CHF Consumers Health Forum of Australia

Speaking Up for Health:

Findings from the 2024 National Consumer Sentiment Survey

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Acronyms

ABS:	Australian Bureau of Statistics
CHF:	Consumers Health Forum of Australia
Department:	Australian Government Department of Health, Disability and Ageing
GP:	general practitioner
HLQ:	Health Literacy Questionnaire
IRSAD:	Index of Relative Socio-economic Advantage and Disadvantage
NCSS:	National Consumer Sentiment Survey
SES:	socio-economic status

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Foreword

The latest National Consumer Sentiment Survey (NCSS) presents a snapshot of Australians' experiences with and expectations of our healthcare system in 2024.

Australians have sent a clear message: our healthcare system must be more affordable, accessible and responsive to their needs. By regularly surveying consumers, we can ensure decisions are driven by solid evidence informed by the challenges Australians face, particularly in relation to healthcare affordability and navigation. By quantifying these issues, the Consumers Health Forum of Australia (CHF) will be able to track and advocate for future improvements.

While many respondents expressed satisfaction and confidence in the quality of care available, there were clear disparities and unmet needs that demand attention, particularly for underserved groups.

As the cost-of-living crisis continues to affect Australians, its impact on health and wellbeing is becoming increasingly clear. Over the past 12 months, one in 10 respondents (10.4%) reported being unable to afford the medical care they needed, highlighting the financial barriers that still exist within our healthcare system. These findings reinforce the need for ongoing efforts to ensure that cost is never an obstacle to accessing essential care.

The survey findings show that access to care remains deeply unequal, with younger adults, people with chronic conditions, individuals from lower socio-economic backgrounds and those without private health insurance reporting significant challenges in accessing care. This was especially true for dental care, highlighting a critical need for policy action.

Australians told us their central concern was the shortage of healthcare workers, with two-thirds of respondents identifying the need for more doctors, nurses and other professionals. This was closely followed by calls to reduce the cost of care and medicines. Additionally, there were strong calls for better access to care, both in terms of availability and location, as well as for improved communication between patients and their healthcare providers.

Many Australians struggle to navigate the healthcare system, and the survey highlights who is most affected. Younger adults, those in lower socio-economic areas, people outside major cities, people with chronic conditions and those without private health insurance recorded lower health navigation scores. With health literacy closely tied to better outcomes, there is a critical need for better education and support for these groups. Despite this, many respondents reported being included in decisions about their health, indicating positive progress with healthcare providers valuing their opinions and reflecting a positive trend towards shared decision-making.

Addressing gaps in awareness and encouraging the use of tools like MyMedicare and My Health Record have the potential to further strengthen the relationships between consumers and healthcare professionals.

As we look ahead, it is essential that health policy continues to evolve in a way that is inclusive, affordable and responsive to the diverse needs of all Australians. The 2024 NCSS serves as a foundation to support efforts to foster a healthcare system that is equitable, accessible and supportive of all individuals, regardless of their circumstances. Moving forward, future surveys will provide valuable data to monitor progress and identify emerging issues.

The NCSS makes it clear: Australians expect a healthcare system that meets their needs. As the peak national health consumer organisation, CHF is driven by the voices of health consumers across Australia. We will continue to champion initiatives that promote greater patient and community involvement in shaping a healthcare system that works for everyone. CHF remains committed to advocating for policies and initiatives that make healthcare more affordable, accessible and consumer centred.

Dr Elizabeth Deveny
CEO

Consumers Health Forum of Australia

Introduction

In 2024, the Consumers Health Forum of Australia (CHF) conducted a survey to better understand how Australians feel about the healthcare system and their experiences with it.

Called the 2024 National Consumer Sentiment Survey (NCSS), it was the first of 4 annual surveys to be funded by the Australian Government Department of Health, Disability and Ageing (the Department). The 2024 NCSS followed 2 earlier consumer sentiment surveys completed in 2018 (CHF 2018) and during the height of COVID-19 in 2021 (Zurynski 2022). While many of the questions included within the current survey were derived from earlier versions, the 2 previous surveys were performed using different methodology. As a result, the findings from the present survey are not directly comparable to the current tranche of consumer sentiment surveys.

In 2024, the survey questions were updated in response to feedback from consumers and from staff in the Department. When asked about priorities for focus in the 2024 survey, these stakeholders shared their concerns about the rising cost of living and its potential impact on healthcare affordability. Consumers also highlighted the need to explore issues with access to care, especially among population groups that might be underserved or experiencing barriers to their care, and challenges to navigating the healthcare system.

The survey was conducted online in late 2024, with over 5,000 adults participating. Quota sampling was applied to ensure that the survey findings broadly represent the characteristics, views and experiences of the Australian population. An important feature of this survey is that it was completed by Australians living in the general community and was not limited to people who are currently using health services. This meant it was possible to explore a range of issues relating to access, including barriers to care and unmet needs. The full method is provided in the Appendix.

Aims

The overall aim of the 2024 NCSS was to improve understanding of the healthcare system from consumers' perspectives, with a focus on primary healthcare. This would help inform better healthcare delivery and planning.

Respondents

A demographic profile of the 5,029 survey respondents is presented in Table 1. Quotas were applied during sampling to ensure that the demographic profile of respondents broadly matched the characteristics of the Australian adult population according to their age, gender and geographical location (Australian Bureau of Statistics [ABS] 2024a).

The 2024 NCSS was conducted in English only and used a panel-based sample. As anticipated, this meant that people who were born overseas (17.7% of the sample, compared to an estimated 27.6% of the general population [ABS 2021a]) and who reported being from a family where a language other than English was spoken (11.8% of respondents compared to an estimated 22.8% nationally [ABS 2021a]) were under-represented in the survey.

The percentage of respondents who identified as Aboriginal and/or Torres Strait Islander (3.5%) was similar to the percentage of adults aged 18 years plus who identify as Aboriginal or Torres Strait Islanders nationally (3.0%) (ABS 2023).

Just over half of the survey respondents (55.4%) reported having obtained qualifications after secondary school. At the time of the survey, 40.6% of the respondents were in full-time work, 19.5% reported working part-time, 4.1% were studying full- or part-time, 4.3% were unemployed and 22.6% were retired.

Regarding their health status:

- 39.2% of respondents reported being in excellent or very good health at the time of the survey
- 14.5% of respondents reported living with a disability
- 62.3% of respondents reported living with a chronic health condition that had lasted, or was expected to last, at least 6 months
- 15.5% reported that, outside of paid work, they looked after someone with a disability, mental illness, drug or alcohol dependency, chronic condition, dementia, terminal or serious illness, or who needed care due to ageing.

Table 1: Respondent characteristics (n = 5,029)

Population group	Weighted *n*	Weighted per cent	Population data
Gender			
Male	2,435	48.4	49.2*
Female	2,564	51.0	50.8*
Persons who identify as non-binary	19	0.4	Not reported
Unknown	11	0.2	Not reported
Age group			
18–24 years	588	11.7	11.4*
25–44 years	1,848	36.7	36.8*
45–64 years	1,493	29.7	29.8*
65 years and over	1,100	21.9	22.0*
State/territory			
New South Wales	1,556	30.9	31.2^
Victoria	1,298	25.8	25.7^
Queensland	1,028	20.4	20.5^
South Australia	356	7.1	6.9^
Western Australia	551	11.0	10.9^
Tasmania	108	2.1	2.1^
Northen Territory	47	0.9	0.9^
Australian Capital Territory	85	1.7	1.7^
Area of residence			
Major city	3,668	72.9	72.8^
Inner regional	926	18.4	17.5^
Outer regional	363	7.2	7.9^
Remote or very remote	46	0.9	1.1^
Unknown	26	0.5	0.7^

Population data derived from:

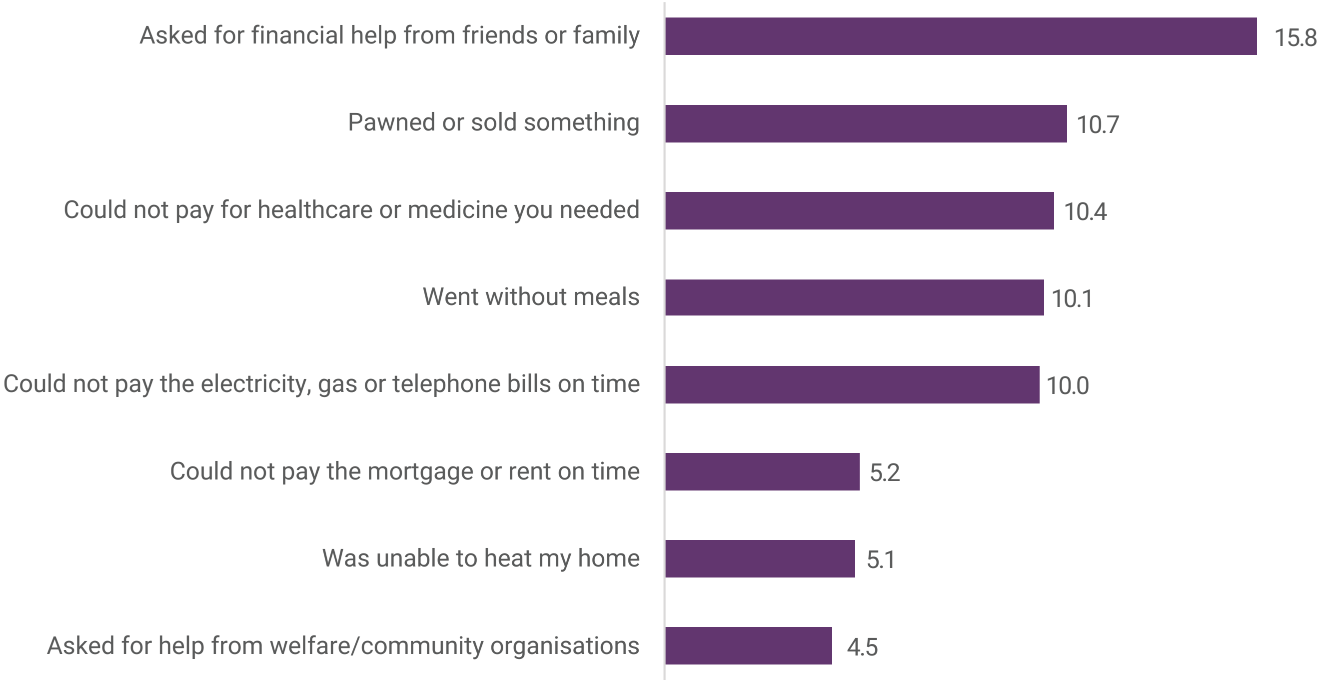
*national, state and territory population, Sept. 2024 (ABS 2025a)

^regional population data 2023–24 (ABS 2025b)

Almost all respondents (97.5%) reported having a Medicare card; 2.1% did not have one and a further 0.3% were unsure. Most of the respondents to the survey (61.8%) also reported having private health insurance, similar to the proportion reported nationally (ABS 2024b). In 2024, the top 3 reasons respondents gave for having private health insurance were for peace of mind (55.7%), to access treatment as a private patient (49.9%) and to obtain the benefits of extras (45.5%). The most common reasons for not having private health insurance were that it's too expensive (69.9%), Medicare cover is good enough (35.6%) and that the out-of-pocket or gap fees are too much even with private health insurance (34.5%). Further reasons why respondents chose, or chose not, to have private health insurance are presented in the Appendix (Tables A1 and A2).

