Consumers Health Forum of Australia

Speaking Up for Health:

Findings from the 2025 National Consumer Sentiment Survey

Executive summary

Australia's healthcare system continues to deliver strong outcomes for most people. Medicare remains a cornerstone of access, and many Australians report positive experiences with their providers. However, gaps in affordability and access persist, creating challenges for those facing financial stress, chronic illness or other barriers. These issues raise important questions about whether current models of care and policy settings fully meet the needs and expectations of health consumers.

This report aims to answer these questions through capturing consumers' perspectives via the 2025 National Consumer Sentiment Survey (NCSS). The results from this survey, alongside insights from the 2024 report, will help inform future healthcare planning, policy and service design to better reflect the lived experiences and expectations of health consumers.

Methodology

Between February and March 2025, we surveyed a nationally representative sample of Australian adults (aged 18 and over) across all states and territories, collecting their demographic details, self-reported health status, views on healthcare, and details of their experiences within the system and barriers to access.

We analysed the data, which was weighted using age, gender and Australian states and territories, using descriptive statistics. We also used chi-square and t-tests to compare 2024 and 2025 results. Multivariable logistic and linear regressions were used to identify factors linked to health outcomes, healthcare views, system experiences and access barriers.

Survey findings

The 2025 survey included 5,160 respondents, whose gender, age, location of residence and other background details closely matched our 2024 data and national Australian Bureau of Statistics (ABS) estimates, providing a consistent snapshot of people's healthcare experiences and expectations.

The survey findings showed a range of views and experiences regarding health and healthcare in 2025, including affordability, access, quality and confidence in the healthcare system.

What people think about their health

- Around 38.2% rated their health as "Very good" or "Excellent", similar to 2024.
- Of all respondents, 61.7% live with at least one chronic condition and 28.2% have 2 or more.
- The most common chronic conditions were mental health conditions (24.8%), arthritis (20.3%) and asthma (13.7%).
- People with chronic illness, financial stress or lower education were more likely to report poor health.

Healthcare access and affordability

- Almost everyone has Medicare (97.0%), but only 60.9% have private health insurance.
- Cost (i.e. too expensive) was the main reason for not having insurance (71.9%).
- In the past year 35.6% of Australians experienced financial stress, making it harder to pay for healthcare, medicines and even household bills.
- Financial stress was the most significant factor linked to poor health outcomes, impacting people's access, satisfaction and confidence in the system.

New digital health services

- Awareness of MyMedicare was limited, with only 32.8% reported having heard of it; among those, just over half (54.0%) had registered.
- More people were aware of My Health Record compared to MyMedicare (70.2%) and most who registered found it useful, especially older people and those with chronic conditions.
- People who speak languages other than English at home and those with lower education are less likely to know about these services.

Unmet healthcare needs and navigation challenges

- Nearly 49.8% missed out on care they needed. Cost was the main barrier, especially for dental care (67.0%), prescriptions (54.2%) and treatments (48.7%).
- The proportion of people reporting they were too busy to seek care was higher in 2025 than in 2024.
- Navigating the system was difficult for many, especially people in rural areas and in culturally and linguistically diverse communities.

Experiences with healthcare providers

- Most people felt they were respected by their providers (86.5%) and included in decisions (72.9%).
- In-person care was rated highly, particularly general practitioners (GPs) and pharmacists.
- Telehealth use was steady at 43.1%, with respondents noting that while it was convenient, it felt less personal than in-person care.
- After-hours care use was limited; 31.7% used it, mostly through emergency departments.

Healthcare satisfaction and respectful care

- Overall satisfaction with healthcare quality was high (81.6%), especially among older and higher income earners.
- Respectful care (86.5%) and cultural sensitivity (77.8%) during healthcare were commonly reported.
- Reports of discrimination or disrespectful care fell to 6.5% in 2025 from 8.1% in 2024, with declines among women, metropolitan residents, English-only speakers and those with lower education.
- Chronic illness and financial stress were the strongest predictors of experiencing healthcare discrimination or disrespectful care.

Views on the healthcare system

- Most people (55.6%) thought the system needed major changes, not a complete overhaul.
- Confidence in care quality was moderate (50.6%), but only 32.3% felt confident they could afford care if seriously ill.
- Over half (57.1%) believed that government spending on healthcare is too low. Top priorities identified were increasing the number of health workers, reducing costs and improving access.

Conclusions

The 2025 findings highlight a trusted but strained healthcare system, challenged by issues of affordability, unmet health needs, and disparate awareness and use of services. Access to equitable care is further hindered by disparities linked to financial stress, language barriers, sexual orientation and geographic isolation. Targeted reforms, improved outreach and strategic investment, especially in rural and remote areas, are essential. Prioritising affordability, cultural competence and inclusive design will be key to building a more responsive and equitable system.

Limitations

The 2025 NCSS offers insights but reflects a single point in time, with timing differences between the 2024 and 2025 surveys potentially affecting comparability. Self-reported data may be influenced by recall and social desirability bias, and while regression analyses controlled for confounders, causal relationships cannot be inferred. Underrepresentation of certain groups and survey mode effects may limit generalisability, and some variables could not be compared due to differences in research methods.

Next steps

The 2024 and 2025 NCSS surveys provided a strong foundation for tracking healthcare experiences as Strengthening Medicare reforms are implemented. To ensure continued relevance, Consumers Health Forum of Australia (CHF) has reviewed the 2025 survey in collaboration with the Australian Government Department of Health, Disability and Ageing and consumer representatives ahead of the 2026 launch. CHF looks forward to the next NCSS findings in late 2026, which will reflect evolving priorities and consumer needs.

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Acknowledgements

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Acronyms

ABS:	Australian Bureau of Statistics
CALD:	culturally and linguistically diverse
CHF:	Consumers Health Forum of Australia
Department:	Australian Government Department of Health, Disability and Ageing
DVA:	Department of Veterans' Affairs
GP:	general practitioner
HLQ:	Health Literacy Questionnaire
IRSAD:	Index of Relative Socio-economic Advantage and Disadvantage
LGBTQIA+:	lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual/aromantic/agender (the "+" [plus] signifies other identities not explicitly listed)
LOTE:	Language other than English spoken at home
MHR:	My Health Record
NCSS:	National Consumer Sentiment Survey
PHI:	private health insurance
SES:	socio-economic status

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Foreword

The 2025 National Consumer Sentiment Survey is not just a snapshot of how Australians experience the health system. It is a measure of how safe people feel relying on it.

Each year consumers tell us what is working, what is failing, and where the pressure is building. This year the message is unmistakable. Australia has a health system capable of delivering world-class care, but too many people are being priced out of it. Financial stress is not sitting at the edges of health policy. It is sitting at the centre of people's lives.

Affordability is not an abstract economic issue. It determines whether someone sees a doctor, fills a prescription, fixes their teeth, or waits and hopes a problem will pass. When care becomes unaffordable, the burden does not disappear. It shifts onto families, communities, and the public system. This is not inevitable. It reflects choices about how healthcare is funded, priced, and prioritised.

This year's report is especially significant. For the first time, the NCSS includes dedicated data from Australia's LGBTQIA+ communities. Their voices, long underrepresented in national health sentiment research, offer valuable insight into their distinct challenges and needs. We know that members of the LGBTQIA+ community can experience higher rates of poor health outcomes, discrimination, and unmet care needs. Having this data is an essential step toward ensuring our health system better reflects and responds to the diversity of Australians.

The survey also forces us to confront an uncomfortable reality: the cost of care is not rising in a vacuum. Healthcare is increasingly shaped by commercial markets, and when prices rise faster than people's ability to pay, access becomes unequal by default. Consumers experience this not as an economic theory, but as a simple question: can I afford to be well? A sustainable health system must balance innovation and enterprise with a clear public commitment that essential care cannot become a luxury good.

Another uncomfortable reality this survey asks us is, are we building a public healthcare system which benefits the rich? The survey clearly shows the link between people's financial health and their physical health. Australians have rightly supported universal access to healthcare and see it as a human right, but is our healthcare system now discriminating against you based on your bank account and postcode?

The 2025 results spotlight clear pressure points in Australia's healthcare system. Gaps in digital health awareness, ongoing difficulties navigating care, and entrenched inequities, felt by people with chronic illness, those in rural and remote communities, culturally and linguistically diverse groups, and now unmistakably LGBTQIA+ Australians, show how far we still have to go. These groups need stronger support to access, afford, and exercise agency over their healthcare.

Australians continue to trust their healthcare providers and value in person care. Yet almost one in two still missed care they needed in the past year. This is not a small number. It is a call to action.

We must do more to reduce costs, expand access, strengthen cultural safety, and build a system that delivers timely, high quality care for everyone—regardless of identity, postcode, language, or income. The findings demand targeted reforms, clearer communication, and greater investment where disparities are deepest.

At the Consumers Health Forum of Australia, we remain committed to elevating the voices of health consumers and ensuring they drive meaningful system change. In response to the insights revealed in this year's NCSS, CHF will intensify its advocacy for a more affordable healthcare system, for stronger primary care reforms, for inclusive digital health design, and for a national focus on the health impacts of financial stress. We will champion policies that strengthen equity, especially for groups whose needs have too often been overlooked.

The NCSS exists for one reason: to anchor health policy in lived reality. The findings in this report are not marginal. They describe pressures that are already reshaping how Australians seek care, whom they trust, and whether they feel the system is on their side.

A consumer-centred health system is not a slogan. It is one where affordability is treated as a safety issue, equity is treated as infrastructure, and inclusion is designed in from the start. The task ahead is not to admire the data, but to act on it.

Australians have been clear about what they need. The responsibility now sits with all of us to build a system that meets them there.

Dr Elizabeth Deveny
CEO

Consumers Health Forum of Australia

Introduction

Australia's population is growing, ageing and becoming more diverse, bringing new pressures to its healthcare system. To continue delivering effective care for everyone, the system must adapt in ways that reflect the lived experiences, expectations and needs of health consumers.

Australian consumers' perspectives and experiences regarding their healthcare can not only help improve understanding of the healthcare system through the lens of the consumer but also help inform future healthcare delivery and planning for the community. By offering an independent voice for health consumers, the Consumer Health Forum of Australia (CHF) plays a vital role in promoting national engagement in health-related issues. As part of efforts to monitor the Strengthening Medicare reforms,[1] the CHF will conduct the National Consumer Sentiment Survey (NCSS) annually from 2024 to 2027. The NCSS is a nationally representative survey designed to capture Australians' perspectives and experiences regarding their healthcare.

Prior to 2024, consumer sentiment surveys were conducted by the CHF in 2018 and 2021. To inform the 2024 update, CHF consulted stakeholders, including health consumers and staff from the Department of Health, Disability and Ageing (the Department). Feedback highlighted that rising living costs are increasingly affecting healthcare affordability. Stakeholders also emphasised the need to examine healthcare access, particularly for underserved populations who may face additional barriers to care or challenges navigating the healthcare system.

Based on these concerns, the 2024 NCSS, the first of 4 annual surveys, was developed and conducted between October and November 2024. The 2025 survey was conducted between February and March 2025.

Aims

This report presents the results of the 2025 NCSS. Given the minimal changes to the survey questions between the 2024 and 2025 iterations (see Method), we also include a comparison of findings across both years. Comparing the 2024 and 2025 NCSS results can provide insights and implications for healthcare policy, service design and consumer engagement.

Method

The full method is outlined in Appendix A. Briefly, the survey captured respondents' demographics, health, healthcare views, system experiences and access barriers. For analysis, we reclassified age, area of residence, socio-economic status (SES), education level and language other than English spoken at home (LOTE) (see A2. Respondent classifications in Appendix A).

Interpretation of findings

We used a sampling method that included people of different ages, genders and locations across Australia to make sure our survey reflected the views and experiences of the wider population.

We summarised the data using the means, frequencies and percentages and used chi-square tests and independent samples t-tests to compare differences in demographics and other key factors between the 2024 and 2025 data (see A3. Statistics used in this report).

Finally, we used multivariable binomial logistic and linear regressions to explore what factors might be linked to health, views on healthcare, experiences with national systems, and barriers to accessing care (see Appendix B: Logistic and linear regression results). These insights help us understand where improvements might be needed and who might be most affected by inequities in health and healthcare access.

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[1] Department of Health, Disability and Ageing, "Strengthening Medicare – Supporting Change Management and Cultural Change," 21 May 2025, https://www.health.gov.au/our-work/strengthening-medicare-measures/supporting-change-management-and-cultural-change.

Profile of survey respondents

A total of 5,160 respondents participated in the 2025 survey. As shown in Table 1, respondents' gender, age, state of residence and area of residence from the 2025 survey closely match those from the 2024 survey and align with national Australian Bureau of Statistics estimates.[2]

The employment status, income and identification as an Aboriginal and/or Torres Strait Islander person among respondents from the 2025 NCSS survey was similar to the national ABS estimates.

As with the 2024 NCSS, the 2025 NCSS reported lower proportions of respondents born outside Australia (18.2%) and those who spoke a language other than English at home (12.5%) compared to national estimates from the ABS,[3] which indicate 33.0% and 22.9% respectively. These discrepancies may reflect limitations in how these categories were defined and captured in the surveys used.

We could not compare 2024 and 2025 NCSS data on sexual orientation, disability and carer status with ABS estimates due to differences in methodology.

Table 1: Socio-demographic characteristics of survey respondents are consistent with external sources

Population group	2025 (*n* = 5,160)		2024 (*n* = 5,029)		ABS
	Weighted *n*	**Weighted per cent**	**Weighted *n***	**Weighted per cent**	**Population data***
Gender		-	-	-	-
Male	2,511	48.7	2,435	48.4	49.1
Female	2,619	50.8	2,564	51.0	50.9
Persons who identify as non-binary	27	0.5	19	0.4	Not reported
I use a different term	3	0.1	11	0.2	Not reported
Age					
18–34 years	1,563	30.3	1,539	30.6	30.4
35–54 years	1,723	33.4	1,672	33.2	33.3
55–74 years	1,295	25.1	1,332	26.5	26.0
75 years and over	579	11.2	485	9.7	10.2
State					
New South Wales	1,614	31.3	1,556	30.9	31.2
Victoria	1,328	25.7	1,298	25.8	25.8
Queensland	1,053	20.4	1,028	20.4	20.4
Western Australia	558	10.8	551	11.0	10.9
South Australia	364	7.0	356	7.1	7.0
Tasmania	109	2.1	108	2.1	2.1
Northern Territory	46	0.9	47	0.9	0.9
Australian Capital Territory	89	1.7	85	1.7	1.7
Area of residence^					
Metropolitan areas	3,474	67.3	3,371	67.0	67.9
Regional and large rural centres	842	16.3	895	17.8	15.1
Small and medium rural centres and remote areas	825	16.0	739	14.7	17.0

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[2] Australian Bureau of Statistics, "Labour Force, Australia, Detailed," January 2025, https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia-detailed/jan-2025.

[3] Australian Bureau of Statistics, "Census of Population and Housing, 2021. Tablebuilder.," June 2022, https://www.abs.gov.au/statistics/microdata-tablebuilder/available-microdata-tablebuilder/census-population-and-housing.

Population group	2025 (*n* = 5,160)		2024 (*n* = 5,029)		ABS
	Weighted *n*	Weighted per cent	Weighted *n*	Weighted per cent	Population data*
Unknown	19	0.4	24	0.5	0.0
Aboriginal and/or Torres Strait Islander origin					
No	4,890	94.8	4,764	94.7	92.6
Yes, Aboriginal	142	2.7	156	3.1	2.3
Yes, Torres Strait Islander	16	0.3	10	0.2	0.1
Yes, both Aboriginal and Torres Strait Islander	20	0.4	8	0.2	0.1
Unknown	92	1.8	91	1.8	4.9
Household income per week					
Negative income	13	0.3	19	0.4	0.4
Nil income	75	1.5	69	1.4	1.4
$1–$299 per week	86	1.7	105	2.1	1.9
$300–$999 per week	1,126	21.8	1,082	21.5	23.5
$1,000–$1,999 per week	1,281	24.8	1,322	26.3	24.9
$2,000–$2,999 per week	817	15.8	778	15.5	18.3
$3,000–$3,999 per week	423	8.2	400	7.9	10.1
$4,000–$4,999 per week	200	3.9	232	4.6	6.3
$5,000–$5,999 per week	119	2.3	119	2.4	2.8
$6,000–$7,999 per week	124	2.4	85	1.7	2.4
$8,000 or more per week	94	1.8	100	2.0	0.9
Unknown	800	15.5	719	14.3	7.1
Current work status					
Employed	3,002	55.5	3,022	57.7	59.1
Not employed	2,075	43.0	1,954	41.3	35.1
Unknown	83	1.5	53	1.0	5.8
Highest level of education	–	–	–	–	–
Up to the end of high school	2,138	41.4	2,108	41.9	37.8
Qualifications after secondary school	2,847	55.2	2,787	55.4	53.9
Other or Prefer not to say	174	3.4	134	2.7	8.2
Language other than English spoken at home					
Yes	644	12.5	596	11.8	22.9
No	4,451	86.3	4,381	87.1	71.3
Unknown	64	1.2	53	1.0	5.8
Born in Australia	–	–	–	–	–
Yes	4,187	81.1	4,093	81.4	61.4
No	937	18.2	890	17.7	33.0
Unknown	36	0.7	46	0.9	5.6

* Data derived from Labour Force Survey data from ABS[4]
^ Data derived from ABS Census of Population and Housing[5]

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[4] Australian Bureau of Statistics, "Labour Force, Australia, Detailed."

[5] Australian Bureau of Statistics, "Census of Population and Housing, 2021. Tablebuilder."

Health status

Health status is a key indicator of individual wellbeing, as it reflects the overall physical, mental and social condition of individuals.[6] It influences quality of life, productivity and life expectancy, and helps guide decisions in healthcare planning, resource allocation and policy development.[7] Understanding health status allows disparities to be identified, progress to be tracked over time and the preparation of responses to emerging health challenges.

Common comorbidities illustrate the complexity of clinical management required to meet diverse and overlapping needs. For individuals with multiple diagnoses, seeking care can be overwhelming, time-consuming and costly due to fragmented services and conflicting treatment plans across various providers.

We asked all respondents to rate their current health status and identify which chronic conditions they have been living with in the past 6 months.

