian Unity	82.3%	2.2%	2.3%	3.8%	81.9%	13.0%
BUPA	87.0%	25.4%	18.0%	23.6%	82.6%	12.7%
CBHS Corporate	64.5%	<0.1%	0.1%	0.0%	79.9%	49.6%
CDH	89.2%	<0.1%	0.0%	0.0%	75.5%	21.3%
GMHBA	80.7%	2.2%	0.9%	0.6%	80.7%	22.0%
HBF	88.9%	8.1%	2.2%	3.2%	83.6%	15.5%
HCF	87.1%	12.6%	9.7%	16.6%	89.0%	12.5%
HCI	85.1%	0.1%	<0.1%	0.0%	79.3%	14.6%
Health Partners	89.9%	0.7%	0.4%	0.0%	84.3%	10.7%
HIF	75.0%	0.7%	0.5%	0.6%	80.5%	16.3%
Latrobe	77.1%	0.7%	0.7%	1.3%	79.4%	14.9%
MDHF	90.7%	0.3%	0.1%	0.0%	83.4%	10.3%
Medibank	85.5%	26.7%	17.9%	14.0%	84.9%	7.5%
NIB	81.3%	9.7%	8.8%	15.3%	80.8%	11.0%
Onemedifund	93.4%	0.1%	<0.1%	0.0%	74.9%	10.5%
Peoplecare	85.2%	0.4%	0.2%	0.0%	79.3%	12.6%
Phoenix	83.9%	0.2%	0.1%	0.0%	79.0%	9.8%

[6] The total gain or loss of members over the last two years, which takes into account consumers who take up membership and leave within that two year period.

[7] Management expenses can also include givebacks to members made by the insurer in the financial year.

QCH[8]	n/a	n/a	0.1%	0.0%	79.7%	8.3%
St Lukes	88.6%	0.6%	0.5%	0.6%	82.7%	13.3%
Westfund	86.7%	0.9%	0.3%	1.9%	82.4%	12.4%
ACA	92.7%	0.1%	0.0%	0.0%	79.9%	13.4%
CBHS	91.4%	1.4%	1.1%	2.5%	87.1%	10.5%
Defence Health	92.0%	2.0%	31.6%	5.7%	85.0%	13.2%
Doctors' Health	90.1%	0.5%	0.3%	0.6%	81.2%	14.1%
Navy	88.4%	0.4%	0.2%	0.6%	84.6%	10.4%
Police Health	91.2%	0.6%	0.3%	0.6%	93.9%	7.3%
Reserve Bank	90.8%	<0.1%	0.1%	0.0%	76.8%	18.1%
Teachers Health	91.9%	2.6%	1.8%	3.8%	89.0%	9.3%
TUH	90.5%	0.6%	0.2%	0.6%	82.9%	25.2%

[8] QCH merged with HBF effective 30 June 2024, so retention and market share are not applicable.

Average policy coverage per insurer

Table 2 summarises the average coverage of each insurer's policies across Australia. More information about each health insurer's benefits, including benefits by state, is available on privatehealth.gov.au. This table includes:

- the proportion of private hospital charges covered on average
- the proportion of medical services for which a gap is not payable by the patient after accounting for insurer benefits, schemes and agreements
- the proportion of medical services for which either a gap is not payable (as above) or which fall under a 'known gap scheme', where the insurer pays an additional benefit on the understanding that any fee charged by the medical provider is lower than the limit set by the insurer (thereby bridging the gap that would otherwise apply for the consumer), and
- the average proportion of service charges each insurer covers per state for all their policies and services associated with general treatment (often known as 'extras').

The effectiveness of insurers' medical gap schemes can differ between states, so state-based information is also published on a per-insurer basis under each insurer's 'Performance' tab on privatehealth.gov.au.

Most differences are due to doctors' fees, which can vary significantly between states, and between regional areas and capital cities. In some states, insurers can cover gaps more effectively because doctors in that location charge less than the national average. Also, where a doctor's fee for an in-hospital service is at or below the Medicare Benefits Schedule fee, there will be no gap to the member.

If a health insurer's percentage of services with no gap is higher than that of an insurer in another state, it does not necessarily mean the insurer's scheme is more effective. State-based differences may also be a factor.

Private hospital treatment

A higher percentage in the **Hospital related charges** column indicates that, on average, the insurer's members are covered for a higher proportion of private hospital charges.

The percentages indicated in this table do not reflect any one policy but are an average of all policies the insurer offered.

Hospital policies provide benefits towards the following costs if you elect to be a private patient in a private or public hospital:

- hospital fees for accommodation, operating theatre charges and other charges raised by the hospital
- the costs of drugs or prostheses required for hospital treatment
- fees charged by doctors (surgeons, anaesthetists, pathologists, etc.) for in-hospital treatment.