Respondents were asked if there had been a time during the past 12 months when a shortage of money had required them to take an action or skip a payment. Most respondents (67.3%) reported that this had not been the case. However, one in 10 respondents (10.4%) reported that there had been a time during the past year when they could not pay for health or medical care they needed due to a shortage of money (Figure 1, below).

Figure 1: Respondents' experiences of shortage of money during the past 12 months (base: all respondents)



Part A: Understanding healthcare consumers' experiences and satisfaction

Overall satisfaction with the quality of care received

When asked to rate their overall satisfaction with the quality of healthcare received during the past year,

81.2% of respondents who had accessed healthcare indicated they were either very satisfied (43.6%) or somewhat satisfied (37.6%), while

10.3% gave neutral responses and

7.5% reported being either somewhat dissatisfied (4.7%) or very dissatisfied (2.9%).

Note: I don't know responses are not shown, see page 38 for details.

Table 2 presents data on Australians' overall satisfaction with the quality of healthcare they received during the past 12 months. For the purposes of reporting, responses of somewhat satisfied and very satisfied are combined. Overall satisfaction with the quality of healthcare was generally high across all population groups who reported accessing healthcare over the past year. Similar satisfaction ratings were observed among males and females, and when comparing respondents by level of education, by area of residence or by health status.

Adults aged over 65 years were the age group most likely to report overall satisfaction with the quality of the healthcare they had received during the past year. Nine out of 10 adults (90.6%) aged 65 and over reported being somewhat or very satisfied with the quality of their healthcare. Three out of 4 adults in the 18 to 24 (74.5%) and the 25 to 44 years (75.0%) age groups reported satisfaction with the quality of healthcare they had received during the past year.

In 2024, the population groups most likely to report overall satisfaction with the quality of the care received in the past 12 months were:

- older adults, aged 65 plus (90.6%) or 45 to 64 years (84.0%), compared to adults aged under 45 years
- people with private health insurance (84.4%), compared to those without it (75.7%)
- respondents living in high (83.5%) or mid (83.2%) socio-economic status (SES) areas, compared to those living in low (76.4%) SES neighbourhoods
- adults from English only speaking households (82.4%), compared to respondents from households where other languages were spoken (75.6%).

Table 2: Satisfaction with the quality of the care received during the past year (base: all respondents who received healthcare within services or remotely during past 12 months)

Population group (base *n*)	**% satisfied with quality of healthcare**
Overall (*n* = 4,825)	81.2
Gender	
Male (*n* = 2,301)^{a}	81.4
Female (*n* = 2,496)	81.3
Age group	
18 to 24 years (*n* = 536)^{b}	74.5
25 to 44 years (*n* = 1,748)^{c}	75.0
45 to 64 years (*n* = 1,455)^{d}	84.0$^{b***, c***}$
65 years and over (*n* = 1,085)	90.6$^{b***, c***, d***}$
Area of residence	
Outside major city (*n* = 1,283)^{e}	79.6
Major city (*n* = 3,517)	81.9
Area-based SES	
Low SES (*n* = 1,403)^{f}	76.4
Mid SES (*n* = 1,925)^{g}	83.2^{f***}
High SES (*n* = 1,470)	83.5^{f***}
Education level	
Qualifications after secondary school (*n* = 2,673)^{h}	80.9
Up to the end of high school (*n* = 2,034)	82.5
Spoken language	
Language other than English (*n* = 574)^{i}	75.6
English only speaking household (*n* = 4,208)	82.4^{h**}
Private health insurance	
Yes (*n* = 3,015)^{j}	84.4
No (*n* = 1,784)	75.7^{j***}
Health status	
Chronic health condition (*n* = 3,080)^{k}	81.1
No chronic health condition (*n* = 1,745)	81.2

a, b, c, d, e, f, g, h, i, j, k reference categories

** $p < 0.01$

* $p < 0.05$

*** $p < 0.001$

Healthcare accessed in person: attendance and satisfaction

Respondents were asked about services they had attended in person during the past 12 months. The most common services were GP and pharmacy visits.

Respondents who had attended health services during the previous year were asked to report on their satisfaction with their most recent in-person visit. The percentages of service users who responded that they were either very or somewhat satisfied with their last visit are presented in Table 3. Satisfaction was generally high; 90.1% of respondents who had seen a nurse in a general practice reported they were very or somewhat satisfied with their most recent visit. More than 85% of respondents who had used a pharmacist, a dentist or oral health service, an allied health service, community-based healthcare services or attended a GP reported satisfaction with their last visits.

While most respondents reported being satisfied with their most recent in-person visit, less-favourable experiences were also reported. Of the 409 respondents who had visited an urgent care clinic within the past 12 months, most (73.0%) were satisfied with their most recent visit; however, 16.3% reported being either very (7.0%) or somewhat (9.4%) dissatisfied. Among the respondents who had visited a public hospital, 15.4% reported dissatisfaction with their last visit (6.4% of respondents were very dissatisfied and 9.0% were somewhat dissatisfied). Among respondents who had attended a pain clinic during the past year, 15.5% reported dissatisfaction – almost all of whom reported being somewhat dissatisfied (12.9%). Most consumers who had attended an Aboriginal Community Controlled Health Service or an Indigenous health practitioner were satisfied with their most recent visit, while 14.9% reported dissatisfaction (14.1% reported having been somewhat dissatisfied).

Table 3: Attendance and satisfaction with services accessed during the past year

Service	*n* who had used the service	% who used the service (base: all respondents)	% satisfied (base: those who used the service)
A GP	4,075	81.0	85.7
A pharmacist	3,375	67.1	88.8
A dentist or oral health service	2,473	49.2	88.2
A specialist doctor outside hospital (such as a cardiologist, psychiatrist)	1,587	31.6	82.8
A public hospital	1,481	29.4	73.6
An allied health service, such as a physiotherapist or dietician	1,257	25.0	87.5
A nurse within a general practice	1,238	24.6	90.1
A private hospital	753	15.0	81.2
A counsellor or psychologist	686	13.6	83.4
An alternative therapist (offering, for example, acupuncture or naturopathy)	440	8.7	83.9
An urgent or priority care clinic	409	8.1	73.0
Another community-based healthcare service not listed above	185	3.7	88.5
A pain clinic	168	3.3	65.0
An Aboriginal Community Controlled Health Service or an Indigenous health practitioner	99	2.0	63.1

Preferences for GP visits

In 2024, GPs were the most frequently cited source of healthcare; approximately 4 out of 5 respondents had visited their GP during the past year. All respondents were asked about their experiences of and preferences towards accessing GPs.

Respondents mostly reported that they almost always see the same GP (62.5%), one-quarter (25.3%) responded that they always go to the same practice but often see different doctors and 8.3% reported often attending different practices. Small percentages of Australians reported that they were either unable to access a GP (0.7%) or that they choose not to access a GP (1.5%).

When Australians who had accessed a GP were asked further questions about their preferences:

- 91.9% believed it was important or very important to get a GP appointment at a location that suited them
- 86.7% responded it was important or very important to see a GP on the day they were sick
- the majority (85.5%) felt it was important or very important to always go to the same GP practice
- 81.7% said it was important or very important to be able to access fully bulk-billed appointments through Medicare
- 4 out of 5 (80.6%) reported it was important or very important to speak to the same GP every time
- most (78.1%) regarded having the choice to go to any GP practice or clinic as important or very important.

Healthcare accessed remotely: use and satisfaction

Respondents were asked to report on their use of and satisfaction with healthcare accessed remotely or in the home (Table 4). More than one-third (37.8%) of respondents reported having taken part in a telephone consultation with a health professional within the past 12 months, while one in 10 (10.5%) respondents reporting having had a video consultation during the past year. Some people had experienced both telephone and online consultations, meaning that overall 42.5% of respondents had received a telehealth consultation of some kind.

Telephone or online support services, such as healthdirect or Lifeline, had been used by 9.3% of respondents. One in 20 respondents (5.0%) reported having received a home visit from a health professional other than a GP, while 3.8% had been visited at home by a GP.

Table 4: Use of and satisfaction with services accessed remotely during the past year (multiple answers permitted)

Service	*n* who had used the service	% who used the service (base: all respondents)	% satisfied (base: those who used the service)
Telephone consultation with a health professional	1,903	37.8	86.2
Video consultation with a health professional	530	10.5	85.5
Telephone or online support service (such as healthdirect, Lifeline, Beyond Blue, Medicines Line: 1300 Medicine)	467	9.3	78.1
Home visit from a health professional (not including a GP)	251	5.0	80.0
Home visit from a GP	193	3.8	76.7

The majority of respondents reported having been somewhat or very satisfied with their latest experience of receiving care remotely or at home, and some respondents also gave neutral responses. Approximately one in 20 respondents reported dissatisfaction with their most recent telephone (4.9%) or video (5.3%) consultation with a health professional. Regarding other experiences, 13.2% of respondents reported being dissatisfied with their most recent home visit from a GP, 7.9% of respondents were dissatisfied with their last home visit from a health professional other than a GP and 8.7% of respondents were dissatisfied with their last experience with a phone or online support service.

Telehealth

Respondents who had taken part in at least one telehealth appointment during the past year were asked further questions to understand how they felt their experiences compared to in-person appointments.

When rating the overall quality of telehealth, most (62.0%) regarded it as similar to an in-person appointment, but approximately one-quarter (27.7%) of respondents who had used telehealth regarded the overall quality of their experience to be worse than an in-person appointment. Telehealth appointments were rated as being about the same as in-person appointments by most respondents on almost all measures (Table 5). There are 2 exceptions to this. The first is that the convenience of a telehealth appointment was regarded as being better than an in-person appointment. The second is that only about half of respondents (51.7%) felt their ability to build rapport with their provider via telehealth was similar to an in-person appointment. It was notable that 38.9% of respondents found the ability to develop a connection with their healthcare provider was not as good as at an in-person appointment.