Self-rated health status

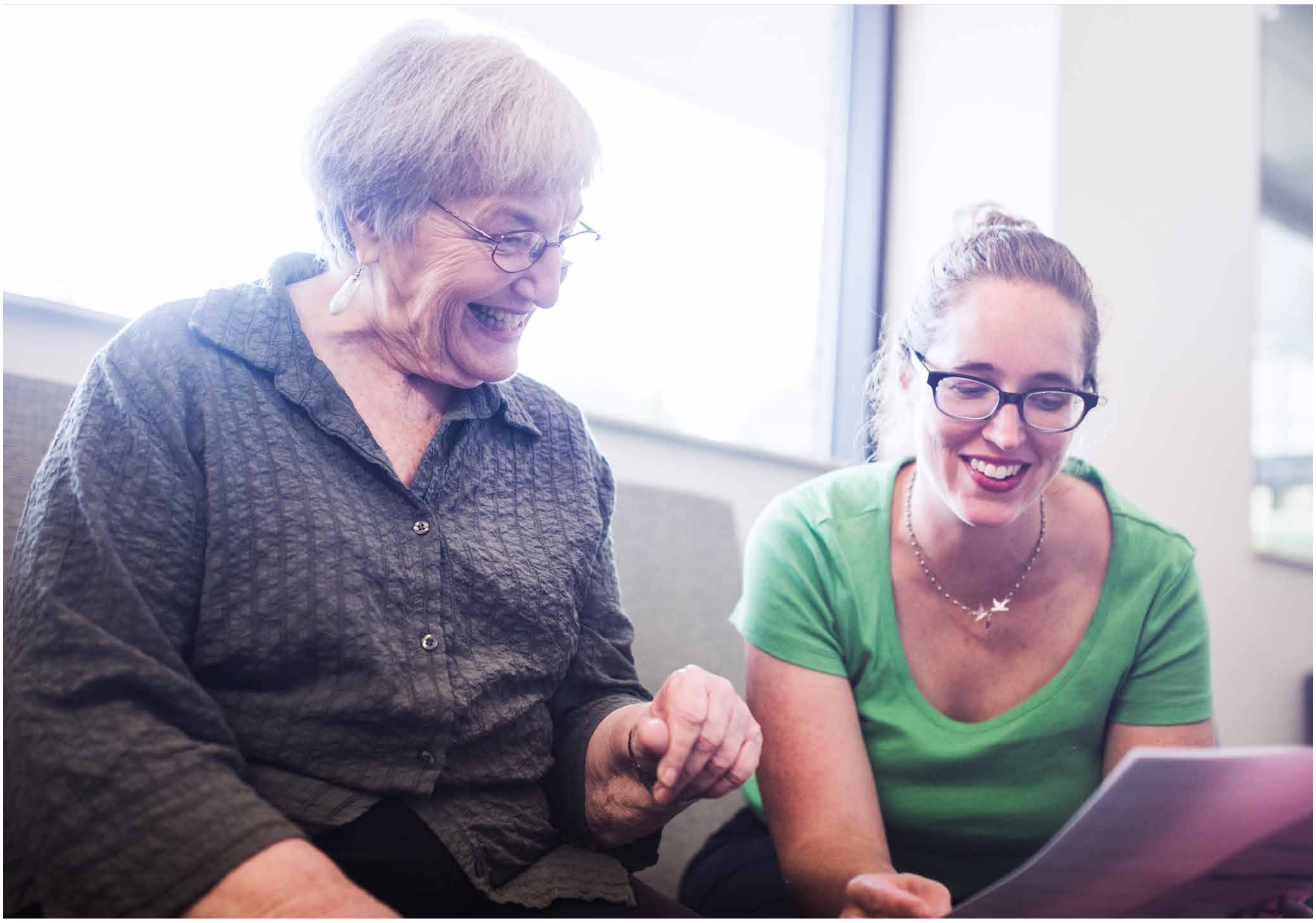
Self-rated health status in 2025 was similar to that reported in 2024. Among respondents in 2025:

- 2 in 5 (38.2%) rated their health as "Very good" or "Excellent" (versus 39.2% in 2024)
- 2 in 5 (39.3%) rated their health as "Good" (versus 38.4% in 2024)
- 1 in 4 (22.3%) rated their health as "Poor" or "Fair" (versus 22.3% in 2024).

Chronic conditions

Among respondents in 2025:

- 3 in 5 (61.7%) reported having at least one chronic health condition (versus 62.3% in 2024)
- 1 in 4 (28.2%) reported having 2 or more chronic health conditions (versus 28.8% in 2024).



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[6] World Health Organization, "Glossary of Health Data, Statistics and Public Health Indicators," January 2025, https://www.who.int/publications/i/item/9789240105485.

[7] Australian Institute of Health and Welfare, "Australian Health Performance Framework (AHPF)," 2023, https://www.aihw.gov.au/reports-data/ahpf/australias-health-performance-framework.

As shown in Figure 1, the most reported chronic conditions in 2025 were mental health conditions (24.8%), arthritis (20.3%) and asthma (13.7%). The most frequently reported comorbidities (i.e. co-occurring chronic conditions) were asthma and mental health conditions (5.4%), arthritis and mental health conditions (5.3%), and arthritis and heart disease (5.0%) (Table 2).

Figure 1: The prevalence of chronic conditions among participants was similar between 2024 and 2025

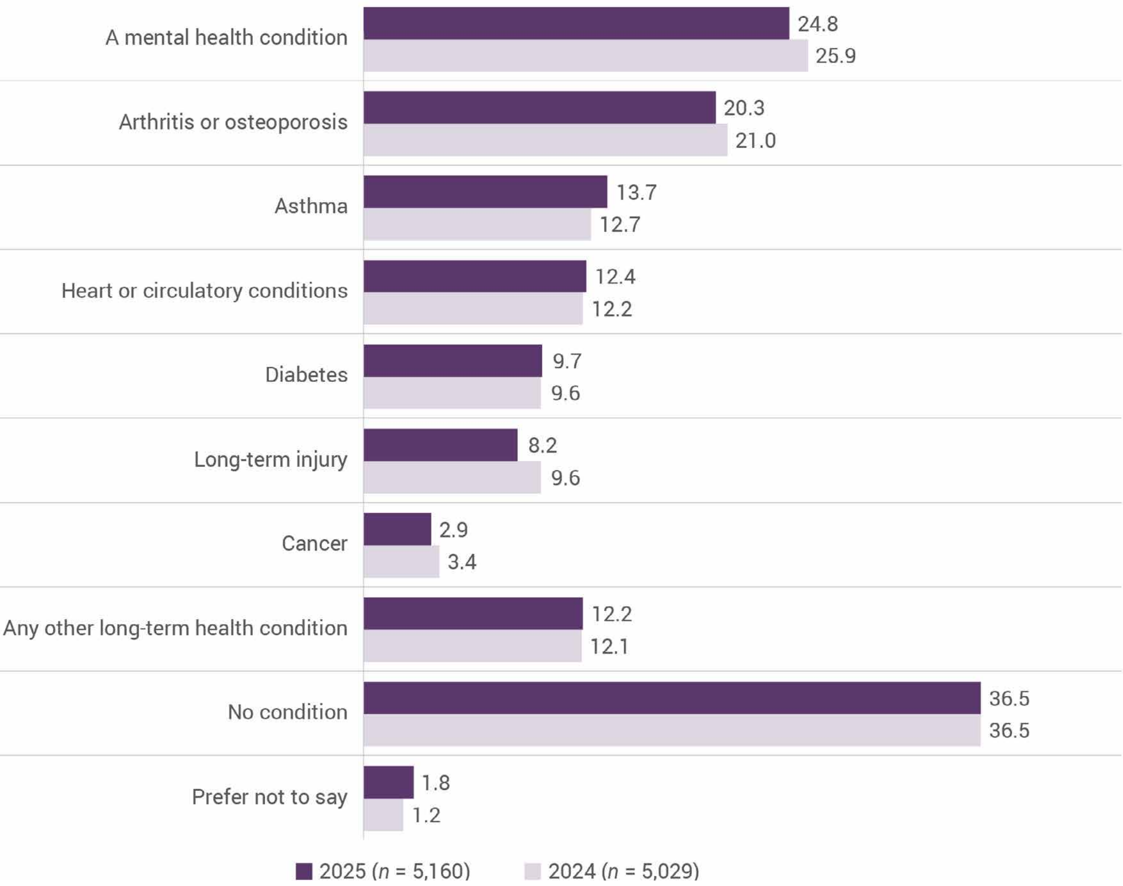

Table 2: The top 10 most common co-occurring chronic health conditions in 2025 featured combinations of asthma, arthritis and mental health conditions

Condition #1	Condition #2	Co-occurrence rate (%)
Asthma	Mental health	5.4%
Arthritis	Mental health	5.3%
Arthritis	Heart disease	5.0%
Arthritis	Asthma	4.2%
Mental health	Any other condition	3.8%
Arthritis	Long-term condition	3.7%
Mental health	Long-term condition	3.3%
Arthritis	Diabetes	3.2%
Diabetes	Heart disease	3.2%
Arthritis	Any other condition	3.2%

Factors significantly associated with self-rated health

Our analysis showed that chronic illness and education emerged as the strongest predictors of self-rated health, with clear socio-economic gradients and age patterns reflecting typical health self-assessments.

Key findings from our 2025 data (see Appendix B1) found the following.

- The strongest predictor, not surprisingly, was chronic illness, with those having at least one chronic condition showing dramatically lower odds of very good or excellent health compared to those without chronic illness (odds ratio [OR] = 0.36).
- Individuals with financial stress were less likely to report very good or excellent health than those without financial stress (OR = 0.80) and individuals with difficulties affording care were less likely to report very good or excellent health than those without difficulties affording care (OR = 0.66). Only the highest income group (> $4,000 weekly) were more likely to report very good or excellent health than the lowest income group (< $1,000 weekly) (OR = 1.68).
- Individuals with post-secondary education were significantly more likely to report very good or excellent health compared to those with secondary education (OR = 1.70). While it is unclear whether further education directly influences perceived health or whether healthier individuals are more likely to pursue higher education, the association may be partly explained by income. Higher education is linked to higher income, and as noted prior, individuals with higher income reported better health than those with lower income.
- Consistent with patterns of health decline,[8] middle-aged adults had lower odds of reporting very good or excellent health compared to those aged 18 to 34: ages 35 to 54 (OR = 0.66) and 55 to 74 (OR = 0.69). Adults aged 75 and older showed no significant difference.
- Compared to heterosexuals, non-heterosexual individuals had significantly lower odds of very good or excellent health (OR = 0.58).
- Lacking private health insurance (PHI) was associated with lower odds of very good or excellent health (OR = 0.82).

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[8] Syed Afroz Keramat et al., "Obesity and the Risk of Developing Chronic Diseases in Middle-Aged and Older Adults: Findings from an Australian Longitudinal Population Survey, 2009–2017," *PloS ONE* (United States) 16, no. 11 (2021): e0260158, https://doi.org/10.1371/journal.pone.0260158.

Summary and reflections

Health status and chronic conditions

Health status shapes quality of life, productivity and life expectancy. It also guides decisions in healthcare planning, resource allocation and policy. Common comorbidities highlight the complexity of clinical management needed to address overlapping consumer needs. Our findings highlighted the consistent trends in the respondents' self-rated health and chronic conditions between 2024 and 2025.

Overall, self-rated health remained stable with about 3 in 4 (77.5%) people reporting good health, consistent with 2024 figures. The high prevalence of chronic conditions, reported by over 60% of respondents in both 2024 and 2025, highlights the ongoing burden of long-term health issues in the Australian population.

Mental health, arthritis and asthma emerged as the most common conditions in 2025, often appearing in comorbid combinations. These patterns suggest that many individuals are managing complex health needs, which may require coordinated and multidisciplinary care. The frequent co-occurrence of mental health with physical conditions like asthma and arthritis also highlights the importance of integrating mental health support into chronic disease management strategies.

Our adjusted analysis found that living with at least one chronic condition was the strongest predictor of poorer self-rated health, reinforcing the substantial impact long-term health conditions have on individuals' perceptions of their overall health.[9,10] Higher level of education and higher income were associated with better self-rated health, suggesting that socio-economic advantages may contribute to more favourable perceptions of health. While it is unclear whether higher education directly improves perceived health or if healthier individuals are more likely to pursue further education, the association may be partly driven by income.[11] Since higher education is often linked to greater earning potential,[12] and individuals with higher incomes tend to report better health, income may act as a mediator in this association.

Interestingly, middle-aged adults (≥ 35 years) and LGBTQIA+ individuals (lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic/agender and other identities not explicitly listed) were less likely to report good health. Middle-aged adults often balance demanding careers, raising children and caring for ageing parents, all of which can contribute to stress and having less time for self-care. Additionally, the onset of age-related health issues, such as early signs of chronic conditions, may emerge,[13] influencing how individuals assess their overall health. LGBTQIA+ individuals may encounter social stigma in healthcare settings, which can manifest as assumptions about sexual orientation, discomfort in disclosing personal information or fear of discrimination.[14] These experiences can lead to avoidance of care, underreporting of symptoms and increased psychological distress, all of which can contribute to poorer self-rated health.[15]

Additionally, we found that not having PHI was associated with poorer self-rated health. Individuals without PHI may face longer wait times, limited provider options or reduced access to certain treatments and allied health services, all of which can influence how they perceive their health.[16] This finding illustrates how financial and structural barriers can limit access to positive healthcare experiences, reinforcing the need for equitable access to quality care across all population groups.

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[9] Agnes Emilia Walker, "Multiple Chronic Diseases and Quality of Life: Patterns Emerging from a Large National Sample, Australia," *Chronic Illness* 3, no. 3 (2007): 202–18.

[10] John D. Glover et al., "The Socioeconomic Gradient and Chronic Illness and Associated Risk Factors in Australia," *Australia and New Zealand Health Policy* 1, no. 1 (2004): 8.

[11] Helen Louise Berry and Jennifer A. Welsh, "Social Capital and Health in Australia: An Overview from the Household, Income and Labour Dynamics in Australia Survey," *Social Science & Medicine* (England) 70, no. 4 (2010): 588–96, https://doi.org/10.1016/j.socscimed.2009.10.012.

[12] Berry and Welsh, "Social Capital and Health in Australia: An Overview from the Household, Income and Labour Dynamics in Australia Survey."

[13] Keramat et al., "Obesity and the Risk of Developing Chronic Diseases in Middle-Aged and Older Adults: Findings from an Australian Longitudinal Population Survey, 2009–2017."

[14] Karinna Saxby et al., "Structural Stigma and Sexual Health Disparities Among Gay, Bisexual, and Other Men Who Have Sex With Men in Australia," *Journal of Acquired Immune Deficiency Syndromes* (United States) 89, no. 3 (2022): 241–50, https://doi.org/10.1097/QAI.0000000000002851.

[15] Roni Diamant-Wilson et al., "'I Felt like a Freak When I Would Go to the Doctor': Investigating Healthcare Experiences across the Lifespan among Older LGBT and Transgender/Gender Diverse Adults," *Qualitative Research in Medicine & Healthcare* (Italy) 8, no. 1 (2024): 11879, https://doi.org/10.4081/qrmh.2024.11879.

[16] Emily Banks et al., "Health, Ageing and Private Health Insurance: Baseline Results from the 45 and Up Study Cohort," *Australia and New Zealand Health Policy* (England) 6 (July 2009): 16, https://doi.org/10.1186/1743-8462-6-16.

Healthcare affordability

The interplay between Medicare and PHI can have real consequences for healthcare experiences.[17] Medicare is vital because it ensures all Australians have access to essential healthcare services, regardless of income or location.[18] PHI gives Australians faster access to treatment, more control over their healthcare choices and coverage for services not always funded by Medicare, like dental and physiotherapy.[19] PHI complements Medicare, making healthcare more flexible and tailored to individual needs.

We asked respondents whether they have Medicare or PHI. We also asked about the reasons as to why they are or are not covered by PHI.

Medicare status

Among respondents in 2025:

- 97.0% had a Medicare card (versus 97.5 % in 2024)
- 2.6% didn't have a Medicare card (versus 2.1% in 2024)
- 0.3% didn't know whether they had a Medicare card (versus 0.3% in 2024).

Respondents who were born outside Australia and arrived less than 5 years ago were more likely to not know whether they had a Medicare card.

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[17] Eddy Van Doorslaer et al., "Horizontal Inequities in Australia's Mixed Public/Private Health Care System," *Health Policy* 86, no. 1 (2008): 97–108.

[18] Rachel J. Knott et al., "How Fair Is Medicare? The Income-related Distribution of Medicare Benefits with Special Focus on Chronic Care Items," *Medical Journal of Australia* 197, nos. 11–12 (2012): 625–30.

[19] PrivateHealth.gov.au, "What Is Covered by Private Health Insurance?," accessed 1 September 2025, https://www.privatehealth.gov.au/health_insurance/what_is_covered/privatehealth.htm.

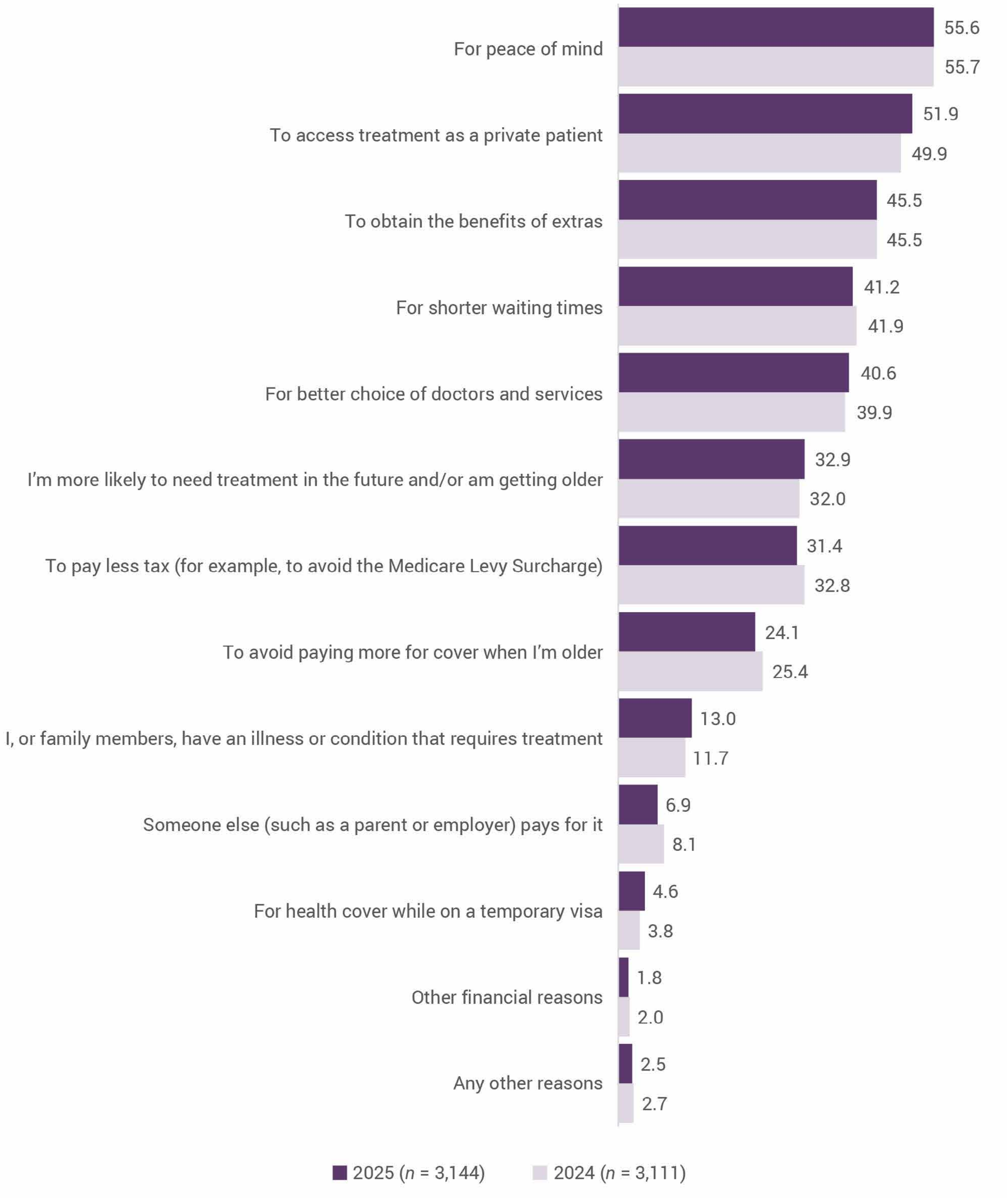
Private health insurance

In 2025, 3 in 5 people had PHI (60.9%), which is similar to the rate reported in 2024 (61.9%).

The top 3 reasons for having PHI did not significantly change since 2024 (Figure 2), and included the following:

- For peace of mind (55.6% in 2025 versus 55.7% in 2024)
- To access treatment as a private patient (51.9% in 2025 versus 49.9% in 2024)
- To obtain the benefit of extras (45.5% in both 2025 and 2024).