Most insurers offer a range of different policies which provide hospital cover. These policies may differ in the range of treatments they cover, the extent to which they cover those treatments, the level of excess or co-payment the member may need to pay for a hospital admission, and the price and discounts available to them.

This column indicates the proportion of total charges for treatment of private patients that each insurer's benefits cover. This includes charges for hospital accommodation, theatre costs, prostheses and specialist fees (not including the Medicare benefit), excesses or co-payments and associated benefits.

Hospital related charges covered (per cent) is calculated as: *(Hospital benefits paid by insurer / Fees excluding Medicare benefit) * 100.*

'Fees' is the total amount the patient would have to pay to the provider(s) in the absence of any private health insurance, inclusive of hospital, medical and prostheses fees. This amount excludes the Medicare benefit. The difference between fees charged and benefits paid is the amount that the patient must pay (out of pocket).

The privatehealth.gov.au website provides information about all private health insurance policies available in Australia, including benefits, prices and agreement hospitals for each health insurer.

Medical gap schemes

'Medical gap schemes' are intended to reduce patients' out of pocket costs for in-hospital medical services, such as fees from surgeons, anaesthetists, assistant surgeons, pathology and diagnostic services.

If a service is 'no gap', it means the patient did not incur any costs, as the full cost was covered by Medicare and the health fund. If a health insurer has a higher percentage of services covered at no gap than other insurers, it indicates the insurer has a more effective gap scheme in that state. This means it is more likely that a medical service can be provided at no cost to the consumer, but it does not guarantee that a particular doctor will choose to use the insurer's gap scheme.

Insurer gap schemes and agreements

Doctors are free to decide whether to use a particular insurer's gap cover arrangements for each patient. Factors that can affect doctors' acceptance of a scheme include:

- whether the insurer has a substantial share of the health insurance market in a particular state or region
- the level of insurer benefits paid under the gap arrangements (compared with the doctor's desired fee)
- the design of the insurer's gap cover arrangements including any administrative burden for the doctor.

Comparing different medical gap schemes

The **Percentage medical services with no gap** and **Percentage medical services with no gap or known gap payment made** columns of Table 2 consider all the insurer's policies. The information in the tables does not reflect any individual policy the insurer offers but is an average across the insurer's total membership.

Percentage of services with no gaps – this column indicates the proportion of medical services for which the patient is not required to pay a gap after accounting for insurer benefits, schemes and agreements.

Percentage of services with no gap or where known gap payment made – this column includes both the percentage of no gap services (as above) as well as what are called

'known gap' services. Known gap schemes are an arrangement where the insurer pays an additional benefit on the understanding that any fee charged by the medical provider is lower than the limit set by the insurer. For example, the insurer may limit the provider to charging a gap fee to the consumer of no more than $300.

General treatment (extras)

General treatment policies, also known as 'ancillary' or 'extras' provide benefits towards a range of out-of-hospital health services.

The **Percentage general treatment (extras) charges covered** column of Table 2 indicates the average proportion of total charges, associated with general treatment services, which is covered by each insurer's benefits. This is an average of outcomes across each insurer's general treatment policies and services. Higher cost policies will generally cover a greater proportion of charges than indicated by this average, while cheaper policies may cover less.

General treatment policies provide benefits towards a range of health-related services not provided by a doctor including, but not limited to:

- dental fees and charges
- optometry – cost of glasses and lenses
- physiotherapy, chiropractic services and other therapies including natural and complementary therapies
- prescribed medicines not covered by the Pharmaceutical Benefits Scheme.

Table 2: Australia-wide average policy coverage per insurer

Insurer name (abbreviated)	% Hospital related charges covered[9]	% Medical services with no gap	% Medical services with no gap or known gap payment made	% General treatment (extras) charges covered
Open membership insurers				
AIA Health	79.2%	84.6%	95.4%	45.2%
Australian Unity	89.3%	91.1%	97.7%	50.5%

[9] Includes charges for hospital accommodation, theatre costs, prostheses and specialist fees (not including the Medicare benefit) and associated benefits (after any excesses and co-payments are deducted).