Table 5: Experiences of telehealth compared to in-person appointments (base: respondents who had taken part in a telephone and/or online telehealth appointment, n = 2,139)

Experience	Better (%)	Similar (%)	Worse (%)	Unsure (%)
Quality of your care	7.8	**68.9**	22.0	1.3
Quality of the communication	8.9	**67.8**	22.4	0.9
Ability to develop a connection with the healthcare provider	7.8	**51.7**	38.9	1.8
Amount of time spent on the appointment	18.4	**55.3**	24.7	1.6
Cost of the appointment	19.5	**60.0**	12.0	8.5
Convenience	57.0	31.0	11.5	0.5
Overall quality	9.1	**62.0**	27.7	1.2

Most common response in bold

Use of afterhours services

A minority (29.9%) of respondents reported there had been a time during the past year when they had needed afterhours medical care for themselves or a family member. Among this group, the most frequently cited services accessed afterhours were an emergency department (59.5%), a telephone advice line (19.5%) or an afterhours GP (18.5%) (Table 6). Urgent care clinics had been accessed by 16.2% of respondents who had needed afterhours care either for themselves or a family member during the past year. A similar proportion of respondents (15.3%) had attended an afterhours pharmacy. Home visits from a GP (7.7%) and use of a virtual emergency department (6.3%) were also reported. Note that a virtual emergency department is defined as a video telehealth service that connects patients who are experiencing a non-life-threatening condition with an emergency clinician who can then triage and treat the patient in a virtual environment (Victorian Virtual Emergency Department 2025). There were respondents who reported needing afterhours care for themselves or a family member but had not accessed any help (7.2%). The reasons why people had not accessed any assistance when they needed afterhours medical care were not collected in the survey. Perceptions of ease of access to afterhours healthcare are explored in Part B of this report.

Table 6: Types of afterhours care accessed during the past 12 months (base: respondents who had accessed afterhours care during the past year; n = 1,503)

Service	n who accessed afterhours care	% who accessed afterhours care
Emergency department (in person)	895	59.5
Telephone advice line	293	19.5
Afterhours GP	278	18.5
Urgent care clinic or priority primary care clinic	244	16.2
Afterhours pharmacy	230	15.3
Home visit from a GP	116	7.7
Did not access any help	109	7.2
Virtual emergency department	94	6.3
Other	44	3.0

Afterhours emergency department access

Of the 1,503 people who had accessed a type of afterhours care in the past year, Table 7 specifically shows the percentage of respondents who accessed emergency department care afterhours. These population groups were more likely to access an emergency department afterhours in the past year:

- respondents aged 65 years and over (76.4%), compared to all other age groups
- people residing outside a major city (69.8%), compared to those residing within a major city (55.2%)
- respondents residing in a low SES area (65.1%), compared to those in a high SES area (53.6%)
- adults who had completed their schooling up to the end of high school (66.2%), compared to those who had completed further qualifications (55.3%)
- people without private health insurance (65.5%), compared to people with private health insurance (55.7%)
- adults with a chronic health condition (64.3%), compared to people without a chronic health condition (50.2%).

Table 7: Percentage of respondents who accessed an emergency department afterhours in the past year (base: respondents who had accessed afterhours care during the past year; n = 1,503)

Population group (base *n*)	% who accessed an emergency department afterhours
Overall (*n* = 1,503)	59.5%
Gender	
Male (*n* = 654)[a]	56.9
Female (*n* = 840)	61.8
Age group	
18 to 24 years (*n* = 153)[b]	52.8
25 to 44 years (*n* = 611)[c]	54.7
45 to 64 years (*n* = 486)[d]	58.9
65 years and over (*n* = 252)	76.4[b**, c***, d***]
Area of residence	
Outside major city (*n* = 441)[e]	69.8
Major city (*n* = 1,060)	55.2[e***]
Area-based SES	
Low SES (*n* = 475)[f]	65.1
Mid SES (*n* = 595)[g]	59.3
High SES (*n* = 431)	53.6[f**]
Education level	
Qualifications after secondary school (*n* = 942)[h]	55.3
Up to the end of high school (*n* = 529)	66.2[h**]
Spoken language	
Language other than English (*n* = 196)[i]	54.2
English only speaking household (*n* = 1,300)	60.4
Private health insurance	
Yes (*n* =889)[j]	55.7
No (*n* = 608)	65.5[j**]
Health status	
Chronic health condition (*n* = 993)[k]	64.3
No chronic health condition (*n* = 510)	50.2[k***]

a, b, c, d, e, f, g, h, i, j, k reference categories
* p < 0.05
** p < 0.01
*** p < 0.001

Use of telephone advice lines and/ or online support services

Following emergency departments, telephone advice lines were the second most frequently cited source of afterhours support accessed. Approximately one in 5 (19.5%) respondents who had needed afterhours medical care used a telephone advice line.

The most-used telephone or online support service at any time of day was healthdirect (branded as NURSE-ON-CALL in Victoria), reported by 43.5% of all who had used a telephone or online support service in the past year, followed by Beyond Blue (19.7%), Lifeline (18.8%) and Medicines Line (18.4%). One in 5 respondents who had used a telephone or online support service were unable to recall the name of the of the service they had used.

The telephone or online support services most often cited as having been used afterhours were again healthdirect, Beyond Blue and Lifeline.

Awareness of MyMedicare

Almost all respondents (97.5%) indicated that they had a Medicare card. Respondents with a Medicare card were asked if they had previously heard of MyMedicare. One-third (33.1%) of respondents with a Medicare card had heard of MyMedicare and 61.2% had not heard of the system, with a further (5.7%) indicating they were unsure.

Awareness of MyMedicare (Table 8) was significantly higher among certain population groups:

- residents of major cities (34.2%), compared to those residing outside major cities (29.9%)
- people living in high SES areas (35.9%), compared to people living in low SES areas (30.4%)
- people who had completed qualifications after secondary school (34.7%), compared to people who had completed schooling up to the end of secondary school (30.4%)
- people who spoke a language other than English at home (42.7%), compared to those who did not speak another language (31.8%)
- respondents who reported having private health insurance (36.1%), compared to those without private health insurance (28.3%).

Respondents aged 45 to 64 years were significantly less likely to report having heard of MyMedicare (29.5%), compared to respondents aged 25 to 44 years (34.9%) or 65 years and over (34.8%). Similar levels of awareness of MyMedicare were seen among males and females and when comparing those living with and without chronic health conditions.

Experiences of MyMedicare

Among respondents who had heard of MyMedicare, approximately half (53.4%) reported they had registered for MyMedicare, while 12.0% intended to register but were yet to do so. A minority of respondents (6.1%) did not intend to register. The remaining respondents were undecided about whether to register with MyMedicare, with 16.1% of respondents reporting that they had either not decided or needed more information before registering and 12.4% responding I don't know.

Respondents who were registered with MyMedicare reported on their experiences. The majority of those who had registered (81.3%) agreed that their registration had been quick and easy. When asked about their reasons for registering with MyMedicare, the most common reasons were:

- to improve how healthcare providers work together to meet my healthcare needs (54.2%)
- because a GP suggested it (40.5%)
- to access benefits through MyMedicare (31.0%)
- because a healthcare provider other than a GP suggested it (11.3%).

Awareness of My Health Record

The majority of respondents (70.4%) had heard of My Health Record, while one in 4 (24.0%) had not. The remaining 5.7% of respondents were unsure. The characteristics of people who had heard of My Health Record are summarised in Table 8. Awareness of My Health Record was lowest in the youngest age group. Less than half (43.7%) of 18 to 24 year olds were aware of My Health Record. Respondents aged 45 and over were significantly more likely to be aware of My Health Record compared to those aged under 45 years. Awareness of My Health Record was also significantly higher among:

- females (75.4%), compared to males (65.2%)
- people who had completed qualifications after secondary school (72.8%), compared to those who completed schooling up to the end of secondary school (67.8)
- individuals from English only speaking households (71.4%), compared to people who did speak another language (65.6%)
- those with private health insurance (71.8%), compared to those without private health insurance (68.7%)
- people who reported living with a chronic health condition (76.5%), compared to those without a chronic health condition (60.2%).

Experiences with My Health Record

My Health Record is designed to provide Australians who choose to have a My Health Record with easy access to their key health information. Of the respondents who had heard of My Health Record, 59.8% reported they knew they were registered to use it, 21.5% thought they were not registered and 18.7% of respondents were unsure if they were registered. Among respondents who had heard of My Health Record, a minority (36.9%) reported that they had ever used it. When looking at this value as a percentage of the whole survey population, this is the equivalent of around one in 4 (26.0%) of all Australian adults having ever used their My Health Record.

Respondents who had used My Health Record were mostly positive about their experiences. They agreed that My Health Record:

- makes it easier to access their health information (77.4%)
- makes it easier to share their health information (74.0%)
- stores all the important information about their health (69.9%)
- stores their health information securely (65.7%)
- is easy to navigate (64.7%)
- makes it easier to coordinate their healthcare (62.8%)
- helps them make informed decisions about their care (56.5%).

Table 8: Australians who reported being aware of MyMedicare and My Health Record

	MyMedicare (base: respondents with a Medicare card)		My Health Record (base: all respondents)	
Population group	*n*	% aware	*n*	% aware
Overall	4,905	33.1	5,029	70.4
Gender				
Male^{a}	2,350	34.1	2,435	65.2
Female	2,526	32.2	2,564	75.4^{a***}
Age group				
18 to 24 years^{b}	539	33.2	588	43.7
25 to 44 years^{c}	1,785	34.9	1,848	69.0^{b***}
45 to 64 years^{d}	1,489	29.5^{c**}	1,493	77.5^{b***,c***}
65 years and over	1,093	34.8^{d*}	1,100	77.3^{b***,c***}
Area of residence				
Outside major city^{e}	1,306	29.9	1,335	72.5
Major city	3,575	34.2^{e*}	3,668	69.7
Area-based SES				
Low SES^{f}	1,445	30.4	1,485	69.8
Mid SES^{g}	1,962	32.8	2,002	71.3
High SES	1,472	35.9 ^{f*}	1,515	70.0
Education level				
Qualifications after secondary school^{h}	2,709	34.7	2,787	72.8
Up to the end of secondary school	2,071	30.4^{h*}	2,109	67.8^{h**}
Spoken language				
Language other than English^{i}	556	42.7	596	65.6
English only speaking household	4,299	31.8^{i***}	4,381	71.4^{i*}
Private health insurance				
Yes^{j}	3,034	36.1	3,109	71.8
No	1,844	28.3^{j***}	1,892	68.7
Health status				
Chronic health condition^{k}	3,089	33.9	3,131	76.5
No chronic health condition	1,816	31.8	1,898	60.2^{k***}

a, b, c, d, e, f, g, h, i, j, k reference categories
* $p < 0.05$
** $p < 0.01$
*** $p < 0.001$

Part A: Summary

Detailed descriptions of Australians' experiences of and satisfaction with healthcare are presented throughout Part A. In 2024, most people expressed satisfaction with the overall quality of the healthcare they had received, but there were exceptions and evidence of disparities. Overall satisfaction was notably higher among older adults, those with private health insurance and people living in higher socio-economic areas. Satisfaction levels were otherwise relatively consistent across the other demographic groups studied, including gender and education status.