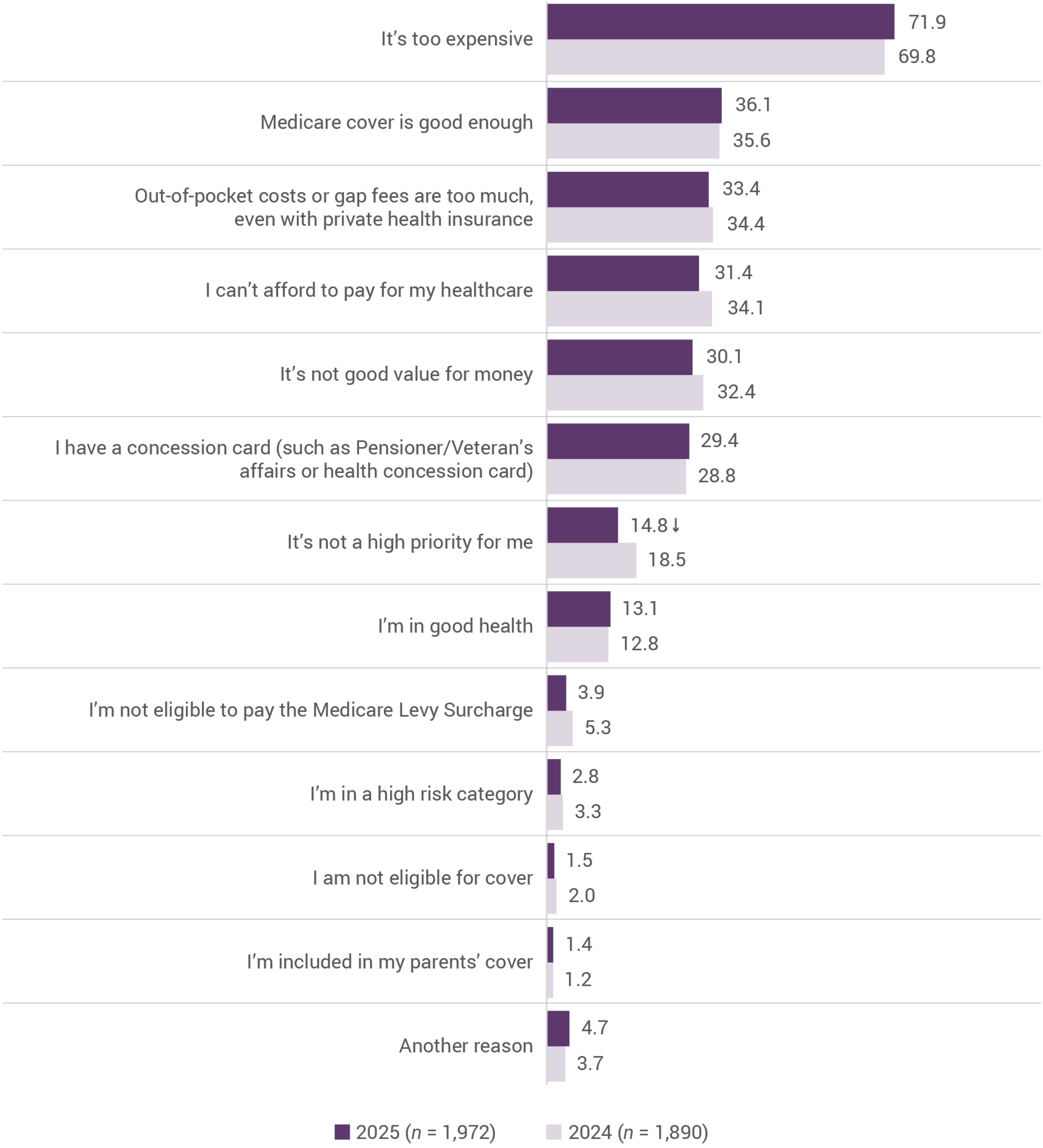
Figure 2: Common reasons for having PHI remained unchanged in 2025 compared to 2024



In contrast, approximately 2 in 5 (38.2%) respondents did not have PHI, which was similar to the rate reported in 2024 (37.6%). Reasons for not having PHI (Figure 3) were as follows:

- It's too expensive (71.9% in 2025 versus 69.8% in 2024)
- Medicare cover is good enough (36.1% in 2025 versus 35.6% in 2024)
- Out-of-pocket costs or gap fees are too much, even with private health insurance (33.4% in 2025 versus 34.4% in 2024)
- I can't afford to pay for my healthcare (31.4% in 2025 versus 34.1% in 2024)
- It's not good value for money (30.1% in 2025 versus 32.4% in 2024).

Figure 3: Common reasons for not having PHI were similar in 2025 compared to 2024, although fewer indicated it was not a priority



↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

Financial stress

As a key social determinant of health, financial stress profoundly shapes health outcomes by influencing a person's ability to access, afford and prioritise essential healthcare services.[20] People who are financially secure are more likely to seek timely medical care, follow treatment plans and maintain their overall health.[21]

To examine financial stress, we asked respondents whether they have personally experienced any difficulties or situations specifically due to not having enough money in the past 12 months.

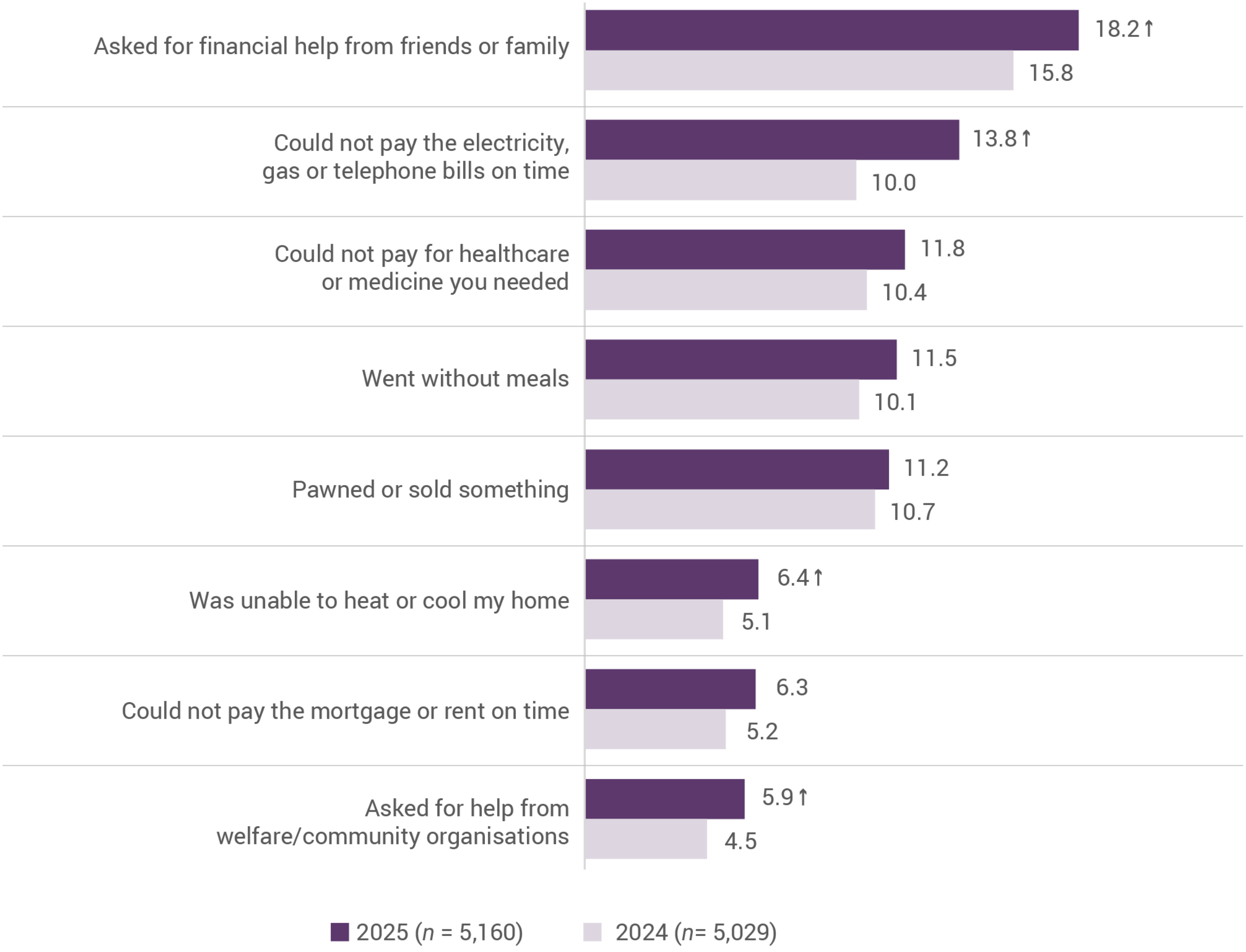
Financial stress is common

In 2025, about 1 in 3 people reported experiencing at least one financial difficulty or situation (35.6%) in the past 12 months, which is similar to the rate reported in 2024 (32.7%).

When they faced financial stress, among respondents in 2025 (Figure 4):

- 18.2% asked for financial help from friends or family (up from 15.8% in 2024)
- 13.8% could not pay the electricity, gas or telephone bills on time (up from 10.0% in 2024)
- 11.8% could not pay for healthcare or medicine they needed (stable against 10.4% in 2024)
- 11.5% went without meals (stable against 10.1% in 2024)
- 11.2% pawned or sold something (stable against 10.7% in 2024).

Figure 4: More respondents in 2025 indicated financial stress behaviours than in 2024, including asking for help from friends, family or welfare institutions and being unable to pay utilities or heat or cool their home



↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

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[20] Emily Brown Weida et al., "Financial Health as a Measurable Social Determinant of Health," *PLoS ONE* 15, no. 5 (2020): e0233359, https://doi.org/10.1371/journal.pone.0233359.

[21] Sicong Sun and Yu-Chih Chen, "Is Financial Capability a Determinant of Health? Theory and Evidence," *Journal of Family and Economic Issues* (United States) 43, no. 4 (2022): 744–55, https://doi.org/10.1007/s10834-022-09869-6.

Summary and reflections

Healthcare affordability

We examined healthcare affordability by assessing respondents' access to Medicare and PHI, as well as the financial stress influencing their healthcare decisions. Our analysis showed that healthcare affordability trends remained consistent between 2024 and 2025.

Despite near-universal Medicare coverage, the continued uptake of PHI suggests that many Australians seek additional security and flexibility in their healthcare. The most common reasons for having PHI – peace of mind, access to private treatment and extras coverage – highlight a need for greater control over care pathways and reduced wait times.[22]

The substantial proportion of respondents without PHI, primarily due to high costs and confidence in Medicare, highlights ongoing affordability concerns and differences in perceptions of value. A significant affordability concern for many Australians is the high cost of PHI premiums, which continue to rise.[23] Even with PHI, individuals often face substantial out-of-pocket expenses for services not fully covered, such as dental, optical or specialist care.[24] These financial pressures are particularly acute for lower income households, who may struggle to justify the cost of having PHI. Additionally, hidden costs and confusing exclusions can lead to unexpected financial stress and dissatisfaction with coverage.[25]

Perceptions of value in having PHI varied widely among respondents. Some expressed strong confidence in Medicare, viewing it as sufficient for their healthcare needs. Younger adults, because of their age and relatively good health, may perceive PHI as unnecessary,[26] while others question the difference in quality between public and private healthcare.[27] People in rural or remote areas often have fewer private service options, which can make having PHI feel less valuable.[28] Furthermore, scepticism towards insurers, often fuelled by negative experiences or media reports,[29] can diminish the perceived worth of PHI. These findings reflect a tension between public and private healthcare, where financial capacity and perceived need shape insurance decisions, potentially reinforcing inequities in access and experience.[30]

Financial stress was a significant barrier to healthcare access, with over a third of respondents in 2025 reporting at least one financial difficulty. Notably, there were increases in those seeking help from family and struggling to pay utility bills compared to 2024. The fact that 11.8% of respondents could not afford necessary healthcare or medication highlights the real-world consequences of financial stress, which can lead to delayed treatment and poorer health outcomes.[31]

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[22] Thomas C. Buchmueller et al., "Preference Heterogeneity and Selection in Private Health Insurance: The Case of Australia," *Journal of Health Economics* 32, no. 5 (2013): 757–67, https://doi.org/10.1016/j.jhealeco.2013.05.001.

[23] P. Marcin Sowa et al., "Private Health Insurance Incentives in Australia: In Search of Cost-Effective Adjustments," *Applied Health Economics and Health Policy* (New Zealand) 16, no. 1 (2018): 31–41, https://doi.org/10.1007/s40258-017-0338-6.

[24] Liana S. Leach et al., "Private Health Insurance, Mental Health and Service Use in Australia," *Australian & New Zealand Journal of Psychiatry* (England) 46, no. 5 (2012): 468–75, https://doi.org/10.1177/0004867411434713.

[25] Sowa et al., "Private Health Insurance Incentives in Australia: In Search of Cost-Effective Adjustments."

[26] Lisa Tam et al., "Determinants of Attitude and Intention towards Private Health Insurance: A Comparison of Insured and Uninsured Young Adults in Australia," *BMC Health Services Research* 21, no. 1 (2021): 246.

[27] Rezwanul Hasan Rana et al., "Selection of Private or Public Hospital Care: Examining the Care-Seeking Behaviour of Patients with Private Health Insurance," BMC Health Services Research 20, no. 1 (2020): 380, https://doi.org/10.1186/s12913-020-05253-y.

[28] Buddhima Lokuge et al., "Private Health Insurance and Regional Australia," *Medical Journal of Australia* 182, no. 6 (2005): 290–93, https://doi.org/10.5694/j.1326-5377.2005.tb06704.x.

[29] Sophie Lewis et al., "Healthcare in the News Media: The Privileging of Private over Public," *Journal of Sociology* 54, no. 4 (2018).

[30] Elizabeth A. Hardie and Christine R. Critchley, "Public Perceptions of Australia's Doctors, Hospitals and Health Care Systems," *Medical Journal of Australia* 189, no. 4 (2008): 210–14, https://doi.org/10.5694/j.1326-5377.2008.tb01985.x.

[31] Rosemary J. Korda et al., "Income-Related Inequalities in Chronic Conditions, Physical Functioning and Psychological Distress among Older People in Australia: Cross-Sectional Findings from the 45 and up Study," *BMC Public Health* 14, no. 1 (2014): 741, https://doi.org/10.1186/1471-2458-14-741.

Awareness and experiences with new services

MyMedicare

MyMedicare is a voluntary registration system in Australia designed to strengthen the connections between a health consumer's regular GP and primary care team. Australians with a Medicare Card or Department of Veterans' Affairs (DVA) Veteran Card are eligible for MyMedicare if they have had at least 1 or 2 face-to-face visits recorded at the same GP.[32]

In 2024, only respondents with a Medicare card were asked questions related to MyMedicare. However, in 2025, all respondents were asked questions related to MyMedicare. For this report, we will be reporting findings only for those who have a Medicare card (Figure 5). Respondents were asked whether they were aware of MyMedicare after being prefaced with the following paragraph.

> *MyMedicare is a new voluntary registration that links a patient with their usual general practice, their general practitioner (GP) and their primary care teams to help deliver and coordinate care.*

Participants were subsequently asked whether they had registered for MyMedicare with their GP, to share their experience with the registration process and to explain their reasons for either registering or not.

Awareness and registration of MyMedicare unchanged since 2024

Awareness of MyMedicare in 2025 was similar to that reported in 2024. Of respondents who had a Medicare card in 2025:

- 32.8% (1 in 3) were aware of MyMedicare (versus 33.1% in 2024)
- 60.6% (3 in 5) were not aware of MyMedicare (versus 61.2% in 2024)
- 6.6% were unsure (versus 5.7% in 2024).

MyMedicare registration in 2025 was similar to that reported in 2024 among respondents who were aware of MyMedicare:

- 54.0% (1 in 2) were registered for MyMedicare (versus 53.4% in 2024)
- 14.7% had not registered but intended to (versus 12.0% in 2024)
- 13.9% hadn't decided or needed more information (versus 16.1% in 2024)
- 5.2% did not intend to register (versus 6.1% in 2024)
- 12.2% were unsure of their registration status (versus 12.4% in 2024).

Respondents who registered for MyMedicare in 2025 reported a registration experience comparable to those who registered in 2024. Among respondents in 2025 who were asked whether registration was quick and easy:

- 78.2% agreed or strongly agreed (versus 81.2% in 2024)
- 2.7% disagreed or strongly disagreed (versus 3.9% in 2024)
- 16.2% were neutral (versus 13.1% in 2024)
- 2.9% were unsure (versus 1.8% in 2024).

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[32] Department of Health, Disability and Ageing, "Information for MyMedicare Patients," 19 August 2025, https://www.health.gov.au/our-work/mymedicare/patients#eligibility.

Figure 5: Levels of MyMedicare awareness and registration, as well as ease of registration for MyMedicare, were similar in 2025 and 2024

Among all survey respondents	**97.0%**	**Have a Medicare Card**	**2024:** 97.5%	Base 2024: *n* = 5,029 2025: *n* = 5,160
Among those who have a Medicare Card	**32.8%**	**Are aware of MyMedicare**	**2024:** 33.1%	Base 2024: *n* = 4,905 2025: *n* = 5,006
Among those aware of MyMedicare	**54.0%**	**Registered for MyMedicare**	**2024:** 53.4%	Base 2024: *n* = 1,624 2025: *n* = 1,693
Among those registered	**78.2%**	**Strongly agree or agree it was easy to register**	**2024:** 81.2%	Base 2024: *n* = 868 2025: *n* = 914

Reasons for MyMedicare registration

Among respondents in 2025 who registered for MyMedicare, reasons for their registration remained relatively unchanged from 2024, except for “A non-GP healthcare provider recommended it”:

- To improve how healthcare providers work together and meet care needs (48.7% in 2025 versus 54.1% in 2024)
- Their GP suggested it (38.0% in 2025 versus 40.4% in 2024)
- Access particular benefits through MyMedicare (28.0% in 2025 versus 31.0% in 2024)
- A non-GP healthcare provider recommended it (6.6% in 2025 versus 11.3% in 2024)
- Another reason (7.6% in 2025 versus 5.4% in 2024).