BUPA	89.5%	90.7%	98.0%	50.1%
CBHS Corporate	85.1%	81.2%	93.9%	45.0%
CDH	94.2%	82.3%	97.1%	32.9%
GMHBA	89.3%	86.5%	95.7%	46.6%
HBF	93.1%	91.3%	99.6%	54.1%
HCF	88.9%	86.0%	97.0%	50.4%
HCI	91.0%	90.5%	97.5%	45.6%
Health Partners	92.3%	89.4%	99.4%	56.5%
HIF	89.3%	89.3%	97.6%	45.7%
Latrobe	88.9%	74.3%	99.4%	39.2%
MDHF	90.5%	81.6%	99.9%	53.2%
Medibank	89.7%	83.1%	96.4%	52.4%
NIB	85.5%	91.7%	92.2%	57.5%
Onemedifund	92.5%	88.7%	97.8%	46.8%
Peoplecare	90.5%	90.7%	97.8%	42.4%
Phoenix	89.9%	91.1%	98.1%	53.6%
QCH	86.5%	87.6%	97.1%	46.5%
St Lukes	91.0%	88.9%	98.4%	55.5%
Westfund	90.1%	89.7%	97.5%	44.5%
Restricted membership insurers				
ACA	93.1%	92.4%	97.9%	55.7%
CBHS	89.7%	84.0%	97.2%	45.8%
Defence Health	91.8%	90.0%	99.4%	43.1%
Doctors' Health	92.2%	92.9%	98.3%	51.6%
Navy	89.2%	88.7%	97.1%	46.8%
Police Health	91.2%	86.4%	97.3%	64.3%
Reserve Bank	92.7%	89.2%	97.4%	68.6%
Teachers Health	90.1%	90.1%	97.5%	43.3%
TUH	89.3%	90.5%	97.9%	51.0%
Industry average	**89.5%**	**87.7%**	**97.1%**	**50.9%**

Health insurer listing

Table 3 lists all Australian registered health insurers. The 'open' membership insurers provide policies to the general public. The 'restricted' insurers provide policies through specific employment groups, professional associations or unions.

During 2023–24, QCH merged with HBF. For this reason, some of the fields in this report relating to QCH are recorded as ‘not applicable’.

Some insurers use several different brand names or have used brand names in the recent past. These are listed under ‘Other brand names’.

Table 3: Health insurer listing

Abbreviation	Full name or other names	Other brand names
Open membership health insurers		
AIA Health	AIA Health Insurance, MyOwn Health Insurance	
Australian Unity	Australian Unity Health Ltd	
BUPA	Bupa HI Pty Ltd	NRMA Health
CBHS Corporate	CBHS Corporate Health Pty Ltd	
CDH	CDH – Hunter Health Insurance	
GMHBA	GMHBA Ltd, Frank	
HBF	HBF Health Ltd	GMF, Healthguard, see-u by HBF
HCF	Hospitals Contribution Fund of Australia	Manchester Unity, Railway and Transport (RT) Health
HCI	Health Care Insurance Ltd	
Health Partners	Health Partners Ltd	
HIF	Health Insurance Fund of Australia Ltd	
Latrobe	Latrobe Health Services	
MDHF	Mildura District Hospital Fund Limited	
Medibank	Medibank Private Ltd, Australian Health Management	Kogan
NIB	NIB Health Funds Ltd, Qantas Assure, APIA	AAMI, GU Corporate Health, Priceline, Suncorp
Onemedifund	National Health Benefits Australia Pty Ltd	
Peoplecare	Peoplecare Health Insurance Limited	
Phoenix	Phoenix Health Fund Ltd	iSelf
QCH	Queensland Country Health Fund Ltd	Territory Health
St Lukes	St. Lukes Health	Astute Simplicity Health
Westfund	Westfund Limited	
Restricted membership health insurers		

ACA	ACA Health Benefits Fund	
CBHS	CBHS Health Fund Ltd	
Defence Health	Defence Health Ltd	
Doctors' Health	The Doctors' Health Fund	
Navy	Navy Health Ltd	
Police Health	Police Health Limited, Emergency Services Health	
Reserve Bank	Reserve Bank Health Society Ltd	
Teachers Health	Teachers Federation Health Ltd	Nurses and Midwives Health, UniHealth
TUH	Teachers' Union Health Fund	Union Health

Using this report to compare insurers

Please note:

- Nothing in this report should be taken as this Office recommending any health insurer or health insurance policy.
- No single indicator should be used as an indicator of an insurer's overall performance.
- The information used in this report to compare health insurers is based on data collected for regulatory purposes. This information was the most appropriate, independent and reliable data available at 13 December 2024.
- This report may help consumers decide which health insurers to consider but will not indicate which policy/ies to purchase. Most insurers offer more expensive policies that can be expected to provide better than average benefits, as well as cheaper policies that provide lower benefits.

Where to find more information about selecting a policy

The Ombudsman's consumer website privatehealth.gov.au includes advice about what factors to consider and what questions to ask when selecting a policy. It also includes information about government incentives relating to hospital cover such as the 'Medicare Levy Surcharge Exemption' and 'Lifetime Health Cover'.

This report does not include detailed information on price and benefits for health insurance policies. Information on specific policies is available from privatehealth.gov.au, where you can search for and compare information about every health insurer and policy in Australia.

For more information visit ombudsman.gov.au or call 1300 362 072.

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Use of the Coat of Arms

Contact us

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