GP and pharmacy visits were the most common types of services accessed. Respondents were highly likely to report satisfaction with their in-person visits to healthcare providers such as GPs, nurses and dentists. With regards to GP access, many respondents stressed the importance of being able to access the practice of their choosing, continuity of care and the ability to be bulk billed, which suggests preferences for primary care options that are convenient, consistent and low cost.

In terms of healthcare accessed remotely, the use of telehealth services has become more standard in recent years. The percentage of Medicare Benefits Schedule (MBS) services that were delivered by telehealth saw an increase over the COVID-19 pandemic from 0.1% in 2019 to 23% in 2021 and 2022 (Snoswell et al. 2024). Across 2023 and 2024, this percentage has been reported as 17% and 16% of all MBS services, respectively (Snoswell et al. 2024). In 2024, 42.5% of survey respondents had taken part in a telehealth appointment during the past year.

The need to maintain the balance between ease of access and the quality of patient–provider relationships was highlighted by survey findings. Telehealth appointments were often considered more convenient than in-person appointments, but some respondents felt less able to form a connection with their healthcare provider during virtual appointments.

Respondents who had needed medical care outside of regular office hours reported accessing a range of supports. The most common ways afterhours support was accessed were via in-person emergency department visits, followed by telephone advice lines, then followed by visits to afterhours GPs, urgent care clinics and afterhours pharmacies. Only one in 5 Australians believed it would be easy to access afterhours care without visiting an emergency department. The groups who were less likely to report that any afterhours care would be easily accessible included older adults, people living outside of major cities, people without private health insurance, those with chronic conditions and those living in low SES areas. This finding illustrates considerable gaps in the accessibility and availability of healthcare outside of traditional opening hours. Further investigation into afterhours emergency department access revealed that there were some population groups who were more likely to access afterhours care in this way. Afterhours emergency department access was significantly higher among older adults, people residing outside a major city, people in a low SES area, those who completed schooling up to the end of high school, people without private health insurance and respondents with a chronic health condition.

MyMedicare, a voluntary registration system allowing patients to formalise their relationship with their GP and primary care teams (Australian Government Department of Health, Disability and Ageing 2025), was a relatively new initiative at the time of the survey, having been launched a year prior in October 2023 (Australian Government Department of Health, Disability and Ageing 2023). One year later, one-third of Medicare card holders were aware of MyMedicare and approximately half of those aware of MyMedicare had registered. People from English only speaking households, those who live outside of major cities or in low SES areas, those without private health insurance and people educated up to the end of secondary school were relatively less likely to be aware of MyMedicare. The finding that people who spoke a language other than English at home were more likely to be aware of MyMedicare was unexpected. Analysis of future survey waves will allow for better understanding of this result, to determine whether this result may be an outlier or one that requires additional analysis to better understand.

My Health Record, a safe and secure online space for storing key health information, available to Australians and their healthcare providers, was more established than MyMedicare (Australian Digital Health Agency [ADHA] 2024). A 2019 audit (ADHA 2019) found that 9 out of 10 Australians had access to My Health Record. In recent years (ADHA 2020), there have been steady increases in the volume of records with data attached and in the number of views records receive (including views by health practitioners). In 2024, however, 70.4% of respondents had heard of My Health Record and the survey findings suggested that as few as one in 4 (26.0%) Australians recall ever using it. While one in 5 people who had heard of My Health Record thought that they were not registered to use it, it is possible that some people may not be aware that they need to opt out in order to not have a My Health Record. So there is likely to be a difference between respondents' awareness of registration and actual registrations. For those who had used My Health Record, many reported positive experiences, particularly in terms of ease of access to and the sharing of their health information.

Findings relating to both MyMedicare and My Health Record suggest that sizeable proportions of the population are not engaged with these initiatives, as they may be unaware of them and/or have not registered. Healthcare providers will be increasingly required to share documents to My Health Record by default in the future. This change has the potential to reduce the burden on consumers to coordinate their care and share their medical histories, and promises to improve coordination of care. Therefore, it has never been more important for consumers to be mindful of what health information is shared to their records. Continuous education and outreach are needed for younger people in particular, many of whom who were not adults when the system was first introduced, to increase awareness of My Health Record and to support Australians to obtain maximum benefit from this platform.

The results of the survey confirm how healthcare experiences and satisfaction can be influenced by personal characteristics such as gender, age and place of residence. Younger adults, aged 18 to 24 and 25 to 44 years, reported lower satisfaction with the quality of their healthcare compared to older adults, with the over-65 age group the most likely to report satisfaction. People without private health insurance also reported lower satisfaction compared to those with insurance. Additionally, those from households where a language other than English was spoken had somewhat lower healthcare satisfaction compared to their peers.

Overall, the report paints a picture of a generally satisfied population when it comes to healthcare. However, there are clear areas for improvement, such as increasing knowledge about underutilised tools and the need for improvements for underserved population groups.

Part B: Barriers to care

Unmet healthcare needs

Respondents were asked if there had been a time during the past year when they did not access healthcare that they needed. Half (49.9%) of respondents stated that there had been at least one time during the past year when they did not get the healthcare they needed, including: not filling a script or taking medicine when needed; not following their doctor's advice to take a medical test or treatment or to attend an appointment; not speaking to a doctor when required; or not visiting a dentist when needed.

Table 9 presents a summary of the broad population groups who reported at least one unmet care need. The population groups who were significantly more likely to say that there had been an occasion when they had not accessed the healthcare they needed during the past year were:

- females (52.5%), compared to males (46.9%)
- adults aged under 45 years (18 to 24 = 61.6% and 25 to 44 = 61.0%), compared to people aged 45 to 64 (49.4%) and people aged over 65 (25.8%)
- people living in low (53.5%) or mid (51.1%) SES areas compared to those in high (45.2%) SES areas
- individuals without private health insurance (62.2%), compared to people with private health insurance (42.5%)
- people living with a chronic health condition (54.9%), compared to those without a chronic health condition (41.8%).

Table 9: Respondents with an unmet healthcare need during the past year (base: all respondents)

Population group	% who did not get healthcare needed
Overall (*n* = 5,029)	49.9
Gender	
Male (*n* = 2,435)[a]	46.9
Female (*n* = 2,564)	52.5[a**]
Age group	
18 to 24 years (*n* = 588)[b]	61.6
25 to 44 years (*n* = 1,848)[c]	61.0
45 to 64 years (*n* = 1,493)[d]	49.4[b***, c***]
65 years and over (*n* = 1,100)	25.8[b***, c***, d***]
Area of residence	
Outside major city (*n* = 1,335)[e]	51.3
Major city (*n* = 3,668)	49.6
Area-based SES	
Low SES (*n* = 1,485)[f]	53.5
Mid SES (*n* = 2,002)[g]	51.1
High SES (*n* = 1,515)	45.2[f***, g**]
Education level	
Qualifications after secondary school (*n* = 2,787)[h]	51.5
Up to the end of secondary school (*n* = 2,109)	47.9
Spoken language	
Language other than English (*n* = 596)[i]	52.8
English only speaking household (*n* = 4,381)	49.4
Private health insurance	
Yes (*n* = 3,109)[j]	42.5
No (*n* = 1,892)	62.2[j***]
Health status	
Chronic health condition (*n* = 3,131)[k]	54.9
No chronic health condition (*n* = 1,898)	41.8[k***]

a, b, c, d, e, f, g, h, i, j, k reference categories
* p < 0.05
** p < 0.01
*** p < 0.001

No differences were found when comparing responses for people who live in major cities to those who do not, by education status or by whether only English was spoken at home. There were a range of reasons why individuals reported they did not obtain the care they needed during the past year; these reasons are summarised in Table 10.

Of the services presented in the survey, respondents were least likely to have seen a dentist when needed. Approximately one in 4 (28.7%) respondents said there had been a time during the past year when they had needed to visit a dentist but had not done so. Of those who had not accessed a dentist when needed, the most common reason was because they could not afford it (66.1%). Other common responses included were that it was not a priority for them at the time (18.4%) or that they were too busy (17.7%). Feelings of shame, nervousness or embarrassment was stated by 14% of respondents as their reason for not accessing a dentist, while 9.3% indicated that the service was not available at a suitable time.

One in 4 Australians (25.6%) reported that there had been a time in the past 12 months when they did not speak to a doctor when needed. The most common reason for this was that the service was not available at a suitable time (37.5%), followed by respondents stating that they could not afford it (34.0%), or that they were too busy (20.5%), and that the service was not available at a suitable location (19.8%).

Approximately one in 5 (21.7%) respondents reported there had been a time when they had not taken a medical test or treatment or attended an appointment that had been recommended to them by a doctor. Among those who reported having not taken up a recommended test, treatment or appointment, 43.8% responded that they could not afford it. The second most common response was that it was not a priority (23.8%), followed by respondents stating they were too busy (20.3%).

In 2024, concern about COVID-19 (either being exposed to it or passing it on to others) remained a factor in a minority of Australians' likelihood of accessing care. For example, of the respondents who had not spoken to a doctor when needed, one in 20 (5.0%) respondents reported this was a reason for not doing so.

Table 10: Reasons for not using needed or recommended healthcare (base: % of those who did not use a service or recommended treatment)

Reason	% did not visit dentist when needed (*n*)	% did not speak to a doctor when needed (*n*)	% did not take up recommended test, treatment or appointment (*n*)	% did not fill a script or take recommended medicine (*n*)
n of respondents who did not use service when needed	(1,445)	(1,286)	(1,089)	(826)
I could not afford it	66.1	34.0	43.8	46.7
It wasn't a priority for me	18.4	16.7	23.8	22.1
I was too busy	17.7	20.5	20.3	17.7
I felt ashamed, nervous or embarrassed	14.0	12.3	10.6	9.7
The service was not available at a suitable time	9.3	37.5	19.6	15.2
The service was not available at a suitable location	6.4	19.8	17.3	13.0
I was too unwell	5.0	14.5	8.8	11.2
I felt I would be treated unfairly or without respect	3.9	6.4	5.1	5.9
I did not want to be exposed to, or expose others to, COVID-19	3.7	5.0	5.9	6.1
I felt unsafe	3.1	3.6	5.2	6.4
Another reason	8.0	12.5	11.9	15.3

Most common response shown in bold

Affordability of care

When thinking back over the past year, affordability was cited as the most common factor for respondents having not:

- filled a prescription for medicine or taken medicine when needed
- taken a medical test, treatment or attended an appointment that had been recommended by a doctor, or
- visited a dentist when needed.

The findings suggest that, overall, 7.7% of Australians had been unable to fill a prescription or take medicine when needed due to cost on at least one occasion in the past year (Table 11). Meanwhile, 8.7% of respondents reported there had been a time during the past year when cost prevented them from speaking to a doctor when needed. Almost one in 10 had, at some point during the past year, not taken a recommended medical test or treatment or attended an appointment due to cost. Almost one in 5 respondents (19.0%) stated there had been a time during the past year when they had not visited a dentist when needed due to cost.