Barriers to registration

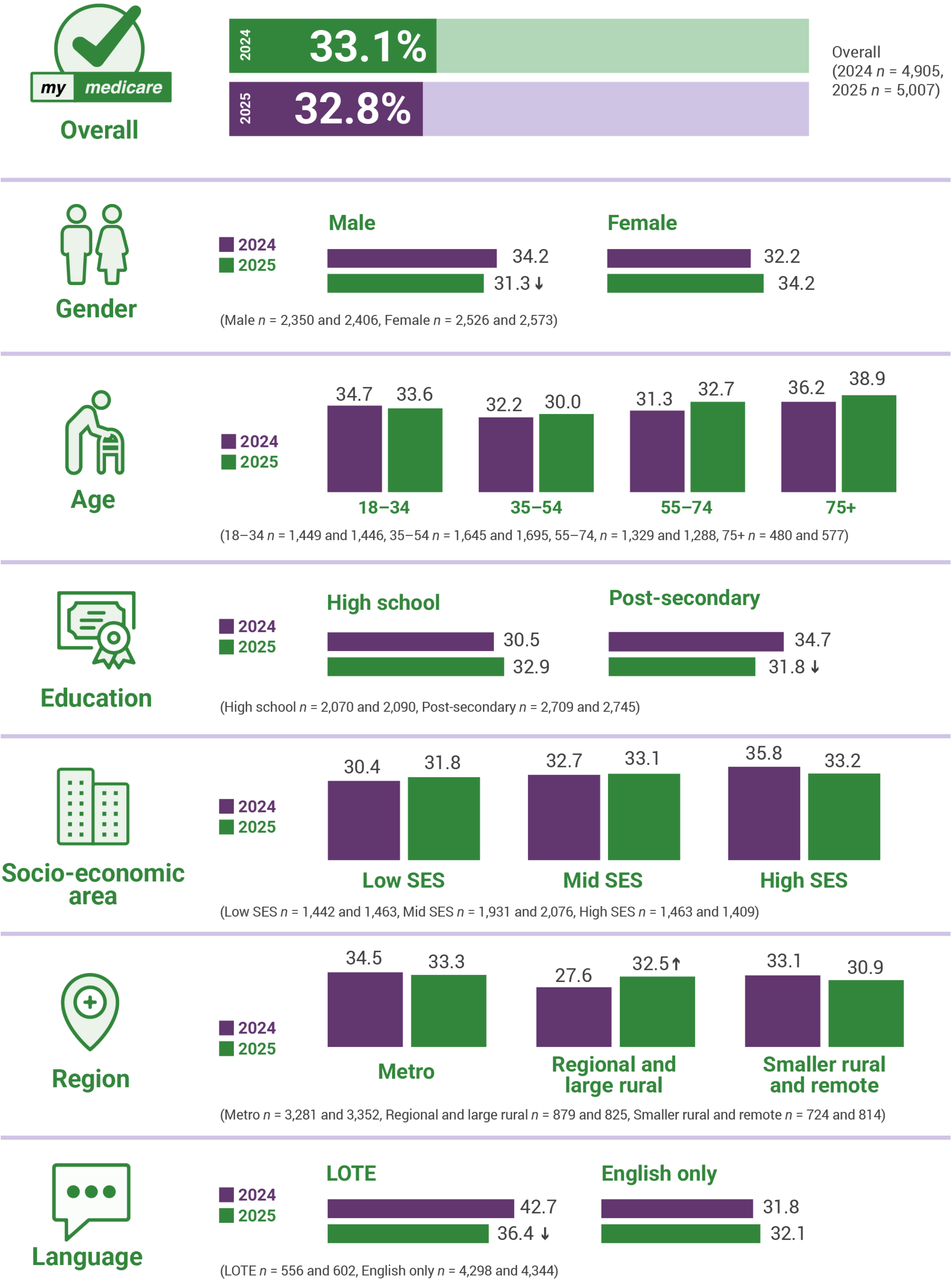
Among respondents who were aware of MyMedicare but had not registered in 2025 or 2024, their main reasons for not registering included the following:

- Not knowing enough about it (42.2% in 2025 versus 41.6% in 2024)
- It not being a current priority (27.1% in 2025 versus 29.4% in 2024)
- It hadn’t been recommended by a GP or other healthcare provider (24.9% in 2025 versus 22.4% in 2024)
- Lack of time (20.2% in 2025 versus 21.8% in 2024)
- Lack of trust in the platform (14.7% in 2025 versus 17.1% in 2024)
- Belief there is not enough benefit (11.4% in 2025 versus 11.5% in 2024)
- Other reasons (5.7% in 2025 versus 6.9% in 2024).

Education impacts awareness of MyMedicare

Respondents in 2025 were less aware of MyMedicare than those in 2024 if they completed qualifications after secondary school (31.8% versus 34.7%) or spoke a language other than English at home (36.4% versus 42.7%). Respondents in 2025 were more aware of MyMedicare than those in 2024 if they lived in rural or regional areas (32.5% versus 27.6%). These and other demographic factors are shown in Figure 6.

Figure 6: Awareness of MyMedicare across demographic groups (base: respondents with a Medicare card)



(Male n = 2,350 and 2,406, Female n = 2,526 and 2,573)

(18–34 n = 1,449 and 1,446, 35–54 n = 1,645 and 1,695, 55–74, n = 1,329 and 1,288, 75+ n = 480 and 577)

(High school n = 2,070 and 2,090, Post-secondary n = 2,709 and 2,745)

(Low SES n = 1,442 and 1,463, Mid SES n = 1,931 and 2,076, High SES n = 1,463 and 1,409)

(Metro n = 3,281 and 3,352, Regional and large rural n = 879 and 825, Smaller rural and remote n = 724 and 814)

(LOTE n = 556 and 602, English only n = 4,298 and 4,344)

↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

Factors significantly associated with awareness of MyMedicare

Our analysis showed that PHI and income were the strongest predictors of MyMedicare awareness, with unexpected patterns across language, gender and financial hardship suggesting complex dynamics in awareness of digital health platforms.

The following are the key findings from our 2025 data (see Appendix B2).

- Those without PHI had significantly lower awareness than those with PHI (OR = 0.72).
- English-only speakers had lower awareness compared to those who speak another language at home (OR = 0.78). This may reflect differences in community networks, multicultural media, or targeted information delivered through services for CALD communities, as well as greater engagement with GPs among some CALD communities, which can increase exposure MyMedicare messages. .
- Those experiencing financial stress had higher awareness (OR = 1.28), while those with difficulties affording care had lower awareness (OR = 0.74). Those experiencing financial stress might be more likely to seek services such as Medicare to access healthcare, and in turn become more familiar with MyMedicare. Those avoiding healthcare for financial reasons may be missing out on information about MyMedicare at their GP. Given that individuals with chronic conditions are the primary target population for MyMedicare, the non-significant trend between MyMedicare awareness and this group suggests the program may not be effectively reaching its intended audience. This finding warrants further investigation into barriers to engagement, as well as additional outreach or tailored support to better align MyMedicare with its intended goals.[33]
- Middle-aged adults (35 to 54 years) had lower awareness compared to younger adults (18 to 34 years) (OR = 0.82), while other age groups showed no significant differences compared to younger adults.
- Women had higher awareness than men (OR = 1.24).
- Only the highest income group (> $4,000 weekly) showed higher awareness (OR = 1.40), while those preferring not to disclose income had lower awareness (OR = 0.68).

My Health Record

My Health Record (MHR) is a secure digital system that centralises key health information, making it easier for healthcare providers to deliver safe, coordinated care. It helps reduce medical errors, avoids unnecessary tests and empowers individuals to manage their own health by providing them access to their own records.[34]

Respondents were asked whether they were aware of MHR after being prefaced with the following paragraph.

> *My Health Record is an online space to keep your health information, so that it can be available to you and your healthcare providers at any time, including in an emergency.*

Respondents were subsequently asked whether they had registered for MHR and to share their experience with using MHR (Figure 7).

Awareness and use of MHR

Awareness of MHR among respondents in 2025 did not significantly vary compared to 2024. Of the respondents in 2025:

- 70.2% reported that they had heard of MHR (versus 70.4% in 2024)
- 24.7% said that they had not (versus 23.9% in 2024)
- 5.1% were unsure if they had heard of MHR (versus 5.7% in 2024).

Of those who had heard of MHR in 2025:

- 61.7 % said they were registered (versus 59.9% in 2024)
- 19.6% said they were not registered and (versus 21.4% in 2024)
- 18.7% said they didn't know if they were registered (18.7% in 2024).

Among those who registered for MHR in 2025, 59.8% reported that they have used MHR, which is similar to the 58.8% reported in 2024.

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[33] Shona M. Bates et al., "The Impact of Patient Enrolment in Primary Care on Continuity and Quality of Care around the World, 2014–2024, and Lessons for Australia: A Scoping Review," *Medical Journal of Australia* 222, no. 9 (2025): 462–71, https://doi.org/10.5694/mja2.52648.

[34] Department of Health, Disability and Ageing, "My Health Record," 7 August 2025, https://www.health.gov.au/topics/health-technologies-and-digital-health/my-health-record.

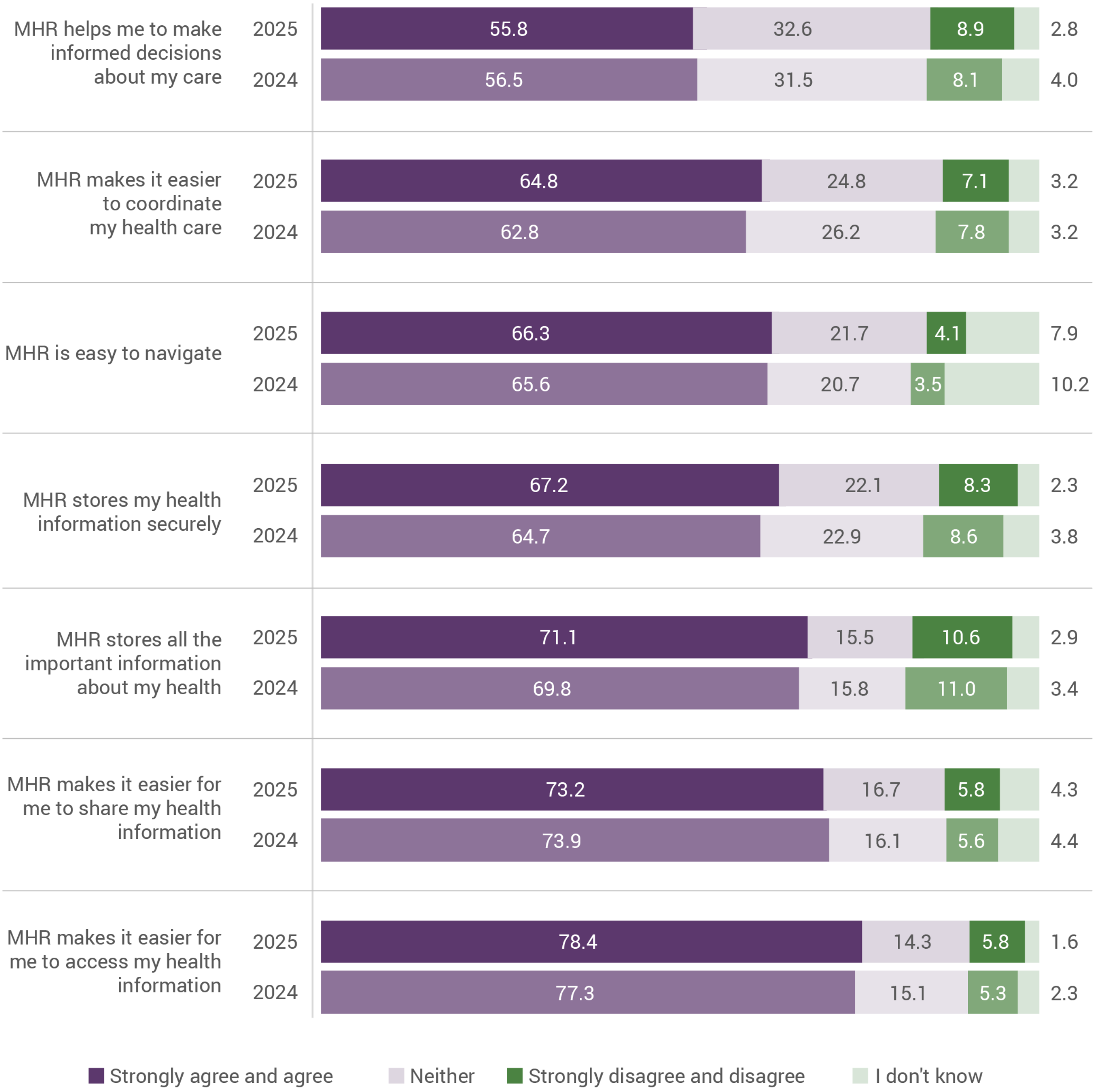
Figure 7: Stable rates of awareness, registration and use of MHR between 2024 and 2025

Among all survey respondents	**70.2%**	**Heard of My Health Record**	**2024:** 70.4%	Base 2024: *n* = 5,029 2025: *n* = 5,160
Among those who have heard of My Health Record	**61.7%**	**Registered for My Health Record**	**2024:** 59.9%	Base 2024: *n* = 3,539 2025: *n* = 3,623
Among those who have registered for My Health Record	**59.8%**	**Used My Health Record**	**2024:** 58.8%	Base 2024: *n* = 2,118 2025: *n* = 2,237

Among respondents who had previously registered for MHR in 2025 (Figure 8):

- 55.8% agreed or strongly agreed that MHR helped them make informed decisions (versus 56.5% in 2024)
- 64.8% agreed or strongly agreed that MHR makes it easier for them to coordinate their healthcare (versus 62.8% in 2024)
- 66.3% agreed or strongly agreed that MHR is easy to navigate (65.6% in 2024)
- 67.2% agreed or strongly agreed that MHR stores their information securely (64.7% in 2024)
- 71.1% agreed or strongly agreed that MHR stores all the important information about their health (69.8% in 2024)
- 73.2% agreed or strongly agreed that MHR makes it easier for them to share their health information (73.9% in 2024)
- 78.4% agreed or strongly agreed that MHR makes it easier for them to access all their health information (77.3% in 2024).

Figure 8: Perceptions of MHR usability and awareness of MHR features did not vary between 2024 and 2025

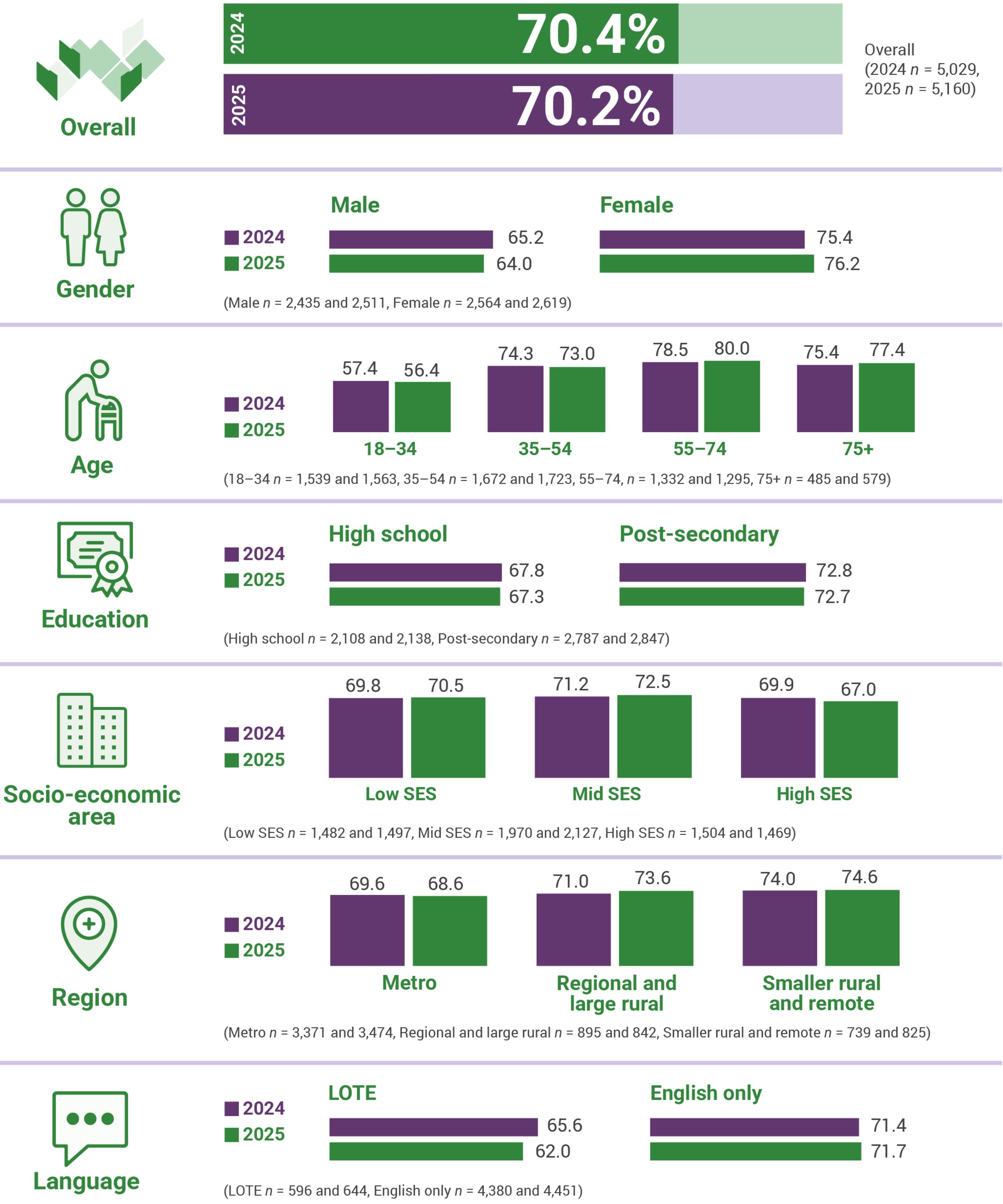


Base: Overall (2024 *n*=1,308, 2025 *n*=1,385)

Factors significantly associated with awareness of MHR

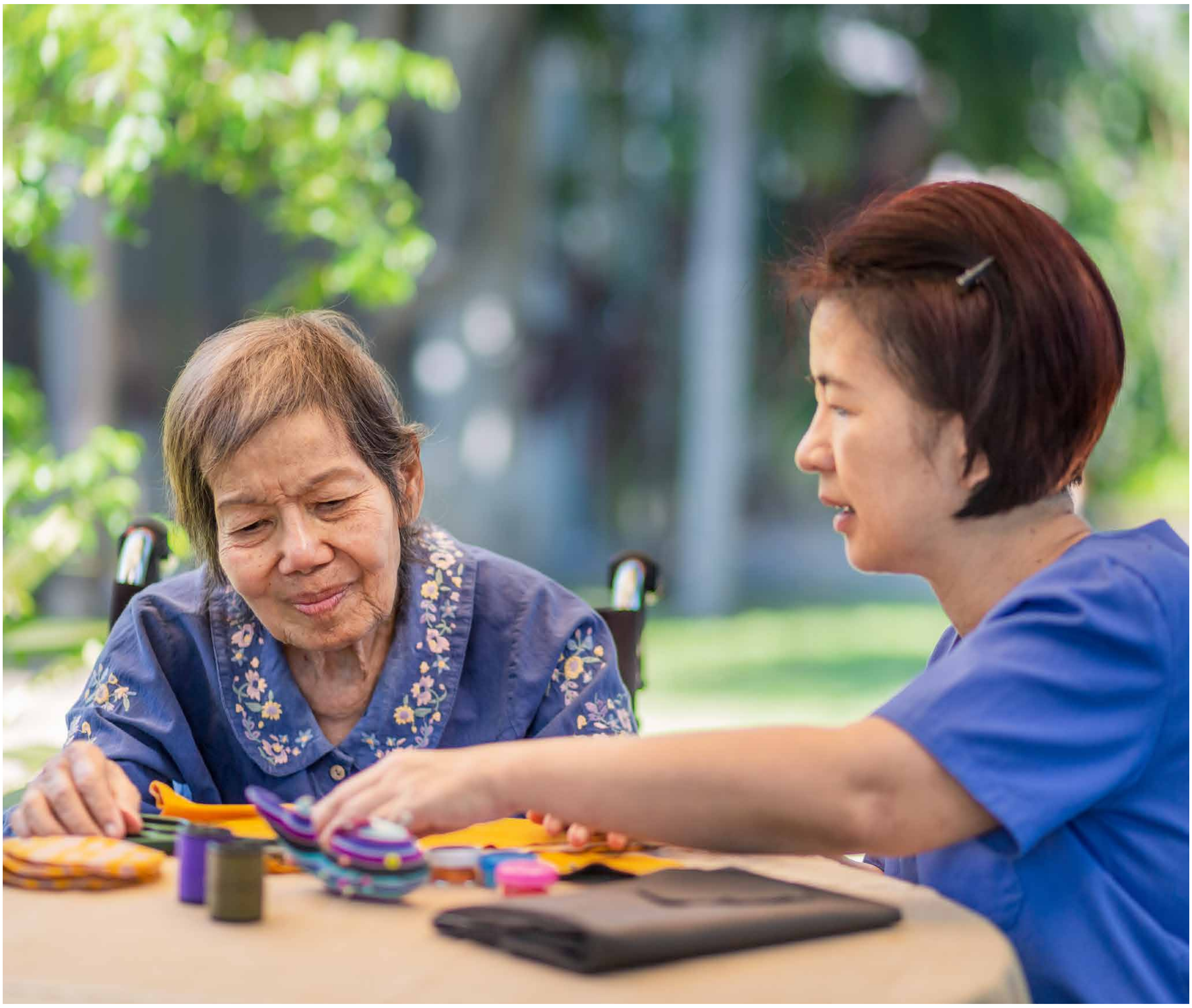
Our analysis showed that age and gender were the strongest predictors of MHR awareness, with additional disparities linked to income, education, internet use and language background, highlighting uneven engagement across population group (Figure 9).