Table 11: Respondents who were unable to get the care they needed and cited cost as a factor

Type of care	*n*	% who were unable to access a service when needed	*n*	% who stated cost was among their reasons for not accessing care needed
Fill a prescription for medicine or take medicine when needed	826	16.4	386	7.7
Speak to a doctor when needed	1,286	25.6	437	8.7
Take a medical test or treatment or attend an appointment that had been recommended by a doctor	1,089	21.7	477	9.5
Visit a dentist when needed	1,445	28.7	955	19.0
Overall	2,511	49.9	1,293	25.7

In 2024, 28.8% of respondents reported that cost had often or always been a barrier to them accessing healthcare over the past 12 months; a further 30.4% of respondents reported that cost had sometimes been a barrier, while 39.4% of respondents reported that this had never or rarely been the case. A further 1.4% reported that they didn't know. Despite this, a majority of respondents (61.4%) indicated that they had often or always been able to access the healthcare they needed at a time and place that suited them.

Perceived ease of access to afterhours care

All respondents were asked about their perceived ease of access to afterhours medical care without the need to visit an emergency department. Afterhours care was defined as being after 6 pm on a weeknight, after 1 pm on a Saturday or at any time on a Sunday or public holiday.

In 2024, approximately one in 5 respondents (21.9%) perceived it would be either somewhat easy (17.0%) or very easy (4.8%) to access afterhours care for themselves or a family member without visiting an emergency department. The most common response was that accessing afterhours care without an emergency department visit would be somewhat difficult (24.8%), with a further 21.0% of respondents reporting it would be very difficult. One in 5 respondents stated that they were unable to say, as they did not know (20.6%).

Table 12 presents data on different population groups' perceived ease of access to afterhours care without requiring an emergency department visit. Responses of easy or very easy were combined in the following summary. In addition to the demographic groups compared throughout the report, analysis for this measure was also conducted for people who had accessed afterhours care in the past year to determine their perceived ease of access to afterhours healthcare. The population groups who were less likely to think access to afterhours care would be easy were:

- females (19.3%), compared to males (24.7%)
- older adults, with adults aged over 65 (15.2%) and adults aged 45 to 64 years (20.0%) significantly less likely to consider accessing afterhours care as easy compared to adults aged under 45 years
- those living outside of a major city (17.1%), compared to those living in a major city (23.5%)
- respondents without private health insurance (17.8%), compared to people with private health insurance (24.3%)
- those living with a chronic condition (18.2%), compared to those without a chronic condition (27.9%)
- people from low (19.9%) or mid (21.2%) SES areas, when compared to residents of high (24.4%) SES areas
- people who did not need to access afterhours care in the past 12 months (20.8%), compared to people who did need to access afterhours care (24.3%).

Table 12: Perceived ease of access to afterhours care without an emergency department visit (base: all respondents)

Population group	% who perceived it would be easy to access afterhours care
Overall (*n* =5,029)	21.9
Gender	
Male (*n* =2,435)^{a}	24.7
Female (*n* =2,564)	19.3^{a***}
Age group	
18 to 24 years (*n* =588)^{b}	25.6
25 to 44 years (*n* = 1,848)^{c}	26.2
45 to 64 years (*n* = 1,493)^{d}	20.0^{c***}
65 years and over (*n* = 1,100)	15.2$^{b***, c***, d*}$
Area of residence	
Outside major city (*n* = 1,335)^{e}	17.1
Major city (*n* = 3,668)	23.5^{e***}
Area-based SES	
Low SES (*n* = 1,485)^{f}	19.9
Mid SES (*n* = 2,002)^{g}	21.2
High SES (*n* = 1,515)	24.4^{f*}
Education level	
Qualifications after secondary school (*n* = 2,787)^{h}	23.6
Up to the end of secondary school (*n* = 2,109)	20.2^{h*}
Spoken language	
Language other than English (*n* = 596)^{i}	22.3
English only speaking household (*n* =4,381)	21.8
Private health insurance	
Yes (*n* = 3,109)^{j}	24.3
No (*n* = 1,892)	17.8^{j***}
Health status	
Chronic health condition (*n* =3,131)^{k}	18.2
No chronic health condition (*n* = 1,898)	27.9^{k***}
Afterhours care needed	
Yes (*n* = 1,503)^{l}	24.3
No (*n* = 3,526)	20.8^{l*}

a, b, c, d, e, f, g, h, i, j, k, l reference categories

* p < 0.05

** p < 0.01

*** p < 0.001

Part B: Summary

Responses to the survey suggest approximately half (49.9%) of Australians had at least one occasion during the past year when they had not accessed healthcare that they needed. The population groups who were most likely to report having an unmet healthcare need during the past year were women, younger adults, people living in lower SES areas, those without private health insurance and individuals with chronic health conditions.

A variety of factors were reported to have contributed to unmet healthcare needs. Personal reasons also played a part, with some individuals not prioritising their care or being too busy to do so. Some respondents reported services were not available at suitable times, and this was the most likely reason respondents had not spoken to a doctor when they needed to. Among the other factors influencing access to services were perceived stigma and ongoing concerns about COVID-19. However, affordability was confirmed to be a critical barrier, with 28.8% of respondents reporting that cost had often or always hindered their ability to access their healthcare. Cost was the most commonly cited reason for people: not having taken medicine when needed; not taking up a recommended medical test or treatment or an appointment; and not seeing a dentist when needed. Dental care was particularly affected by affordability, with two-thirds of those who skipped a dental visit citing cost among their reasons. Around one-third of respondents said that a shortage of money had caused them to take an action (such as pawning or selling an item or asking for financial help) or miss a bill payment during the past year. This included one in 10 respondents (10.4%) who indicated that they had been unable to pay for the medical care they needed. The survey therefore shows how financial barriers are significantly affecting people's ability to receive essential healthcare services.

Perceived challenges to accessing afterhours care without visiting an emergency department were highlighted; 45.7% of respondents believed it would be somewhat or very difficult to get care outside of traditional hours. Females, residents of low SES areas, those living outside major cities and individuals with chronic conditions were particularly likely to expect challenges to accessing afterhours care, with people aged 65 and over most likely to anticipate access difficulties. Additionally, respondents who had reported that they had needed to access afterhours care in the past year were significantly more likely to perceive it would be easy to access care afterhours.

Part C: Understanding the healthcare system

Navigating the healthcare system

Australians were asked about their ability to navigate the healthcare system using a series of questions from the Health Literacy Questionnaire (HLQ) (Osborne et al. 2013). Higher scores suggested greater ease navigating the healthcare system, with scores below 3.5 suggesting that respondents would, on average, find certain tasks difficult to do (Osborne 2022).

Across the HLQ scale related to navigating the healthcare system, the average score for all respondents was 3.49 out of 5 (Table 13). The population groups with higher scores on the scale were:

- adults aged over 65 years, who had a higher average score when compared to all other age groups
- those living in major cities, compared to people living outside of major cities
- respondents living in mid or high SES areas, who had higher average scores than respondents from low SES neighbourhoods
- people with private health insurance, compared to those without private health insurance
- individuals without chronic health conditions, who recorded a higher average score than people living with chronic health conditions.

Table 13: Ability to navigate the healthcare system: average score (base: all respondents

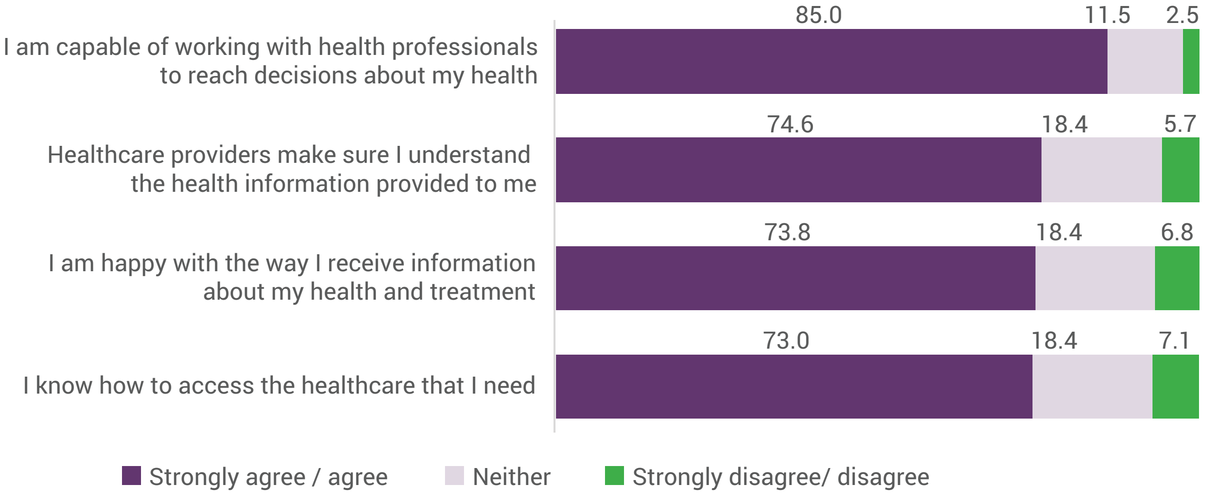
Population group	Average score
Overall (*n* = 5,029)	3.49
Gender	
Male (*n* = 2,435)[a]	3.51
Female (*n* = 2,564)	3.46
Age group	
18 to 24 years (*n* = 588)[b]	3.36
25 to 44 years (*n* = 1,848)[c]	3.40
45 to 64 years (*n* = 1,493)[d]	3.47
65 years and over (*n* = 1,100)	3.72[b***, c***, d***]
Area of residence	
Outside major city (*n* = 1,335)[e]	3.40
Major city (*n* = 3,668)	3.52[e***]
Area-based SES	
Low SES (*n* = 1,485)[f]	3.39
Mid SES (*n* = 2,002)[g]	3.50[f**]
High SES (*n* = 1,515)	3.56[f***]
Education level	
Qualifications after secondary school (*n* =2,787)[h]	3.46
Up to the end of secondary school (*n* =2,109)	3.53
Spoken language	
Language other than English (*n* =596)[i]	3.39
English only speaking household (*n* = 4,381)	3.50
Private health insurance	
Yes (*n* =3,109)[j]	3.58
No (*n* = 1,892)	3.34[j***]
Health status	
Chronic health condition (*n* =3,131)[k]	3.44
No chronic health condition (*n* = 1,898)	3.57[k***]

a, b, c, d, e, f, g, h, i, j, k reference categories
* $p < 0.05$
** $p < 0.01$
*** $p < 0.001$

Australians were asked further questions about their experiences navigating the healthcare system. The percentages of respondents who agreed or strongly agreed with each statement are presented in Figure 2.

When asked to respond to the statement I am capable of working with health professionals to reach decisions about my health, respondents were highly likely to agree or strongly agree (85.0%), a small minority (2.5%) disagreed or strongly disagreed and 11.5% stated they neither agreed nor disagreed. Three out of 4 respondents (74.6%) agreed or strongly agreed with the statement that healthcare providers make sure I understand the health information provided to me, 5.7% disagreed this was the case, while 18.4% neither agreed nor disagreed. Similar responses were received from respondents about the statement I am happy with the way I receive information about my health and treatment: 73.8% agreed, 18.4% neither agreed nor disagreed and 6.8% disagreed. Most respondents (73.0%) agreed or strongly agreed with the statement I know how to access healthcare that I need. Meanwhile, 18.5% of respondents neither agreed nor disagreed, while 7.1% of respondents disagreed or strongly disagreed.

Figure 2: Per cent who agreed to statements about navigating the healthcare system (base: all respondents)

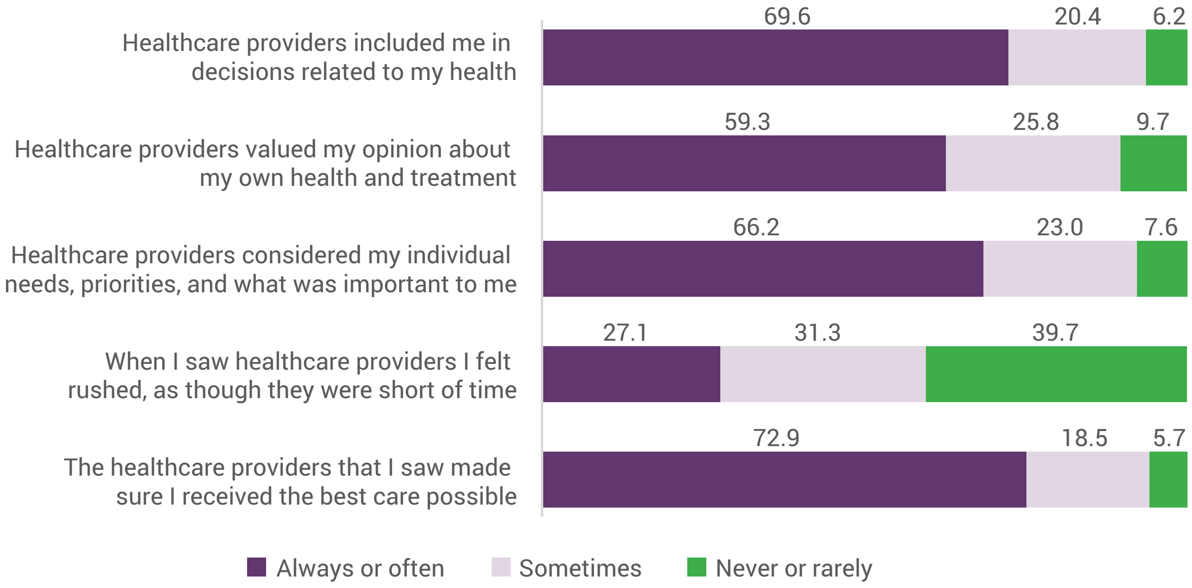


Interactions with healthcare providers

Respondents were then asked a series of questions about their experiences interacting with healthcare providers. The percentages in Figure 3 show the frequency with which respondents felt they had experienced each statement.

When asked how often in the past 12 months healthcare providers had included them in decisions about their health, 69.6% responded that this had often or always been the case. More than half of respondents (59.3%) reported that healthcare providers had often or always valued their opinion about their own health and treatment. Two-thirds of respondents (66.2%) answered that healthcare providers often or always considered their individual needs and priorities. Around one in 4 respondents (27.1%) reported often or always feeling rushed when seeing their healthcare providers, with a further 31.3% reporting that this was sometimes the case.

Figure 3: Experiences of interactions with healthcare providers (%) (base: all respondents)



The 95.9% of respondents who had accessed a health service in the past year were then asked: Do you feel that you have been discriminated against or disrespected when receiving healthcare the last 12 months? Responses were as follows:

- 8.1% answered yes, they had experienced discrimination or disrespect
- 87.1% answered no
- 3.6% responded I don't know
- the remaining 1.2% preferred not to say.

Experiences of discrimination and disrespect

Table 14 presents data on the 4,825 respondents who accessed a form of healthcare in the past year and details the percentage who stated that they had experienced discrimination or disrespect while receiving this healthcare. Overall, 8.1% of respondents who had accessed care in the past 12 months reported that they had experienced discrimination or disrespect during their healthcare service. When examining responses by demographic groups, this highlighted several groups who were significantly more likely to report having experienced discrimination or disrespect in the past year:

- females (9.9%), compared to males (5.9%)
- people aged 25 to 44 (11.2%), compared to people aged 45 to 64 years (6.8%) and compared to people aged over 65 (4.7%)
- respondents residing in a low SES area (10.1%), compared to those living in a high SES area (6.5%)
- people without private health insurance (9.8%), compared to those with private health insurance (7.1%)
- adults with a chronic health condition (10.0%), compared to those without a chronic health condition (4.7%).

Table 14: Percentage of respondents who experienced discrimination or disrespect while receiving healthcare in the past year (base: all respondents who received healthcare within services or remotely during past 12 months)

Population group (base *n*)	% who experienced discrimination or disrespect
Overall (*n* =4,825)	8.1
Gender	
Male (*n* =2,301)[a]	5.9
Female (*n* = 2,496)	9.9[a]***
Age group	
18 to 24 years (*n* = 536)[b]	7.9
25 to 44 years (*n* = 1,748)[c]	11.2
45 to 64 years (*n* = 1,455)[d]	6.8[c]**
65 years and over (*n* = 1,085)	4.7[c]***
Area of residence	
Outside major city (*n* = 1,283)[e]	7.9
Major city (*n* =3,517)	8.2
Area-based SES	
Low SES (*n* = 1,403)[f]	10.1
Mid SES (*n* = 1,925)[g]	7.9
High SES (*n* = 1,470)	6.5[f]**
Education level	
Qualifications after secondary school (*n* =2,673)[h]	8.9
Up to the end of high school (*n* =2,034)	7.0
Spoken language	
Language other than English (*n* =574)[i]	9.0
English only speaking household (*n* = 4,208)	7.9
Private health insurance	
Yes (*n* = 3,015)[j]	7.1
No (*n* = 1,784)	9.8[j]*
Health status	
Chronic health condition (*n* = 3,080)[k]	10.0
No chronic health condition (*n* = 1,745)	4.7[k]***

a, b, c, d, e, f, g, h, i, j, k reference categories

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

Approximately half of respondents who had accessed healthcare during the past year reported that they were always treated with respect (53.8%), 32.5% said they had often been treated with respect, 10.6% had only sometimes been treated with respect, 1.6% felt they had been rarely treated with respect and 0.5% reported that healthcare providers had never treated them with respect during the past year.

Similar proportions of respondents reported that health professionals had been respectful of their culture during the past year. When asked how often healthcare providers have been respectful of their culture during the past year, 53.3% responded always, 23.3% responded often, 7.2% of respondents stated sometimes, 1.9% rarely and 0.9% responded this was never the case.

Part C: Summary

Health literacy has been defined as the ability of individuals to 'gain access to, understand and use information in ways which promote and maintain good health' (Nutbeam 1998). The 2024 NCSS collected data on one aspect of health literacy – the ability to navigate the healthcare system. Lower scores on the health navigation scale indicate that individuals will on average face greater difficulties identifying and accessing the support they need. In practice this might mean an individual has greater difficulty advocating for themselves or finding people to help address their health needs, or that they have limited knowledge of the resources and supports to which they are entitled (Osborne et al. 2013). In 2024, the average score for all survey respondents was 3.49; this appeared to be lower than when the health navigation scale was included in the 2018 National Health Literacy Survey, where the average health navigation scale score for people aged 18 years and over was reported to be 4.02 (ABS 2018). Adults under the age of 65, people residing outside major cities, those in low SES neighbourhoods, those without private health insurance and respondents living with chronic conditions had lower scores, suggesting that on average people from these groups find it more difficult to navigate the healthcare system. Earlier studies have shown lower levels of health literacy to be associated with a range of poorer outcomes, including more hospital stays and greater use of emergency departments, lower uptake of preventive health services, along with poorer health outcomes, and ultimately increased healthcare costs (Berkman et al. 2011, Dewalt et al. 2004). These population groups may be at increased future risk of ill health.

Despite potential challenges to navigating the healthcare system, most respondents felt they knew how to access care and were generally likely to report that they felt capable to work with health professionals to make decisions about their health. Conversely, around one in 4 respondents reported feeling rushed during healthcare appointments (27.1%), while 8.1% had experienced discrimination or disrespect in healthcare settings. Upon further analysis, the groups more likely to report having experienced discrimination or disrespect were females, people aged 25 to 44 years, respondents residing in a low SES area, people without private health insurance as well as those with a chronic health condition.

Part D: Attitudes towards the healthcare system

Confidence in the healthcare system

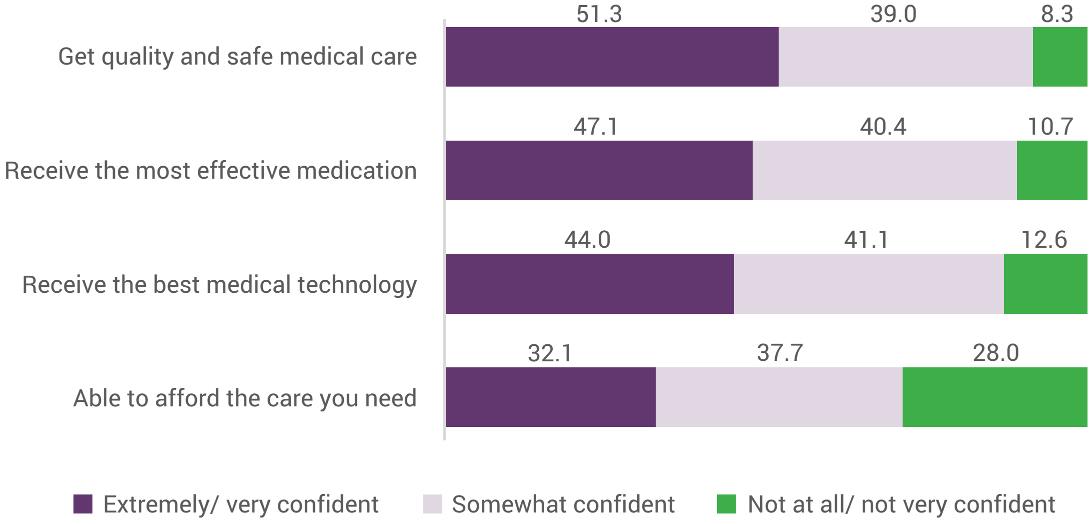
Respondents were asked about their perceived confidence in accessing healthcare if they were seriously ill (Figure 4). Approximately half of respondents (51.3%) reported they were extremely or very confident that they could get quality and safe medical care if they were seriously ill, a further 39.0% reported they were somewhat confident while 8.3% of respondents reported they were not at all or not very confident that they would be able to get quality and safe medical care when seriously ill.