Figure 9: Awareness of My Health Record across demographic groups



The following are the key findings from our 2025 data (see Appendix B3).

- Middle-aged (35 to 54 years: OR = 2.03) and older adults (55 to 74 years: OR = 3.20; ≥ 75 years: OR = 2.96) showed substantially higher awareness compared to younger adults (18 to 34 years).
- Compared to men, women had significantly higher awareness than men (OR = 1.88), while non-binary people or individuals who reported a different gender showed no significant difference.
- Only the highest income group (> $4,000 weekly) showed significantly higher awareness compared to the lowest income group (< $1,000 monthly) (OR = 1.46), suggesting income-related disparities in awareness.
- Those with post-secondary education had higher awareness compared to those who had high school education (OR = 1.38), indicating the role of education role in healthcare system knowledge.
- Individuals with chronic illness showed higher awareness (OR = 1.54), likely reflecting their greater engagement with healthcare.
- Individuals without PHI had lower awareness compared to those with PHI (OR = 0.81), while those uncertain about their PHI status had much lower awareness (OR = 0.38).
- English-only speakers had higher awareness compared to those speaking other languages at home (OR = 1.29), suggesting potential language barriers to MHR awareness for culturally and linguistically diverse (CALD) communities.
- Non-heterosexual individuals showed higher awareness (OR = 1.55), possibly reflecting greater engagement with the healthcare system among this population group.
- Those with lower internet usage (once daily or less) had significantly lower awareness compared to those with higher usage (3 or more times daily) (OR = 0.51), highlighting links between higher internet usage and increased levels of awareness.



Summary and reflections

Awareness and experiences with new services

Being aware of services like MyMedicare and MHR is essential for better, safer healthcare. MyMedicare can strengthen the relationship between individuals and their GP and unlock benefits such as longer telehealth consultations and tailored chronic care, while MHR gives individuals and their providers convenient and secure access to health information. Our findings revealed that awareness and registration of MyMedicare and MHR remained consistent from 2024 and 2025.

Despite its national rollout in 2023, awareness of MyMedicare among Medicare cardholders was relatively low in both 2024 and 2025, with only 1 in 3 reporting they were aware of it. This suggests that communication and outreach efforts may not have reached a broad enough audience. The modest registration rate among those aware (54.0%) further highlights a gap between awareness and action, possibly due to uncertainty about the benefits of MyMedicare or a lack of perceived urgency to register.[35]

However, the high satisfaction with the registration process, reported as easy by 78.2% of registrants, is a positive indicator for future uptake. The most common motivations for registering, such as improving care coordination and following GP recommendations, highlights the importance of trusted healthcare relationships in driving engagement.[36] These findings suggest that increasing GP-led promotion and clearly communicating the benefits of MyMedicare could be key strategies to boosting both MyMedicare awareness and registration.

The barriers to MyMedicare registration highlighted key communication and engagement challenges. A substantial portion of respondents (42.2%) cited a lack of information as the main reason for not registering. Other barriers included low prioritisation and the absence of encouragement from healthcare providers, suggesting that provider endorsement of MyMedicare can play a role in motivating registration.[37]

Interestingly, awareness of MyMedicare was lower among English-only speakers and those with post-secondary education. While education is linked to health literacy,[38] awareness of specific programs depends on exposure and perceived relevance.[39] People with higher education may assume they already understand Medicare and overlook new initiatives like MyMedicare, whereas others like non-English speakers might actively seek clarification, increasing their engagement with program information. Rural residents and those experiencing financial stress showed higher awareness of MyMedicare, likely because they perceive greater benefit from government programs and actively seek these measures. These findings suggest that awareness of initiatives like Medicare may be driven by need and targeted outreach rather than education alone.

Stable awareness of MHR (70.2%) and a moderate registration rate (61.7% among those aware) indicate that while MHR has achieved good visibility, there is still room to boost engagement. Encouragingly, a majority of registrants (59.8%) have actively used MHR and found it helpful for accessing and sharing health information, suggesting that MHR can deliver value when adopted.

However, disparities in awareness present ongoing challenges. Older adults, women, individuals with chronic conditions, higher income earners and frequent internet users were more likely to know about MHR. In contrast, lower awareness among those who speak languages other than English at home and lack PHI suggests that CALD communities may not be adequately reached, which can lead to reduced continuity of care and missed opportunities for better coordination, particularly for chronic conditions.[40] These findings highlight the need for more inclusive, accessible communication and support to ensure equitable digital health participation.

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[35] Ashfaq Chauhan et al., "What Are the Barriers and Facilitators for the Uptake of MyMedicare Voluntary Patient Registration Scheme in Australia?: A Consumers Perspective," paper presented at Western Health Research Network 2025 Research Symposium, 2025.

[36] Bates et al., "The Impact of Patient Enrolment in Primary Care on Continuity and Quality of Care around the World, 2014–2024, and Lessons for Australia: A Scoping Review."

[37] Bates et al., "The Impact of Patient Enrolment in Primary Care on Continuity and Quality of Care around the World, 2014–2024, and Lessons for Australia: A Scoping Review."

[38] Robert J. Adams et al., "Risks Associated with Low Functional Health Literacy in an Australian Population," *Medical Journal of Australia* 191, no. 10 (2009): 530–34, https://doi.org/10.5694/j.1326-5377.2009.tb03304.x.

[39] Esther Thorson and Christopher E. Beaudoin, "The Impact of a Health Campaign on Health Social Capital," *Journal of Health Communication* 9, no. 3 (2004): 167–94.

[40] Bates et al., "The Impact of Patient Enrolment in Primary Care on Continuity and Quality of Care around the World, 2014–2024, and Lessons for Australia: A Scoping Review."

Accessing health services

Unmet healthcare needs

Unmet healthcare needs represent a significant public health concern, as they can result in delayed diagnoses, progression of untreated conditions and increased dependence on hospital services.[41] The inability to access timely and appropriate care undermines individual health outcomes and places additional strain on healthcare systems.[42]

We asked respondents about a time when their healthcare needs were not met for 4 different healthcare types in the past 12 months, including not visiting a dentist, not visiting a doctor, not attending recommended testing and treatment, and not filling a prescription or taking medication.

Respondents were also asked why they did not take these actions for their health.

Unmet healthcare needs affect nearly half the population

In 2025, about 1in 2 (49.8%) respondents indicated they did not access at least 1 of the 4 healthcare types in the past 12 months, which was similar to the rate in 2024 (50.0%).

In 2025, when respondents needed to access healthcare services or take actions for their health:

- 3 in 10 (29.3%) did not visit a dentist (versus 28.8% in 2024)
- 1 in 4 (25.0%) did not speak to a doctor (versus 25.6% in 2024)
- 1 in 5 (21.2%) did not take a medical test or treatment or attend an appointment that had been recommended by a doctor (versus 21.7% in 2024)
- 1 in 6 (17.8%) did not fill a prescription or take medicine (versus 16.4% in 2024)
- 1 in 20 (5.1%) had skipped all 4 healthcare types at least once (versus 4.7% in 2024).

Table 3 lists respondents' reasons for not accessing healthcare or taking actions for their health. In 2025, respondents' inability to financially afford healthcare prevented:

- 2 in 3 (67.0%) from visiting a dentist when needed (versus 66.0% in 2024)
- 1 in 2 (54.2%) from filling a prescription for medicine, or taking medicine when needed (versus 46.7% in 2024)
- 1 in 2 (48.7%) from taking a medical test or treatment or attending an appointment that had been recommended by a doctor (versus 43.8% in 2024).

In 2025, among respondents who did not speak to a doctor when needed:

- 1 in 3 (37.3%) reported the service was not available at a suitable time (versus 37.5 in 2024)
- 1 in 3 (36.9%) could not afford it (versus 34.0% in 2024)
- 1 in 4 (25.3%) were too busy (versus 20.5 in 2024).

There were significant changes between 2025 and 2024 in being too busy or not having time to access healthcare services or taking actions for their health. Among respondents in 2025:

- 1 in 4 (25.3%) did not speak with a doctor when needed (versus 20.5% in 2024)
- 1 in 4 (25.9%) did not have medical testing or treatment or attend an appointment that had been recommended by a doctor (versus 20.3% in 2024).

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[41] Md. Mizanur Rahman et al., "A Systematic Review and Meta-Analysis of Unmet Needs for Healthcare and Long-Term Care among Older People," *Health Economics Review* 12, no. 1 (2022): 60, https://doi.org/10.1186/s13561-022-00398-4.

[42] Stephanie A. Ponce et al., "Inability to Get Needed Health Care during the COVID-19 Pandemic among a Nationally Representative, Diverse Population of US Adults with and without Chronic Conditions," *BMC Public Health* 23, no. 1 (2023): 1868, https://doi.org/10.1186/s12889-023-16746-w.

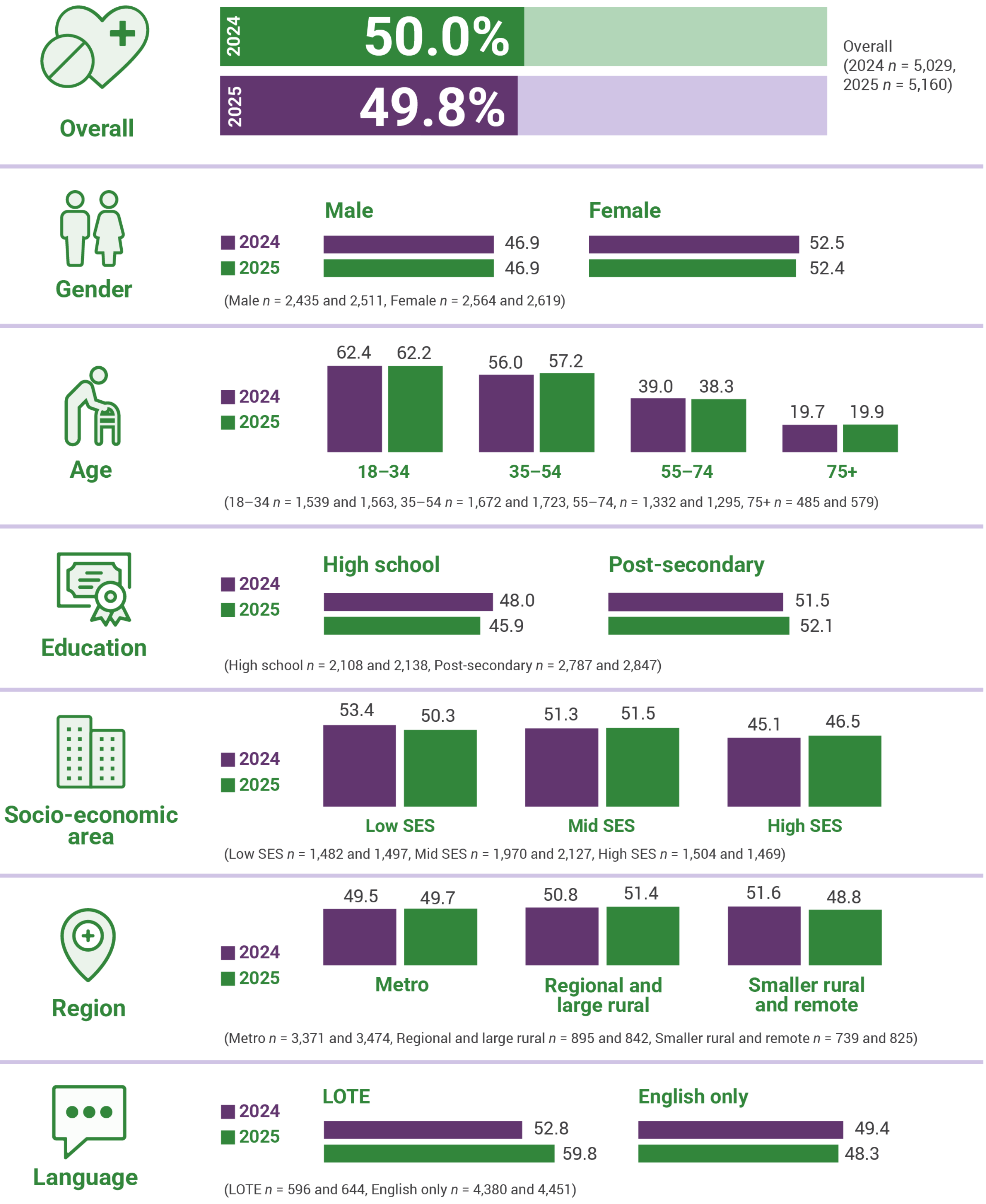
Table 3: Reasons for not accessing different types of healthcare commonly included "I could not afford it"

Reason	Didn't visit a dentist when needed		Didn't speak to a doctor when needed		Didn't take recommended medical test or treatment or attend an appointment		Didn't fill a prescription for medicine, or take medicine when needed	
	2025 (*n* = 1,510) (%)	Point change	2025 (*n* = 1,290) (%)	Point change	2025 (*n* = 1,094) (%)	Point change	2025 (*n* = 917) (%)	Point change
I could not afford it	67.0%	+0.9	36.9%	+2.9	48.7%	+4.9↑	54.2%	+7.5↑
I was too busy	17.0%	−0.7	25.3%	+4.8↑	25.9%	+5.6↑	22.5%	+4.8
The service was not available at a suitable time	9.3%	0.0	37.3%	−0.2	19.7%	+0.1	15.5%	+0.3
It wasn't a priority for me	14.8%	−3.6	16.0%	−0.7	21.4%	−2.4	17.7%	−4.4
The service was not available at a suitable location	6.6%	+0.2	17.8%	−2.0	15.3%	−2.0	11.9%	−1.1
I felt ashamed, nervous or embarrassed	13.1%	−0.9	11.9%	−0.4	10.6%	+0.0	10.1%	+0.4
I was too unwell	2.7%	−2.3↓	11.2%	−3.3	6.5%	−2.3	10.7%	−0.5
I felt I would be treated unfairly or without respect	3.4%	−0.5	5.7%	−0.7	5.4%	+0.3	6.4%	+0.5
I felt unsafe	2.3%	−0.8	3.1%	−0.5	3.1%	−2.1↓	4.9%	−1.5
I did not want to be exposed to, or expose others to, COVID-19	2.1%	−1.6↓	3.7%	−1.3	4.3%	−1.6	4.1%	−2.0
Another reason	9.2%	+1.2	10.5%	−2.0	11.9%	0.0	13.0%	−2.3

↑↓ Difference between 2024 and 2025 is statistically significant ($p < 0.05$)

Figure 10 shows differences between people with at least one unmet healthcare need compared to those who did not have an unmet healthcare need in the past 12 months.

Figure 10: Unmet healthcare needs across demographic groups



In 2025, the only statistically significant change from 2024 was among people who speak a language other than English. This group saw a 7-percentage point increase in reported unmet healthcare needs.

Factors significantly associated with having unmet healthcare needs

Our analysis showed that financial stress was the strongest predictor of unmet healthcare needs, with additional disparities linked to age, insurance status, income and language. This highlights persistent barriers in healthcare access across vulnerable groups.

Key findings from our 2025 data (see Appendix B4) were as follows.

- The strongest predictor was experiencing financial stress, with individuals facing financial stress having dramatically higher odds of unmet needs compared to those without financial stress (OR = 4.50).
- Compared to younger adults (18 to 34 years), older adults having significantly lower odds of unmet needs (55 to 74 years: OR = 0.51; ≥ 75 years: OR = 0.24).
- Individuals without PHI had substantially higher odds of unmet needs than those with PHI (OR = 1.66), highlighting insurance status as a key factor to healthcare access.
- Compared to the lowest income group (< $1,000), higher income groups showed less unmet needs, with those earning $1,000 to $1,999 (OR = 0.75), $2,000 to $3,999 (OR = 0.76) or > $4,000 weekly (OR = 0.78). Those preferring not to disclose income also showed lower odds of unmet healthcare needs compared to the lowest income group (OR = 0.62).
- Individuals with chronic illness had higher odds of unmet healthcare needs than those without chronic illness (OR = 1.52), while those with post-secondary education had higher odds than those with high school education (OR = 1.28), possibly reflecting higher healthcare expectations or awareness.
- English-only speakers had lower odds of unmet healthcare needs compared to those who speak other languages at home (OR = 0.77), suggesting potential language-related access barriers for CALD communities.
- Non-heterosexual individuals showed higher odds of unmet healthcare needs than heterosexuals (OR = 1.38), possibly reflecting barriers to the healthcare system for LGBTQIA+ individuals.

Navigating the healthcare system

Understanding how to navigate the healthcare system is key to getting timely and appropriate care and can help minimise financial stress by avoiding unexpected costs and inefficiencies.[43] We examined healthcare system navigation using Domain 7 of the Health Literacy Questionnaire (HLQ), which investigates respondents' ability to navigate the healthcare system.[44] Domain 7 asks respondents to rate 6 statements using a 5-point scale, indicating how easy or difficult each task is for them to complete. These scores reflect how easily respondents can access and use healthcare services, with higher mean scores indicating greater ease (> 3.5), while scores below 3.5 suggest that some navigation tasks were generally difficult.

Changes in ability in navigating healthcare system since 2024

As shown in Figure 11, the average health navigation score for 2025 was 3.48, indicating that some navigation tasks were generally difficult. However, ability to navigate the healthcare system did not significantly change between 2024 and 2025 overall and according to respondents' socio-demographic characteristics and health-related details.

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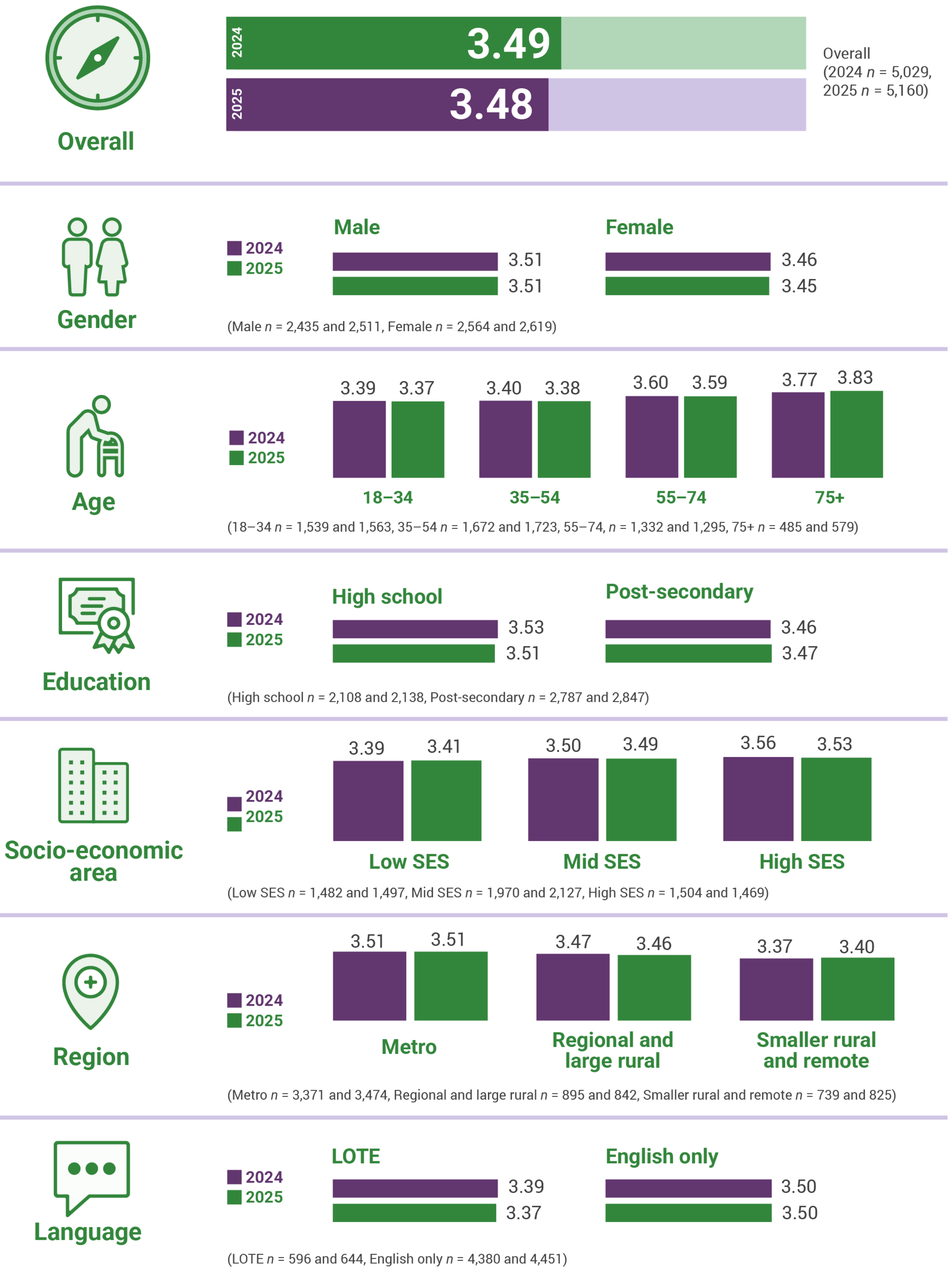
[43] Yvonne Zurynski et al., "Accessible and Affordable Healthcare? Views of Australians with and without Chronic Conditions," *Internal Medicine Journal* 51, no. 7 (2021): 1060–67, https://doi.org/10.1111/imj.15172.

[44] Richard H. Osborne et al., "The Grounded Psychometric Development and Initial Validation of the Health Literacy Questionnaire (HLQ)," *BMC Public Health* 13, no. 1 (2013): 658, https://doi.org/10.1186/1471-2458-13-658.

Figure 11: Health navigation scores across demographic groups



Overall (2024 *n* = 5,029, 2025 *n* = 5,160)

(Male *n* = 2,435 and 2,511, Female *n* = 2,564 and 2,619)

(18–34 *n* = 1,539 and 1,563, 35–54 *n* = 1,672 and 1,723, 55–74, *n* = 1,332 and 1,295, 75+ *n* = 485 and 579)

(High school *n* = 2,108 and 2,138, Post-secondary *n* = 2,787 and 2,847)

(Low SES *n* = 1,482 and 1,497, Mid SES *n* = 1,970 and 2,127, High SES *n* = 1,504 and 1,469)

(Metro *n* = 3,371 and 3,474, Regional and large rural *n* = 895 and 842, Smaller rural and remote *n* = 739 and 825)

(LOTE *n* = 596 and 644, English only *n* = 4,380 and 4,451)

Factors significantly associated with ability to navigate the healthcare system

Our analysis showed that financial stress and age were the strongest predictors of healthcare system navigation, with additional disparities linked to income, area of residence, language and digital access, highlighting uneven health navigation across population groups.

Key findings from our 2025 data (see Appendix B5) were as follows.

- Individuals with difficulties affording healthcare (β = –0.259) or experiencing financial stress (β = –0.197) were less able to navigate the healthcare system.
- Older adults aged 55 to 74 (β = 0.155) and ≥ 75 years (β = 0.363) showed significantly greater healthcare navigation than younger adults aged 18 to 34, likely reflecting accumulated healthcare experience.
- Positive income effects were clear, with those earning $2,000 to $3,999 (β = +0.081) and > $4,000 weekly (β = 0.146) showing significantly higher health literacy compared to the lowest income group.
- Regional/large rural residents (β = –0.066) and medium or small rural towns and remote areas (β = –0.146) showed less ability for healthcare navigation than metropolitan residents.
- English-only speakers had higher health literacy (β = 0.087) compared to those who speak other languages at home, suggesting language barriers impact healthcare system navigation.
- Compared to heterosexuals, non-heterosexual (β = –0.118) or gender diverse individuals (other/non-binary) (β = –0.323) were less able to navigate the healthcare system.
- Those with less-frequent internet use (once daily or less) were less able to navigate the healthcare system compared those who use the internet more frequently (3 or more times daily) (β = –0.136), highlighting the importance of digital access for health information.

Summary and reflections

Accessing health services

Unmet healthcare needs in the community highlight critical gaps within the healthcare system, as they often lead to delayed diagnoses, worsening untreated conditions and increased reliance on emergency services.[45]

Our findings on unmet healthcare needs, reported by nearly half of respondents (49.8%), highlight significant barriers to equitable healthcare access. Dental care emerged as the most commonly missed service (29.3%), followed by not speaking to a doctor (25.0%), skipping recommended tests or treatments (21.2%) and not filling prescriptions (17.8%).

We found that respondents' inability to financially afford healthcare was the most common reason that they missed out on services including dental care (67.0%), prescriptions or necessary treatments (54.2%), and medical tests or treatment and appointments recommended by a doctor (48.7%), highlighting the strain of out-of-pocket costs. We also found that time constraints have become a more prominent obstacle, with an increased proportion of respondents in 2025 identifying lack of time as a reason for having unmet healthcare needs since 2024. This shift suggests that beyond affordability, the accessibility and flexibility of after-hours healthcare services or telehealth may be increasingly important in addressing gaps in care.[46]

Our adjusted analysis found that experiencing financial stress was the most significant predictor of having unmet healthcare needs, demonstrating the impact of financial stress on access to care. Other groups with greater unmet healthcare needs included individuals without PHI, with a lower income, who spoke a language other than English at home, who identify as LGBTQIA+, and who live with chronic illness, highlighting multiple sources of disadvantage in access to healthcare. These groups face greater unmet healthcare needs due to overlapping structural and social barriers. Lack of insurance and low income can limit affordability and choice,[47] while language barriers can hinder communication and navigation of services.[48] LGBTQIA+ individuals and those with chronic illness often encounter stigma, fragmented care and higher costs,[49] compounding disadvantage and reducing timely access to appropriate healthcare.

We found that older adults and higher income individuals were significantly better at navigating the healthcare system. Older adults navigate healthcare better because of accumulated experience, long-standing relationships with healthcare providers and more time to manage appointments.[50] Higher income individuals benefit from financial resources, PHI, higher education and digital access, all of which make it easier to understand options and coordinate care.[51] These advantages can help improve confidence in navigating the healthcare system.

We also found that people experiencing financial stress, living in rural or regional areas, speaking a language other than English at home or using the internet infrequently report greater difficulty navigating the healthcare system. These challenges stem from cost pressures,52 limited local services,53 language barriers,54 and reduced access to digital options.55 Addressing these issues requires targeted support and simplified care pathways to improve equity and access for underserved populations.

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[45] Rahman et al., "A Systematic Review and Meta-Analysis of Unmet Needs for Healthcare and Long-Term Care among Older People."

[46] Victor C. Ezeamii et al., "Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care," *Cureus* (United States) 16, no. 7 (2024): e63881, https://doi.org/10.7759/cureus.63881.

[47] Malerie Lazar and Lisa Davenport, "Barriers to Health Care Access for Low Income Families: A Review of Literature," *Journal of Community Health Nursing* (United States) 35, no. 1 (2018): 28–37, https://doi.org/10.1080/07370016.2018.1404832.

[48] Mamata Pandey et al., "Impacts of English Language Proficiency on Healthcare Access, Use, and Outcomes among Immigrants: A Qualitative Study," *BMC Health Services Research* (England) 21, no. 1 (2021): 741, https://doi.org/10.1186/s12913-021-06750-4.

[49] Jill Del Pozzo et al., "Self-Reported Health Care Disparities and Barriers Among LGBTQIA+ Individuals: Implications for Equitable Health Care Delivery," *Family & Community Health* 48, no. 4 (2025): 290–306, https://journals.lww.com/familyandcommunityhealth/fulltext/2025/10000/self_reported_health_care_disparities_and_barriers.4.aspx; Jee Young Joo, "Fragmented Care and Chronic Illness Patient Outcomes: A Systematic Review," *Nursing Open* 10, no. 6 (2023): 3460–73; Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs among Chronically Ill Patients," *The American Journal of Managed Care* (United States) 21, no. 5 (2015): 355–62.

[50] Da Hae Kwon and Young Dae Kwon, "Patterns of Health Literacy and Influencing Factors Differ by Age: A Cross-Sectional Study," *BMC Public Health* (England) 25, no. 1556 (2025), https://doi.org/10.1186/s12889-025-22838-6.

[51] Kristine Sørensen et al., "Building Health Literacy System Capacity: A Framework for Health Literate Systems," *Health Promotion International* (England) 36, no. Supplement_1 (2021): i13–23, https://doi.org/10.1093/heapro/daab153; Sicong Sun and Yu-Chih Chen, "Is Financial Capability a Determinant of Health? Theory and Evidence."

[52] Nicola Brackertz, "The Impact of Financial Counselling on Alleviating Financial Stress in Low Income Households: A National Australian Empirical Study," *Social Policy and Society* 13, no. 3 (2014): 389–407, Cambridge Core, https://doi.org/10.1017/S1474746413000511.

[53] Nagesh Shukla et al., "A Review of Models Used for Investigating Barriers to Healthcare Access in Australia," *International Journal of Environmental Research and Public Health* (Switzerland) 17, no. 11 (2020), https://doi.org/10.3390/ijerph17114087.

[54] Resham B. Khatri and Yibeltal Assefa, "Access to Health Services among Culturally and Linguistically Diverse Populations in the Australian Universal Health Care System: Issues and Challenges," *BMC Public Health* 22, no. 1 (2022): 880, https://doi.org/10.1186/s12889-022-13256-z.

[55] Michelle A. Krahe et al., "Factors That Influence Digital Health Implementation in Rural, Regional, and Remote Australia: An Overview of Reviews and Recommended Strategies," *The Australian Journal of Rural Health* (Australia) 33, no. 2 (2025): e70045, https://doi.org/10.1111/ajr.70045.

Healthcare experiences

Positive experiences with health services are important for building trust, encouraging individuals to seek care early and promoting ongoing engagement with healthcare providers.[56] Good healthcare experiences also contribute to health equity by reducing anxiety and barriers,[57] especially for First Nations communities,[58] people with disabilities[59] and those from culturally diverse backgrounds.

We asked respondents to rate how frequently (ranging from Never to Always) they had navigated healthcare services and engaged with healthcare providers over the past 12 months.

Small but positive indications to suggest more received consumer-centric care in 2025

In 2025, respondents reported different experiences of navigating healthcare services and engaging with healthcare providers (Figure 12).

Changes were reported regarding some experiences of navigating healthcare services and engaging with healthcare providers in 2025 compared to 2024. Of the respondents in 2025:

- 3 in 4 (75.6%) reported their healthcare providers often or always made sure they received the best care possible (versus 72.9% in 2024)
- 3 in 4 (72.8%) reported that getting to and from their healthcare appointments was often or always easy (versus 73.2% in 2024)
- 3 in 4 (72.6%) reported their healthcare providers often or always included them in decisions about their health (versus 69.6% in 2024)
- 3 in 10 (28.8%) reported that cost had often or always been a barrier to them accessing healthcare (versus 28.8% in 2024)
- 1 in 4 (24.7%) reported that when they saw their healthcare providers, they rarely or never felt rushed as though they were short of time (versus 27.1% in 2024).

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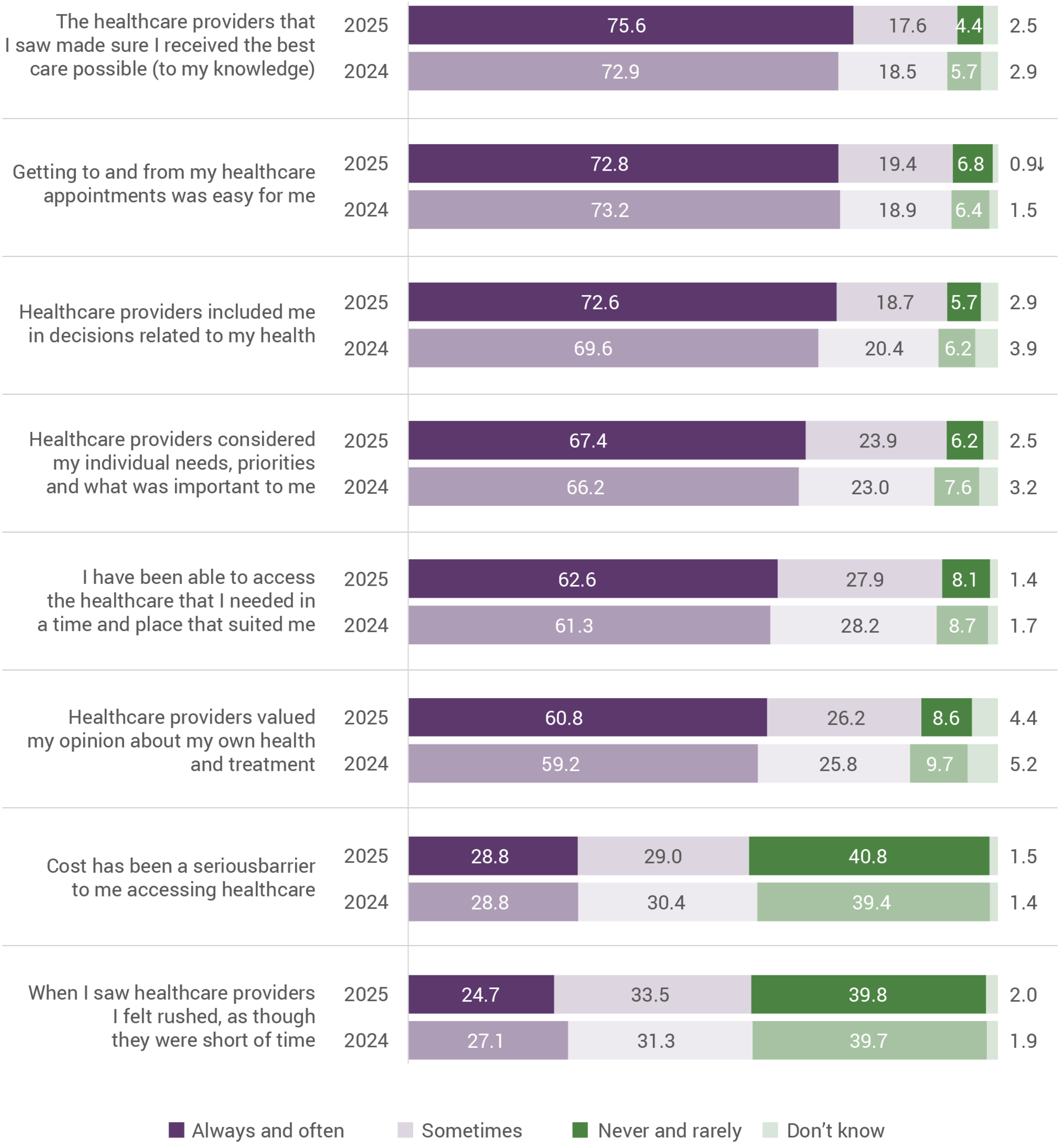
[56] Stephanie M. Topp et al., "Building Patient Trust in Health Systems: A Qualitative Study of Facework in the Context of the Aboriginal and Torres Strait Islander Health Worker Role in Queensland, Australia," *Social Science & Medicine* 302 (June 2022): 114984, https://doi.org/10.1016/j.socscimed.2022.114984.

[57] Ewout Daniël Lieven Lauwers et al., "The Patient Perspective on Diversity-Sensitive Care: A Systematic Review," *International Journal for Equity in Health* 23, no. 1 (2024): 117, https://doi.org/10.1186/s12939-024-02189-1.

[58] Vicki Kerrigan et al., "'If They Help Us, We Can Help Them': First Nations Peoples Identify Intercultural Health Communication Problems and Solutions in Hospital in Northern Australia," *Journal of Racial and Ethnic Health Disparities*, 12, (30 September 2024): 3601–12, https://doi.org/10.1007/s40615-024-02160-4.

[59] Jeromey B. Temple et al., "Discrimination and Avoidance Due to Disability in Australia: Evidence from a National Cross Sectional Survey," *BMC Public Health* 18, no. 1 (2018): 1347, https://doi.org/10.1186/s12889-018-6234-7.

Figure 12: Several positive indications of greater prevalence of consumer-centric healthcare experiences in 2025 compared to 2024



Base: Overall (2024 *n*=5,029, 2025 *n*=5,160)

↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

In-person services

In-person healthcare services are essential, as they provide accurate clinical assessments, physical treatments and emotional support.[60] These services are vital for managing chronic conditions, mental health and emergencies, where timely diagnosis and personal interaction can dramatically improve outcomes.[61] For rural and Indigenous Australian communities, in-person care ensures accessibility, cultural sensitivity and equitable healthcare.[62]

We asked respondents about the types of in-person services they have attended, and to rate how satisfied they were with these services.

Accessing in-person services

In 2025, most respondents (95.8%) accessed at least one in-person healthcare service, which is similar to the rate reported in 2024 (95.3%).

Figure 13 presents the types of in-person healthcare services accessed by respondents in 2025 and their satisfaction with these services, showing similar proportions reported in 2024. The 5 most common in-person health services were a:

- GP (83.1% in 2025 versus 81.0% in 2024)
- pharmacist (68.3% in 2025 versus 67.1% in 2024)
- dentist or oral health service (48.2% in 2025 versus 49.2% in 2024)
- specialist doctor not in a hospital (31.9% in 2025 versus 31.6% in 2024)
- public hospital (30.1% in 2025 versus 29.5% in 2024).

Respondents' satisfaction with the 5 most common in-person healthcare services they attended in 2025 were similar to 2024. Among respondents in 2025:

- 9 in 10 (89.0%) were somewhat or very satisfied with accessing a pharmacist (versus 88.8% in 2024)
- 9 in 10 (88.5%) were somewhat or very satisfied with accessing a dentist or oral health service (versus 88.2% in 2024)
- nearly 9 in 10 (86.4%) were somewhat or very satisfied with accessing a GP (versus 85.7% in 2024)
- 8 in 10 (85.0%) were somewhat or very satisfied with accessing a specialist doctor not in a hospital (versus 82.8% in 2024)
- 7 in 10 (71.5%) were somewhat or very satisfied with accessing a public hospital (versus 73.5% in 2024).