When asked about their confidence to receive the most effective medication if they were seriously ill, 47.1% of respondents reported being extremely or very confident and an additional 40.4% responded being somewhat confident. Approximately one in 10 respondents (10.7%) noted that they were either not at all or not very confident that they would receive the most effective medication if they were seriously ill.

Forty-four per cent of respondents indicated they were extremely or very confident they would receive the best medical technology should they be seriously ill. A further 41.1% reported being somewhat confident and 12.6% responded that they were either not at all or not very confident in receiving the best medical technology if seriously ill.

One-third of respondents (32.1%) reported being extremely or very confident that they would be able to afford the care they needed if seriously ill, while 37.7% reported being somewhat confident that they could afford their care. More than one in 4 respondents (28.0%) reported being not at all or not very confident they could afford the care they would need if they were seriously ill.

Figure 4: Confidence to receive healthcare if seriously ill (base: all respondents)



Respondents were asked to consider whether how their confidence in the Australian healthcare system had changed over the past 12 months (Table 15). Respondents mostly reported that their confidence in the healthcare system had stayed the same (62.3%), while only 6.4% reported that their confidence had increased over the past year. Concerningly, around one in 4 Australians (28.1%) perceived their confidence in the Australian healthcare system as having decreased during the past year. A small percentage (3.2%) were unsure if their confidence had changed.

The population groups who were more likely to report that their confidence in the healthcare system had decreased in the past year were:

- females, with roughly one-third (34.2%) reporting that their confidence in the healthcare system had declined in the past year, compared to one in 5 males (21.7%)
- adults living in both low (32.8%) and mid (28.8%) SES areas compared to adults in high (22.7%) SES areas
- people living with chronic health conditions (32.0%), compared to those without chronic conditions (21.8%)
- people without private health insurance (32.2%), compared to those who were insured (25.7%).

Meanwhile, the youngest adults, aged 18 to 24 years, were significantly less likely to say that their confidence in the healthcare system had declined during the past year, when compared to each of the older age groups. Similar responses were observed when comparing population groups by area of residence, education level and whether or not English was the only language spoken at home.

Table 15: Percentage of respondents who stated their overall confidence in the healthcare system decreased in the past year (base: all respondents)

Population group	% who reported their confidence in past year had decreased
Overall (*n* = 5,029)	28.1
Gender	
Male (*n* = 2,435)[a]	21.7
Female (*n* = 2,564)	34.2[a***]
Age group	
18 to 24 years (*n* = 588)[b]	18.9
25 to 44 years (*n* = 1,848)[c]	28.3[b**]
45 to 64 years (*n* = 1,493)[d]	31.5[b***]
65 years and over (*n* = 1,100)	28.2[b**]
Area of residence	
Outside major city (*n* = 1,335)[e]	30.5
Major city (*n* = 3,668)	27.3
Area-based SES	
Low SES (*n* = 1,485)[f]	32.8
Mid SES (*n* = 2,002)[g]	28.8
High SES (*n* = 1,515)	22.7[f***, g**]
Education level	
Qualifications after secondary school (*n* = 2,787)[h]	28.3
Up to the end of secondary school (*n* = 2,109)	27.3
Spoken language	
Language other than English (*n* = 596)[i]	28.3
English only speaking household (*n* = 4,381)	28.0
Private health insurance	
Yes (*n* = 3,109)[j]	25.7
No (*n* = 1,892)	32.2[j***]
Health status	
Chronic health condition (*n* = 3,131)[k]	32.0
No chronic health condition (*n* = 1,898)	21.8[k***]

a, b, c, d, e, f, g, h, i, j, k reference categories

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

Views on healthcare in Australia

During the survey, respondents' opinions about the state of the healthcare system were collected. Around half (55.8%) of respondents responded that there are some good things about our healthcare in Australia, but major changes are needed to make it work better. Approximately one-third (34.0%) reported it usually works pretty well and only minor changes are needed, while 7.2% stated healthcare in Australia has so much wrong with it that we need to completely rebuild it. A minority felt that none of the presented statements reflected their views and responded none of the above (3.1%).

Respondents also gave their opinions on the amount the government spends on healthcare. More than half (56.3%) of respondents felt spending was too low and one-quarter (24.5%) stated it was about the right amount. A small minority (3.4%) believed government spending on healthcare was too high. A further 15.7% responded that they did not know.

Respondents indicated which areas of the healthcare system require improvement from a list of options allowing them to provide multiple answers. The most common responses identified for improvement were (% of all respondents):

- more doctors, nurses and other healthcare workers (66.0%)
- the cost of care and/or medicines (59.5%)
- better access to care (42.2%)
- better quality of care (26.7%)
- listening to patients more (25.3%)
- communication among the health professionals who look after me (24.9%)
- more information to help me make choices (24.4%)
- use of shared electronic records (21.2%)
- health professionals' knowledge (17.8%)
- coordination of my care (15.4%).

Respondents were asked to the nominate the one area of the healthcare system that they considered to need most urgent improvement. In 2024, the 3 most often cited areas identified as requiring the most urgent action were (% of all respondents):

- more doctors, nurses and other healthcare workers (39.4%)
- the cost of care and/or medicines (22.1%)
- better access to care (8.4%).

Part D: Summary

Approximately half of respondents were extremely or very confident that they would be able to access safe and quality care if they were to become seriously ill in the future. Similar proportions expressed confidence to receive effective medication and the best medical technology available. However, around one in 10 respondents lacked confidence they could expect to receive the best medications and technology if faced with serious illness. Affordability again emerged as a significant concern, with 28% of Australians lacking confidence in their ability to afford the care they would need if seriously ill in the future.

Confidence in the healthcare system had remained relatively stable for most respondents over the past year. However, it was concerning that around one in 4 respondents indicated that their confidence had declined over the past year. The groups who were most likely to report that their confidence in the Australian healthcare system had recently declined were females, people aged over 25, people residing in low to mid SES areas, people without private health insurance and people living with chronic health conditions.

When asked about their overall views on the healthcare system, around half of respondents (55.8%) felt that while there are positive aspects to the system, significant changes are needed. The primary areas respondents identified for improvement included the need for more healthcare workers, reduced costs for care and medications, better access to care and improvements in the quality of care. Some respondents also emphasised the importance of healthcare providers listening to patients more and improving communication generally.

Overall, the data suggest that while Australians generally have confidence in the healthcare system, there are notable concerns, particularly around affordability and access to services. There were clear calls to address staffing shortages, improve the affordability of care and enhance communication and coordination in the system. These findings provide an opportunity for policymakers to focus on addressing the concerns raised by the public to improve the healthcare experience for all Australians.

Conclusion

The 2024 NCSS highlights that while Australians are generally satisfied with the healthcare they receive, there are notable disparities in satisfaction as well as access, awareness and confidence. Key population groups – including younger people, those with chronic conditions, people from lower socio-economic backgrounds and those without private insurance – are especially likely to face ongoing challenges in accessing care.

The survey was undertaken at a time when Australians have been feeling the impacts of the rising cost of living. Cost was identified as a significant barrier to care, in particular dental treatment. The affordability of healthcare and medicines was regarded as the second most urgent priority for improving the healthcare system, following the provision of more healthcare workers. The survey also points to gaps in awareness and usage of systems like MyMedicare and My Health Record, suggesting a need for more targeted and ongoing promotion of these platforms.

Addressing these issues requires a focus on improving accessibility, affordability and health literacy, particularly among vulnerable and underserved groups. Ensuring that healthcare systems evolve to be more inclusive and responsive to diverse population needs will be critical in creating a more equitable and effective healthcare system in Australia.

The NCSS offers opportunities to track changes over time and to compare differences between population groups. We anticipate the survey data will be used in planning and advocacy efforts, adding weight to community feedback. Regularly surveying consumers on their experiences of and views regarding the healthcare system ensures that decisions, strategies and actions are based on solid and measurable evidence, complementing community insights to offer a more comprehensive understanding of the current status of the healthcare system.

Limitations

The NCSS does provide valuable insights into the status of the Australian healthcare system. As with any survey or data collection, the findings are another part of the puzzle and should be interpreted alongside other sources of evidence.

The survey was administered online and in English. This excluded individuals who were unable to complete the survey in this format. Therefore, survey estimates relating to barriers to care are likely to be conservative, as people with no or limited access to digital technologies or with low levels of English proficiency would be expected to face additional barriers to their care. CHF supports the development of further data collections to obtain insights into minority population groups who were not targeted by this survey.

It is important to note that the recruitment criteria required respondents to live in Australia; however, the survey did not collect data on respondents' citizenship status. The report refers to Australians generally, given that the survey aimed to be nationally representative and because the use of weighted data helped to bring the demographics of the respondents more in line with population estimates.

The survey was conducted with members of the general community, rather than with patient groups, allowing the study of unmet care. The sample was drawn from a panel, and while quota sampling was applied to match the profile of respondents (based on broad demographic factors) to the general population, there is evidence that the characteristics of people who join panels may be different to people in the general population, and some biases may not be corrected by weighting (Cornesse et al. 2020).

This first report has aimed to establish a baseline level of reporting of broad demographic groups. Analysis was conducted using independent logistic regression analysis for each variable, rather than including all independent variables as covariates. We acknowledge that this approach does not account for the effect that mediating variables may have on the reference variable, and note this should be considered in the interpretation of the results.

Major revisions were made to the questions asked in the 2024 NCSS; therefore, survey estimates may not be directly comparable to earlier iterations of the survey.

The 2024 NCSS was the first in the series of 4 planned surveys. Later surveys will allow exploration of changes over time and exploration of emerging issues.

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Appendix

Method

Field work for the 2024 National Consumer Sentiment Survey (NCSS) was undertaken online between 14 October and 13 November 2024. Following a data-cleaning process to remove responses (n = 92) where there was evidence of duplication, straight lining or speeding, 5,029 responses remained. On average, the survey took just under 16 minutes to complete. Ethics approval for the study was obtained (reference: 2024-07-939-A-1) from the Bellberry Human Research Ethics Committee.

Questionnaire development

CHF undertook an initial review of the 2021 NCSS questionnaire and other government surveys early in 2024. Survey contents were reviewed during 3 workshops with consumers and Department staff, with the aim of obtaining participants' thoughts on priority themes for data collection and reporting.