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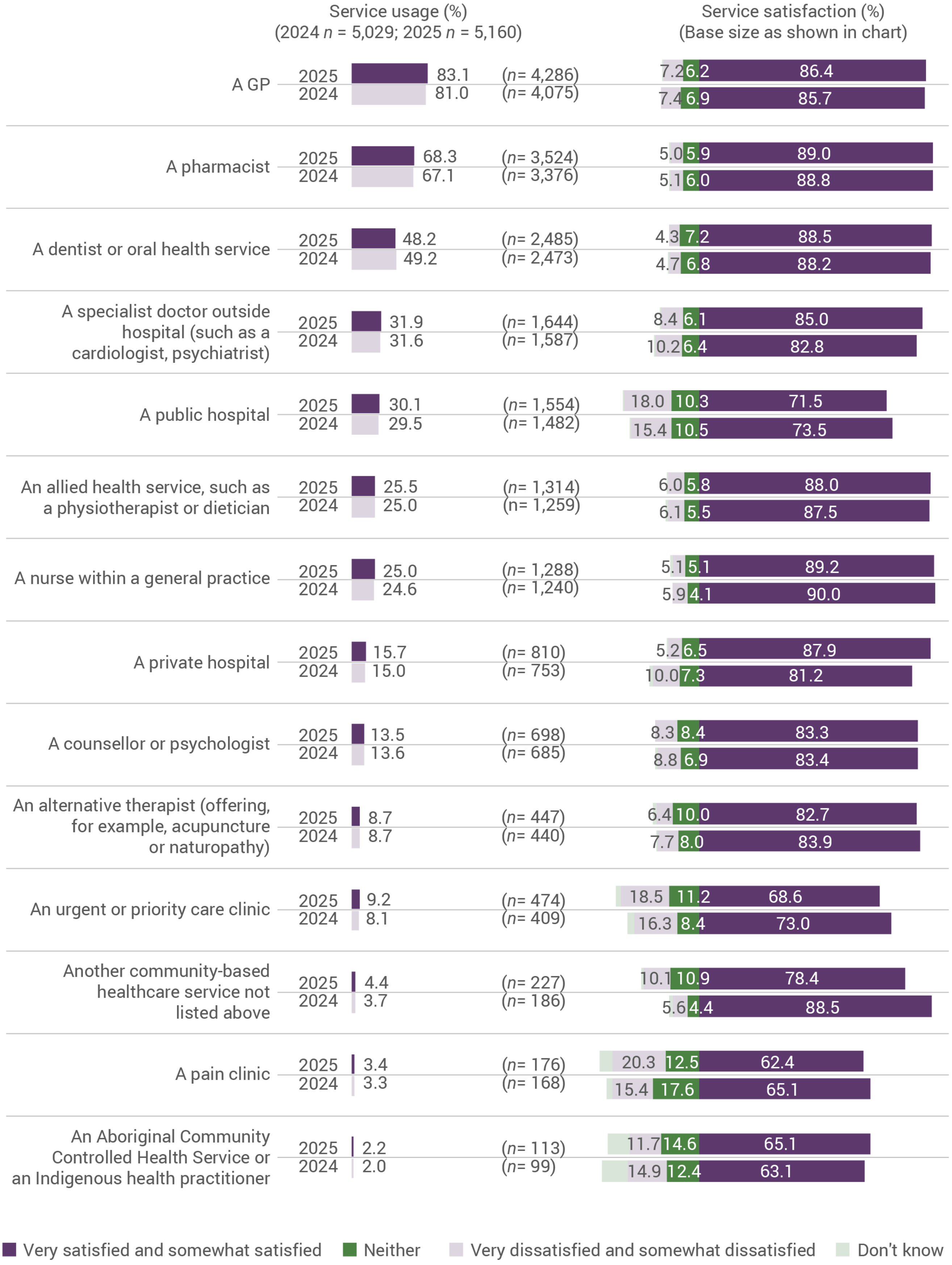
[60] Joseph S. Alpert, "Face-to-Face Versus Digital Encounters in the Clinic," *The American Journal of Medicine* 137, no. 5 (2024): 379–80, https://doi.org/10.1016/j.amjmed.2023.06.015.

[61] Cibeles Moreno-Chico et al., "Effectiveness of a Nurse-Led, Face-to-Face Health Coaching Intervention in Enhancing Activation and Secondary Outcomes of Primary Care Users with Chronic Conditions," *Research in Nursing & Health* 44, no. 3 (2021): 458–72, https://doi.org/10.1002/nur.22132.

[62] Hannah Beks et al., "Mobile Primary Health Care Clinics for Indigenous Populations in Australia, Canada, New Zealand and the United States: A Systematic Scoping Review," *International Journal for Equity in Health* 19, no. 1 (2020): 201, https://doi.org/10.1186/s12939-020-01306-0

Figure 13: GPs, pharmacists and dentist or oral health services were the most accessed health services and received the highest satisfaction ratings



Note: Percentages for "I don't know" responses to healthcare service satisfaction question are not shown in the chart.

GP services

Having a good relationship with a GP is vital for maintaining long-term health and wellbeing. A trusted GP provides continuity of care, understands your medical history and can offer personalised advice and early intervention. This relationship encourages open communication, making it easier to discuss sensitive issues and follow treatment plans.[63]

All respondents were asked about their preferences when visiting a GP regardless of whether they have accessed GP services in the past 12 months. We also asked those who have used GP services to rate the importance of 6 statements related to accessing a GP.

Preferences when accessing GP services

In 2025, respondents' preferences for accessing GP services were similar to preferences in 2024:

- 3 in 5 (62.6%) went to the same GP (versus 62.5% in 2024)
- 1 in 4 (25.2%) always went to the same practice but saw different doctors (versus 25.3% in 2024)
- 1 in 11 (8.9%) often visited different practices (versus 8.3% in 2024).

The remainder did not visit a GP or did not know if they did or not in the previous 12 months. Specifically:

- 1.4% chose not to access a GP (versus 1.5% in 2024)
- 0.6% were unable to access a GP (versus 0.7% in 2024)
- 1.3% did not know (versus 1.7% in 2024).

Among those who have used GP services in 2025 (Figure 14):

- 9 in 10 (92.5%) believed that it was important or very important to get an appointment at a suitable location (versus 91.9% in 2024)
- almost 9 in 10 (87.2%) believed that it was important or very important to see a GP on the day they are sick (versus 86.7% in 2024)
- 4 in 5 (85.5%) believed that it was important or very important to always go to the same GP (versus 85.5% in 2024)
- 4 in 5 (83.1%) believed that it was important or very important to have bulk-billing through Medicare, so they would not have to pay fees (versus 81.7% in 2024)
- 4 in 5 (82.0%) believed that it was important or very important to speak to the same GP (versus 80.6% in 2024)
- 4 in 5 (77.8%) believed that it was important or very important to have the choice to go to any GP practice or clinic they want (versus 78.1% in 2024).

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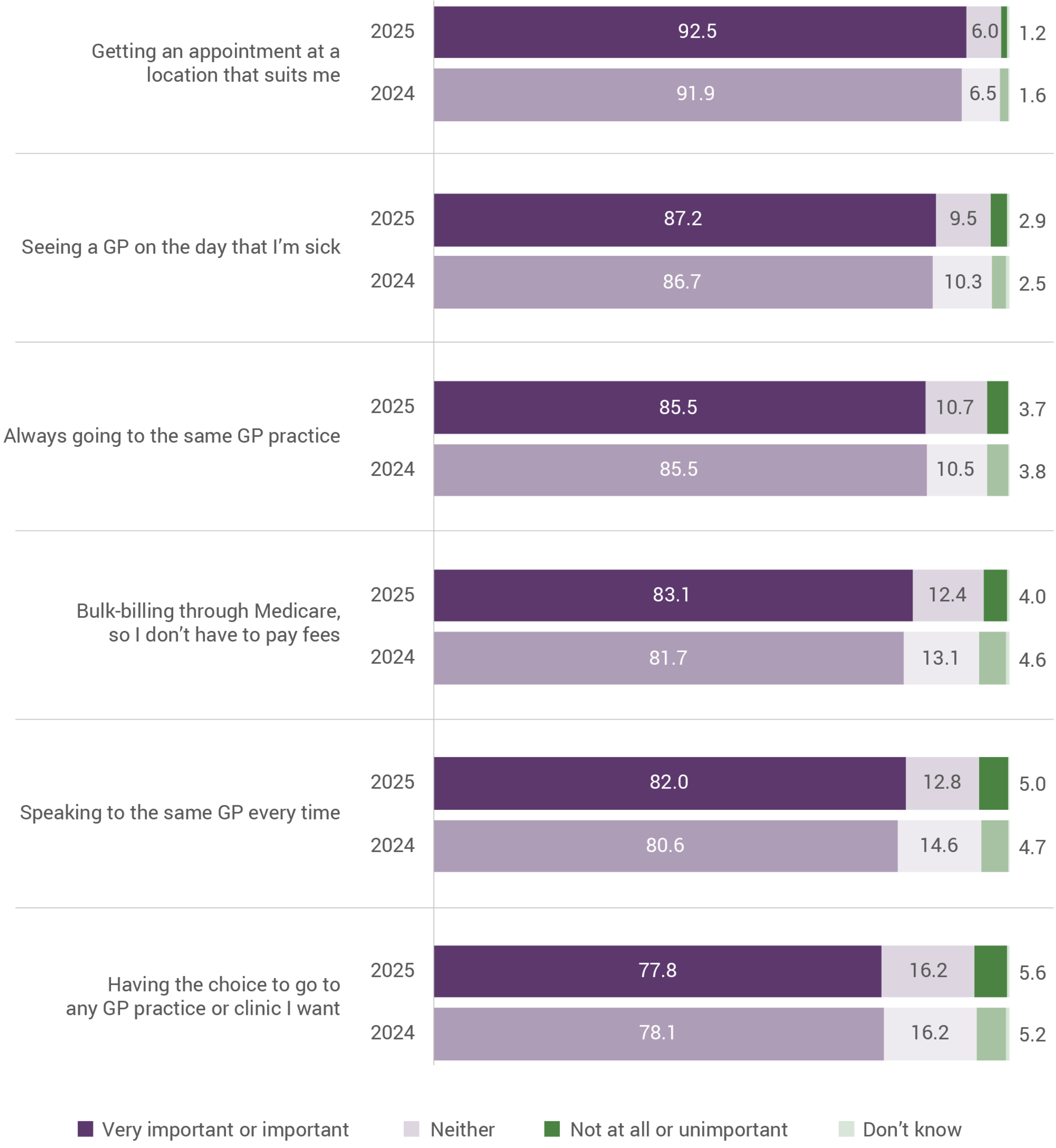
[63] Gregory Shumer et al., "Convenience or Continuity: When Are Patients Willing to Wait to See Their Own Doctor?," *The Annals of Family Medicine* 23, no. 2 (2025): 151, https://doi.org/10.1370/afm.240299.

Figure 14: Most consumers in 2024 and 2025 indicated it was important or very important to have access to a GP at a suitable location and being able to do so when they are sick



Base: Overall (2024 *n*=4,837, 2025 *n*=4,994)

Accessing telehealth and home-based healthcare services

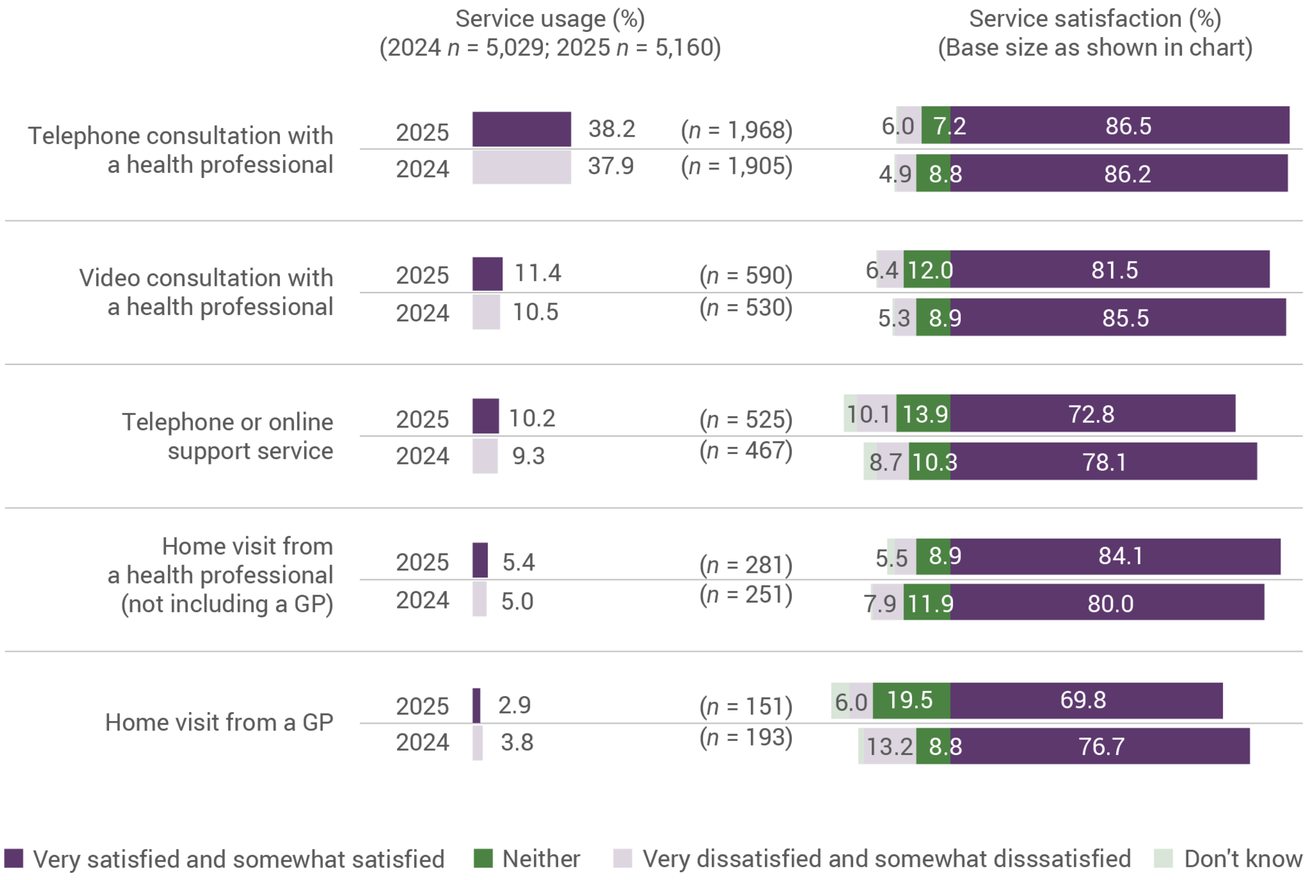
Telehealth and home-based healthcare services can play a vital role in expanding access to care, especially for individuals with mobility challenges or chronic conditions or those living in remote areas.[64] These services can reduce hospital visits, lower healthcare costs and enhance consumer comfort by delivering medical support directly to the home.[65]

We asked respondents whether they had accessed telehealth or home-based healthcare services that did not require them to attend a clinical practice or hospital in person in the past 12 months. We asked respondents who had used at least 1 of 5 telehealth or home-based healthcare services to rate their satisfaction with the services they received. Respondents who accessed telehealth services through telephone or video consultations were asked to evaluate 6 aspects of care. They were also asked to compare their most recent telehealth appointment with a traditional in-person visit, including an assessment of overall quality.

While not as common as in-person services, 43.1% respondents in 2025 accessed telehealth and 7.5% accessed home-based services. Both rates were similar to the rates reported in 2024 (telehealth: 42.6%, home services: 7.5%) (Figure 15). Specifically, among respondents in 2025:

- 38.2% (2 in 5) accessed a telephone consultation with a health professional (versus 37.9% in 2024)
- 11.4% (1 in 10) accessed a video consultation with a health professional (versus 10.5% in 2024)
- 10.2% (1 in 10) accessed a telephone or online support service (such as Healthdirect, Lifeline, Beyond Blue, Medicines Line: 1300 Medicine) (versus 9.3% in 2024)
- 5.4% had a home visit from a non-GP health professional (versus 5.0% in 2024)
- 2.9% had a home visit from a GP (versus 3.8% in 2024).

Figure 15: Rates of using telehealth, telephone or online support or home-visit services did not change significantly between 2024 and 2025



Note: "I don't know" responses to healthcare service satisfaction question are not shown in the chart.

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[64] Jennifer G. Goldman et al., "Patient Experiences Receiving Rehabilitation Care via Telehealth: Identifying Opportunities for Remote Care," *Frontiers in Rehabilitation Sciences* 4 (2023), https://www.frontiersin.org/journals/rehabilitation-sciences/articles/10.3389/fresc.2023.1049554.

[65] Sagda Osman et al., "Beyond the Planned and Expected: The Unintended Consequences of Telehealth in Rural and Remote Australia through a Complexity Lens," *Medical Journal of Australia* 220, no. 10 (2024): 496–98, https://doi.org/10.5694/mja2.52294.

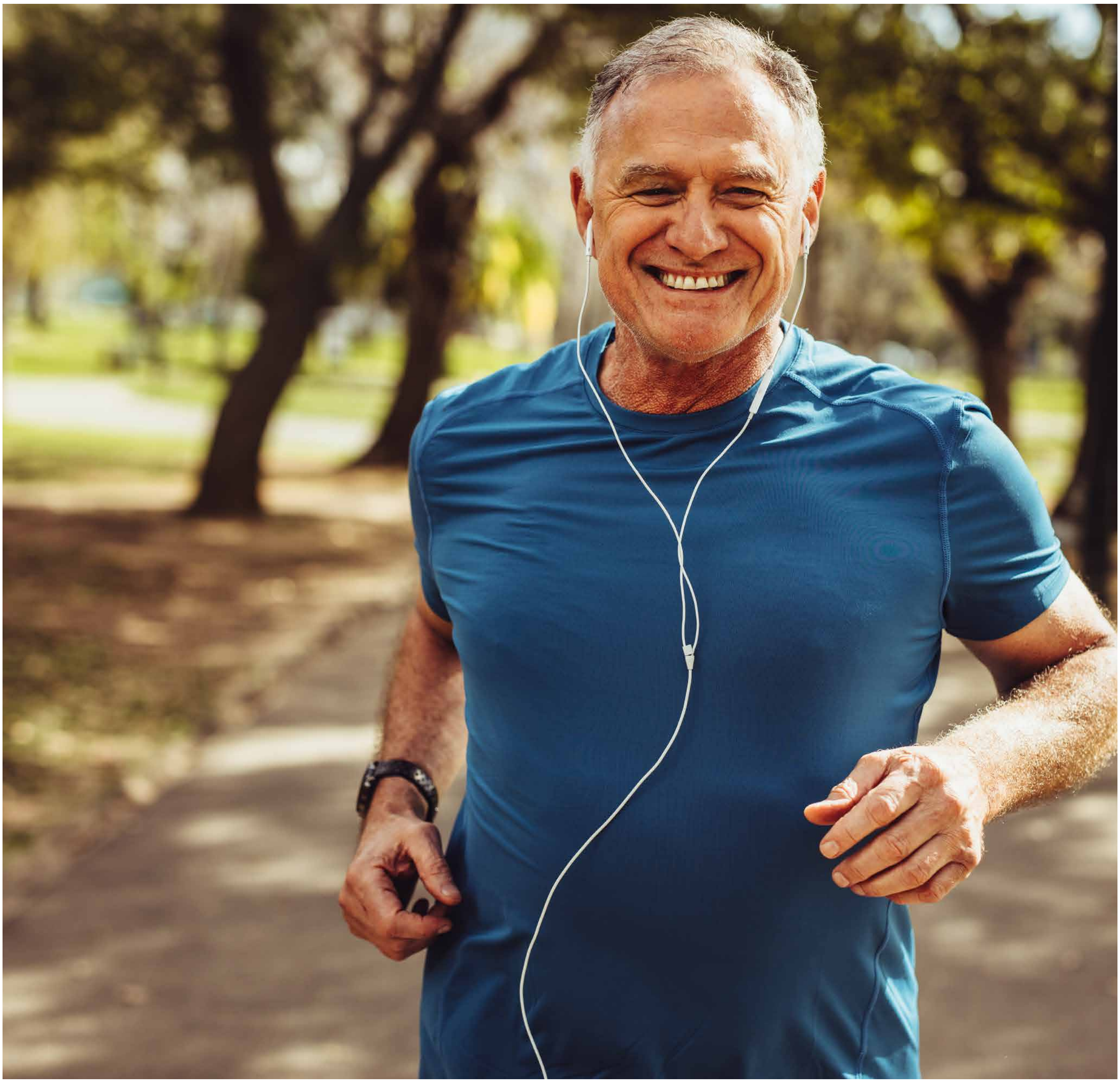
Respondents' satisfaction with telehealth and/or home-based services in 2025 remained consistent with the levels observed in 2024. Among respondents who reported being somewhat or very satisfied with telehealth and/or home-based services:

- 4 in 5 (86.5%) rated their telephone consultation with a health professional favourably (versus 86.2% in 2024)
- 4 in 5 (81.5%) rated their video consultation with a health professional favourably (versus 85.5% in 2024)
- 7 in 10 (72.8%) rated their telephone or online support service favourably (versus 78.1% in 2024)
- 4 in 5 (84.1%) rated their home visit from a non-GP health professional favourably (versus 80.0% in 2024)
- 7 in 10 (69.8%) rated their home visit from a GP favourably (versus 76.7% in 2024).