CHF reviewed the themes identified during the workshops, with a view to avoiding duplication with existing data sources, where possible. Topics that were flagged as no longer being of importance during the workshops were deleted. Where gaps were identified, CHF prioritised sourcing existing questions or scales with established validity. Standard or recommended questions were adopted to capture socio-demographics (ABS 2021b, ABS 2024c), health characteristics (ABS 2024c, Gill et al. 2009) and ability to navigate the healthcare system (Osborne et al. 2013). Questions on ability to navigate the healthcare system were sourced from the Health Literacy Questionnaire (HLQ). Novel questions were developed as a last resort, often to reflect services that are new or unique to Australia. Department staff reviewed the survey and gave feedback prior to it being finalised.

The questionnaire was programmed to be viewed and completed on a variety of devices (such as smartphones, tablets and personal computers). Given most respondents were expected to respond using smart phones, it was programmed to work effectively and clearly on the small, portrait-format screens. Grid-style questions that might not be viewed easily on smartphone screens were presented using a carousel format.

The questionnaire is comprised of core content that is expected to remain unchanged in future waves of the survey, with scope for some questions or modules to be replaced or rotated out of future surveys, in response to emerging priorities.

Piloting

Prior to going live, the questionnaire underwent internal testing and was then piloted with 66 respondents to identify any operational issues with the survey programming, such as incorrect skips. Respondents to the pilot survey were asked to provide feedback on the questions. The pilot sample was drawn entirely from the Roy Morgan Research panel using the sampling protocols outlined for the main survey, including seeking survey respondents of different ages.

Sampling and recruitment

All respondents were recruited to the main survey from one of 2 market research panels, either Roy Morgan Research (the organisation leading sampling and data collection) or Pureprofile. Two panels were used to ensure that quotas relating to population groups that are smaller and/or potentially harder to reach (such as young adults in the least-populous states) could be fulfilled in this and future waves of the survey. Respondents were remunerated for their participation with points that could be redeemed at major retailers.

To achieve a sample that was broadly representative of the Australian population, interlocking quotas were applied based on a matrix comprising:

- gender
- six age groups – 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65+ years
- geographical regions – Sydney, rest of New South Wales (including the Australian Capital Territory), Melbourne, rest of Victoria, Brisbane, rest of Queensland, Perth, rest of Western Australia, Adelaide, rest of South Australia (including Northern Territory), Hobart and rest of Tasmania.

Quotas reflected the population of Australian adults in each interlocking cell according to the ABS Labour Force Survey data (ABS 2024a) most recently available at the time of the survey. Appropriate numbers of panellists were recruited to fulfil the proportional quota in each cell.

Recruitment

To be eligible to participate, individuals needed to live in Australia and be aged 18 years or older. Participation in the survey was voluntary. Consent was obtained via a check box at the end of the introductory script.

To ensure a wider cohort of respondents, including people who are not heavily engaged online, Roy Morgan Research employed a range of methods to recruit participants from their panel, including:

- tailored invitations to potential respondents via email
- invitations via SMS for some respondents, particularly those in younger age groups or for whom there was no recorded email address
- reminder messages to panellists via email and SMS to target required quotas.

The survey was made available to Pureprofile panellists via Pureprofile's online portal and was visible to the panellists who met the study eligibility criteria and quota requirements. Pureprofile did not send out invitations or reminders to their panellists.

Data handling

On completion of data collection, Roy Morgan Research ran initial quality checks. These included checking for and deleting responses that were returned in an unrealistically quick timeframe or where straight lining occurred (suggesting respondents sped through the survey without thought). Duplicates (based on IP address, age, gender and postcode) were flagged and checked, or deleted. Given the survey was administered online using a programmed script, respondents were prompted to complete questions as they progressed through the survey, meaning there were no missing data. Responses of 'I don't know' or 'Prefer not to say' are reported alongside other response categories in this report. If a respondent dropped out without completing the survey, their responses were not analysed.

Data weights

While the survey was quota controlled; it was still necessary to weight the data back to the target population to account for some slight discrepancies in the overall quotas achieved (Roy Morgan 2024). Five dimensions were included in the weighting process. In addition to a core matrix of gender, age and location, the data were rim weighted by education (highest completed level of education) and internet usage (the amount of time a respondent used the internet on a daily basis).

To minimise the chances of very high weights, responses were merged into broader categories, and some outlier weights were capped.

- Gender: male, female (respondents who selected non-binary or use a different term were randomly allocated to one of the 2 main categories, since there are no non-binary data categories available in ABS population data)
- Age: 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65+ years
- Geographical regions: Sydney, rest of New South Wales (NSW), Melbourne, rest of Victoria (VIC), Brisbane, rest of Queensland (QLD), Perth, rest of Western Australia (WA), Adelaide, rest of South Australia (SA), Hobart, rest of Tasmania (TAS), the Australian Capital Territory (ACT) and the Northern Territory (NT).
- Education: postgraduate degree/graduate diploma, bachelor's degree, diploma, certificate III and IV, secondary education and below.
- Internet usage: 3+ times a day, twice a day, once a day, a few times a week and less

Data for gender, age, location and education were taken from ABS sources (Roy Morgan 2024), with the population estimates based on the October 2024 ABS Labour Force Survey data (ABS 2024a).

- Data on educational attainment were obtained from the 2021 ABS Census of Population (ABS 2021c). Internet usage was taken from Roy Morgan's Single Source data, using responses from the 12-month period prior to June 2024. The above categories were used by Roy Morgan Research to derive a weight variable for inclusion in the dataset.

Respondent classifications

Major city and outside major city classification

Area of residence (metropolitan area or regional area) was allocated based on the Australian Statistical Geography Standard (ASGS) Remoteness Structure (ABS 2021d). The ASGS Remoteness Structure divides Remoteness Areas into 5 classes of remoteness: Major Cities, Inner Regional, Outer Regional, Remote and Very Remote. Based on their postcodes, respondents were allocated to Remoteness Areas. Respondents were grouped into either residing in a major city (respondents classed as Major Cities on the ASGS Remoteness Structure), or outside a major city in a regional area (all other groups). Using this classification, Hobart and Darwin are not classified as major cities.

Socio-economic status

The Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) (ABS 2021e) was used to determine respondents' socio-economic area of residence. The IRSAD is an index that includes both relative advantage and disadvantage across measures relating to economic and social conditions of people living within an area (ABS 2021e). Postcodes were used to categorise respondents into IRSAD deciles before these were combined to create socio-economic status (SES) values for each individual. Respondents with IRSAD deciles denoting relatively greater disadvantage and a lack of advantage (i.e. deciles 1 to 4) were grouped into a low SES group. Respondents with IRSAD deciles of 5 to 8 were grouped into a mid SES group, while respondents with IRSAD deciles indicating a relative lack of disadvantage and greater advantage (i.e. deciles 9 and 10) were grouped into a high SES group.

Chronic conditions

For consistency in reporting across the sector, the questionnaire derived a question on chronic conditions from the Patient Experience Survey (ABS 2024b). Respondents were presented with a list of 7 conditions, with the option to report any other condition/s that have lasted, or are expected to last, 6 months or more. For analyses and reporting purposes, respondents who reported at least one chronic condition were compared to respondents living without any chronic conditions.

Education status

For reporting purposes, respondents were allocated to 2 groups depending on the highest level of education that they had obtained. Respondents who reported that they had received any education up to the end of secondary school were allocated to the 'up to the end of secondary school' group. Respondents who reported certificate-level, diploma-level, undergraduate or postgraduate qualifications were allocated to the 'qualifications after secondary school' group.

Navigating the healthcare system

Respondents' ability to navigate the healthcare system was assessed using scale 7 of the HLQ, 'Navigating the healthcare system' (Osborne et al. 2013). The HLQ provides insight into health literacy strengths and limitations for individuals and communities and each scale can be used independently to measure specific constructs (Osborne et al. 2013). The scale comprised of 6 questions with 5-point Likert-response options ranging from one ('Cannot do or always difficult') to 5 ('Always easy'). A mean score for each respondent was calculated across the 6 questions. A higher mean score indicates greater ease navigating the healthcare system.

Statistical analyses

Statistical analyses of the survey data were undertaken in RStudio version 2023.09.1+494. Data were weighted using the weight variable provided by Roy Morgan Research. Generalised linear models (GLMs) were constructed for both categorical and continuous dependent variables. Categorical models used binary variables that were derived for the purposes of comparing the responses of socio-demographic groups. Logistic regression was performed for each of these binary variables. Linear regression was performed for the one continuous variable – the scores from scale 7 of the HLQ. The respective models explored each level of the socio-demographic variables, and in each model a reference category was assigned for comparison to other levels of each independent variable. For example, each age group was assigned as the reference category in a separate model, to ensure that all interactions between variable levels were explored. GLMs did not include covariates; each independent variable was assessed independently for its effect on the dependent variable. All GLMs were built and run using the 'survey' package in RStudio to better account for data from a complex survey design (Lumley 2023). The survey package accounts for survey design features such as stratification and weighting. As quota sampling was applied to ensure representation of the sample and weights were used to adjust to the broad demographic characteristics of the Australian population, use of the survey package assisted in accounting for these features. Group differences were only reported if results of the regression analysis reached significance at the $^{*}p < 0.05$, $^{**}p < 0.01$, or $^{***}p < 0.001$ level.

Weighted numbers and percentages are presented throughout the report. Due to rounding, percentages may not add up to 100 per cent. For clarity of presentation, 'I don't know responses' are not included in graphs in this report. Survey responses of people from small groups, such as the respondents who identified as non-binary, are also not included. For the purposes of summarising survey responses, response categories are sometimes collapsed.

Table A1: Ranked reasons for private health insurance (multiple answers permitted)

Reason	Weighted *n*	Weighted %
For peace of mind	1,732	55.7
To access treatment as a private patient	1,550	49.9
To obtain the benefits of Extras	1,414	45.5
For shorter waiting times	1,304	41.9
For better choice of doctors and services	1,240	39.9
To pay less tax (for example, to avoid the Medicare Levy Surcharge)	1,021	32.8
I'm more likely to need treatment in the future and/or am getting older	994	32.0
To avoid paying more for cover when I'm older	791	25.4
I, or family members, have an illness or condition that requires treatment	364	11.7
Someone else (such as a parent or employer) pays for it	252	8.1
For health cover while on a temporary visa	119	3.8
Other financial reasons	61	2.0
Any other reasons	83	2.7

Table A2: Ranked reasons for not having private health insurance (multiple answers permitted)

Reason	Weighted *n*	Weighted %
It's too expensive	1,322	69.9
Medicare cover is good enough	674	35.6
Out-of-pocket costs or gap fees are too much, even with private health insurance	653	34.5
I can't afford to pay for my healthcare	644	34.0
It's not good value for money	614	32.5
I have a concession card (such as Pensioner/Veteran's affairs/ or health concession card)	544	28.8
It's not a high priority for me	350	18.5
I'm in good health	243	12.9
I'm not eligible to pay the Medicare Levy Surcharge	100	5.3
I'm in a high-risk category	63	3.3
I am not eligible for cover	38	2.0
I'm included in my parents' cover	23	1.2
Another reason	71	3.7