Satisfaction with telehealth services

Comparing satisfaction with telehealth to in-person care is essential for understanding how well telehealth meets consumer expectations, identifying areas for improvement and guiding decisions about its future role in healthcare delivery.

Respondents who accessed either a telephone or video consultation with a health professional (telehealth) in the past 12 months were asked to evaluate their satisfaction with telehealth services, compared to in-person care, across 6 aspects.

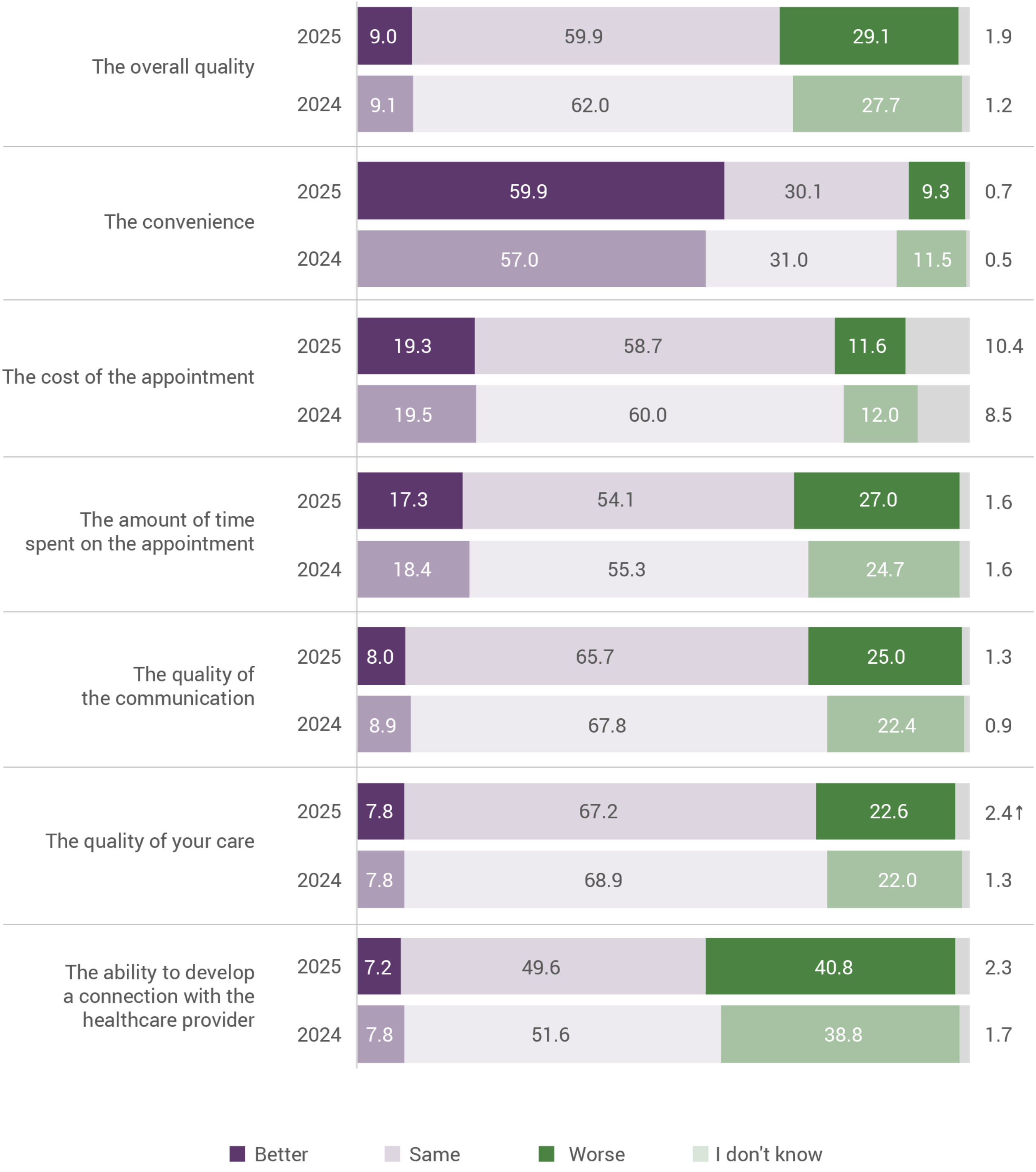


Telehealth versus in-person services

In 2025, overall satisfaction with telehealth remained high among those who accessed a telephone and video consultation, with the majority (59.9%) of respondents considering its quality to be equivalent to in-person care. This trend was consistent with findings reported in 2024 (Figure 16). More specifically, among those who accessed telehealth services in 2025:

- 3 in 5 (59.9%) considered telehealth appointments to be more convenient than in-person appointments (versus 57.0% in 2024)
- 2 in 5 (40.8%) considered telehealth services to be not as good for developing a connection with the healthcare provider as in-person appointments (versus 38.8% in 2024).

Figure 16: Telehealth consumers find most aspects of telehealth comparable to in-person services; more tend to find telehealth convenient and fewer can develop a connection with the healthcare provider compared to in-person services



Base: Overall (2024 *n*=2,140, 2025 *n*=2,225)

Accessing after-hours healthcare

Accessing after-hours healthcare is essential for ensuring timely medical support when regular services are unavailable, particularly during evenings, weekends and holidays.[66] It helps individuals manage urgent but non-emergency issues, reduces unnecessary hospital visits and provides reassurance and continuity of care.[67]

The survey defined after-hours care as being after 6 pm on a weeknight, after 1 pm on a Saturday or any time on a Sunday or public holiday. We asked respondents whether they or a family member had accessed after-hours medical care in the past 12 months, and to rate how easy it was to access these services without visiting an emergency department.

We also asked respondents whether they had accessed after-hours telephone advice lines or online support services in the past 12 months, and to specify which types of services they had used.

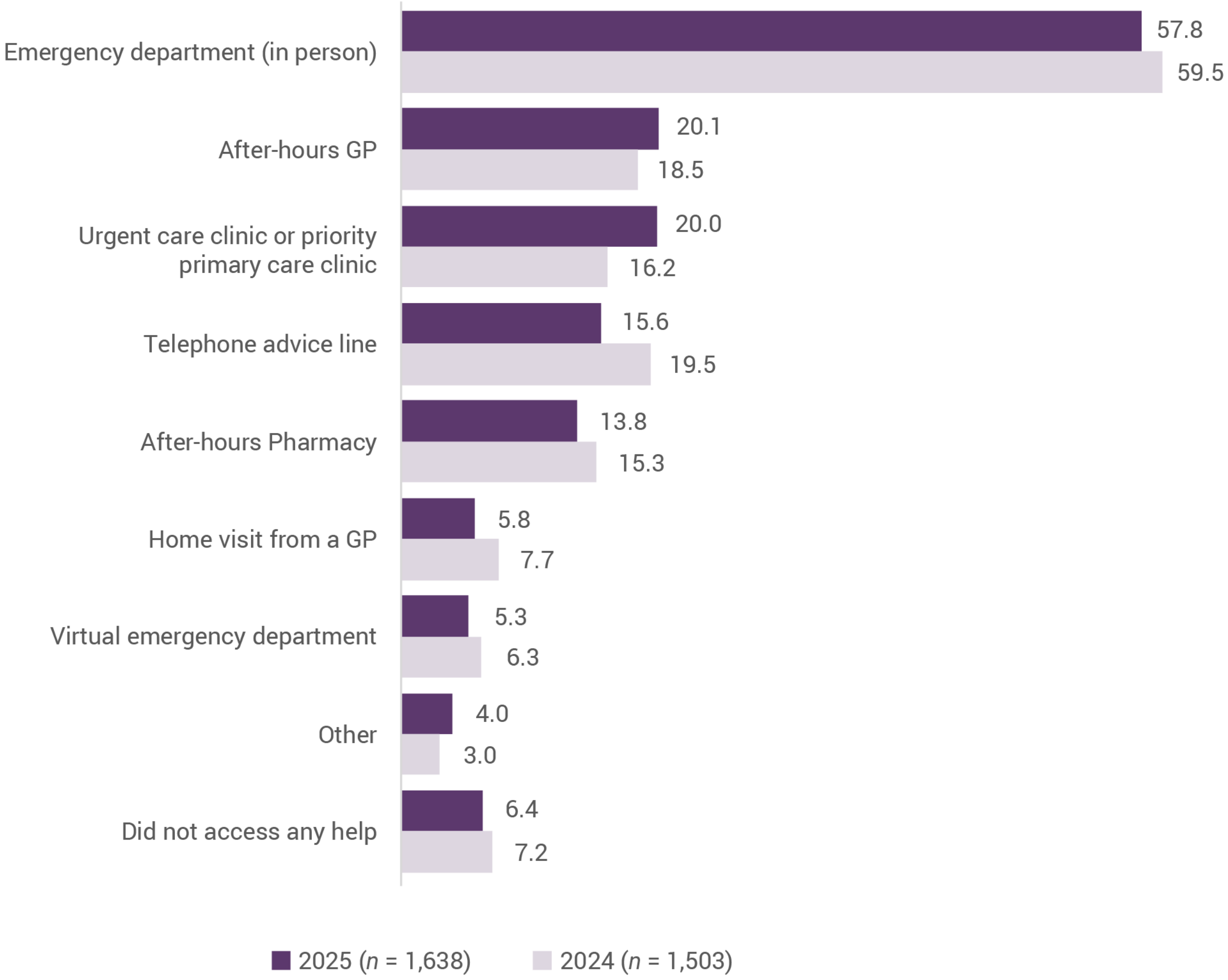
After-hours care access

In 2025, nearly 1 in 3 people (31.7%) accessed after-hours healthcare, a rate consistent with 2024 (29.9%). Figure 17 shows the types of after-hours healthcare accessed in 2025.

Among those who accessed after-hours healthcare:

- 3 in 5 (57.8%) went to an emergency department in person (versus 59.5% in 2024)
- 1 in 5 (20.1%) went to an after-hours GP (versus 18.5% in 2024)
- 1 in 5 (20.0%) went to an urgent care clinic or priority primary care clinic (versus 16.2% in 2024).

Figure 17: Emergency departments were the most common service accessed by those requiring after-hours care in 2024 and 2025



Other services, such as telephone advice lines, after-hours pharmacies, GP home visits and virtual emergency departments, were accessed less frequently.

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66 Kristy Payne et al., "An After Hours GP Clinic in Regional Australia: Appropriateness of Presentations and Impact on Local Emergency Department Presentations," *BMC Family Practice* 18, no. 1 (2017): 86, https://doi.org/10.1186/s12875-017-0657-6.

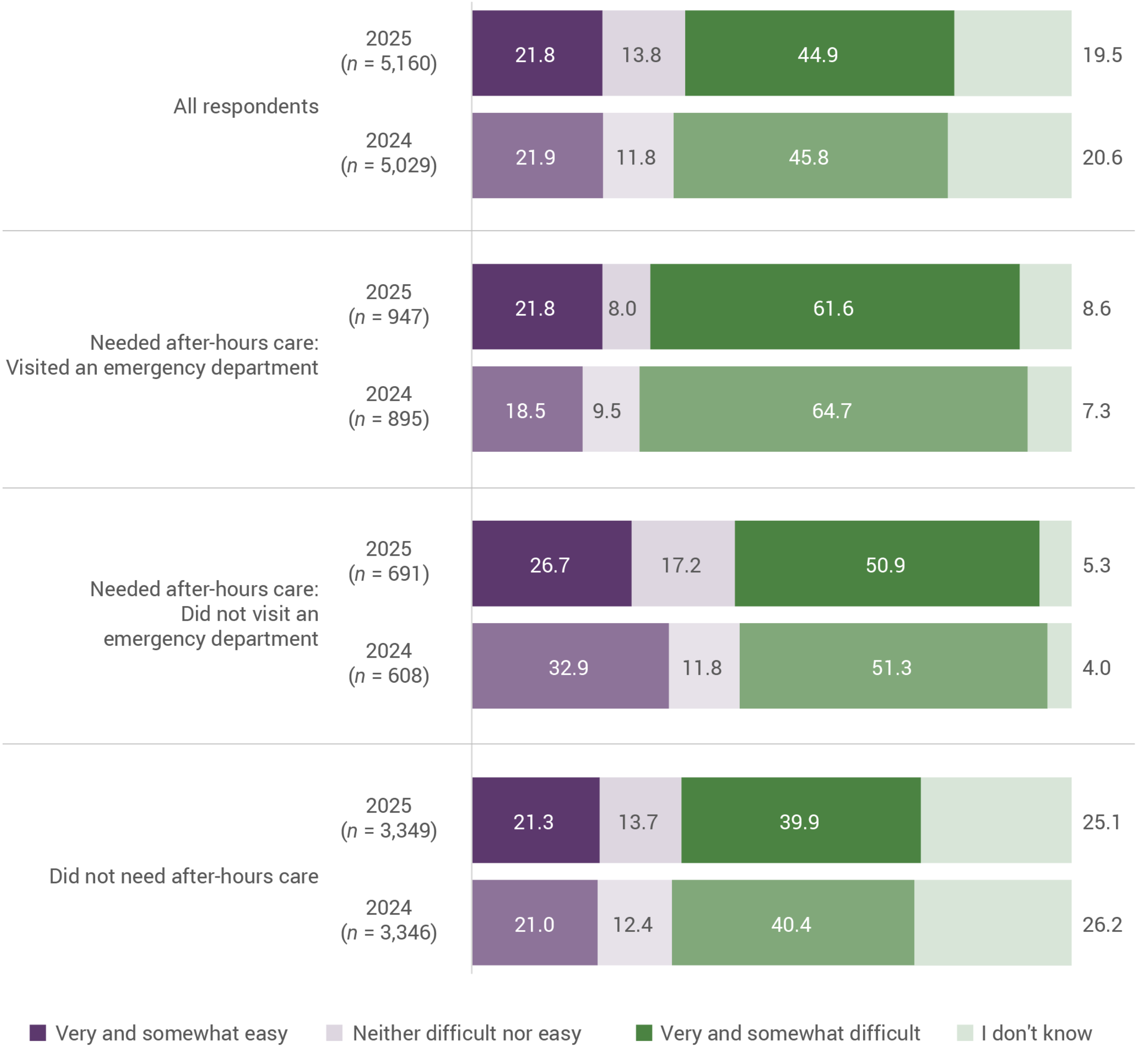
67 David J. Buckley et al., "The Effect of a General Practice After-Hours Clinic on Emergency Department Presentations: A Regression Time Series Analysis," *Medical Journal of Australia* 192, no. 8 (2010): 448–51, https://doi.org/10.5694/j.1326-5377.2010.tb03583.x.

Figure 18 compares 2025 and 2024 perceptions of ease of accessing after-hours care (without visiting an emergency department) across three groups: those who used an emergency department for after-hours care, those who needed after-hours care but did not use an emergency department, and those who did not need after-hours care. Among all respondents who were asked to rate how easy it was to access these services without visiting an emergency department:

- 2 in 5 (44.9%) reported that it somewhat or very difficult (versus 45.8% in 2024)
- 1 in 5 (21.8%) thought that it was somewhat or very easy (versus 21.9% in 2024)
- 1 in 10 (13.8%) reported it was neither easy nor difficult (versus 11.8% in 2024).

In 2025, 19.5% of respondents, approximately 1 in 5, were uncertain about how easy it would be to access care outside regular hours.

Figure 18: Perceived ease of accessing after-hours care without visiting an emergency department remains stable overall, with the greatest difficulty reported among emergency department users



Telephone advice and online support services

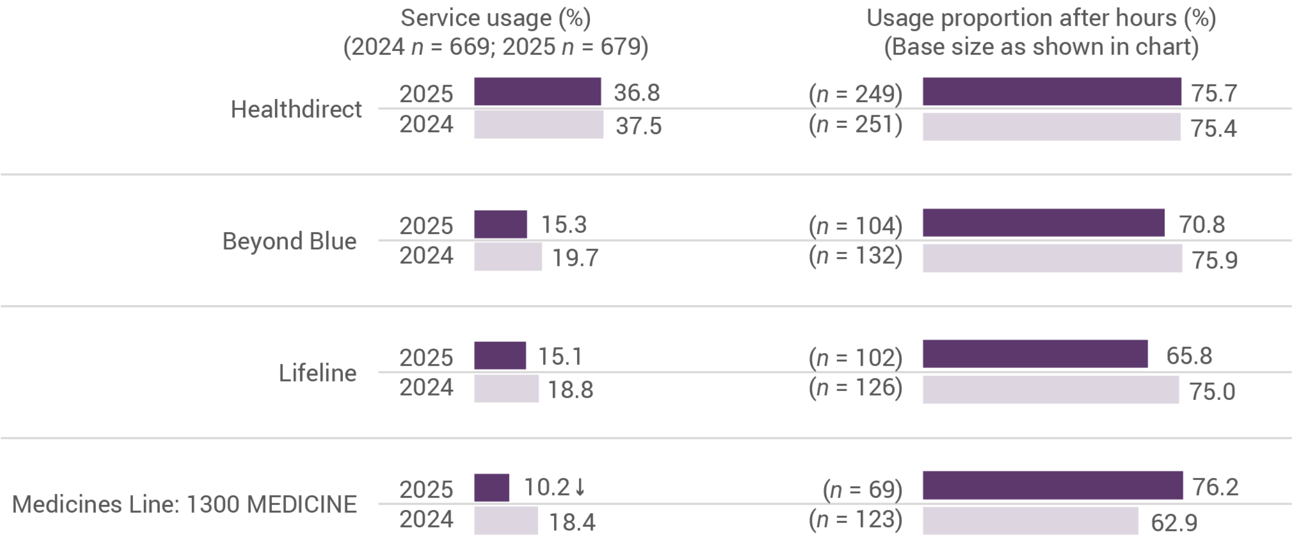
Of the respondents accessing telephone advice or online support services for themselves or a family member in 2025 (Figure 19):

- 1 in 3 (36.8%) accessed Healthdirect (versus 37.5% in 2024)
- 1 in 5 (15.3%) accessed Beyond Blue (versus 19.7% in 2024)
- 1 in 5 (15.1%) accessed Lifeline (versus 18.8% in 2024)
- 1 in 10 (10.2%) accessed 1300 MEDICINE (versus 18.4% in 2024).

Among respondents who accessed telephone advice or online support services in 2025:

- 3 in 4 (75.7%) accessed Healthdirect after-hours (versus 75.4% in 2024)
- 7 in 10 (70.8%) accessed Beyond Blue after-hours (versus 75.9% in 2024)
- 2 in 3 (65.8%) accessed Lifeline after-hours (versus 75.0% in 2024)
- 3 in 4 (76.2%) accessed 1300 MEDICINE after-hours (versus 62.9% in 2024).

Figure 19: Healthdirect was the most used telephone or advice line, with three-quarters of consumers accessing the service after-hours



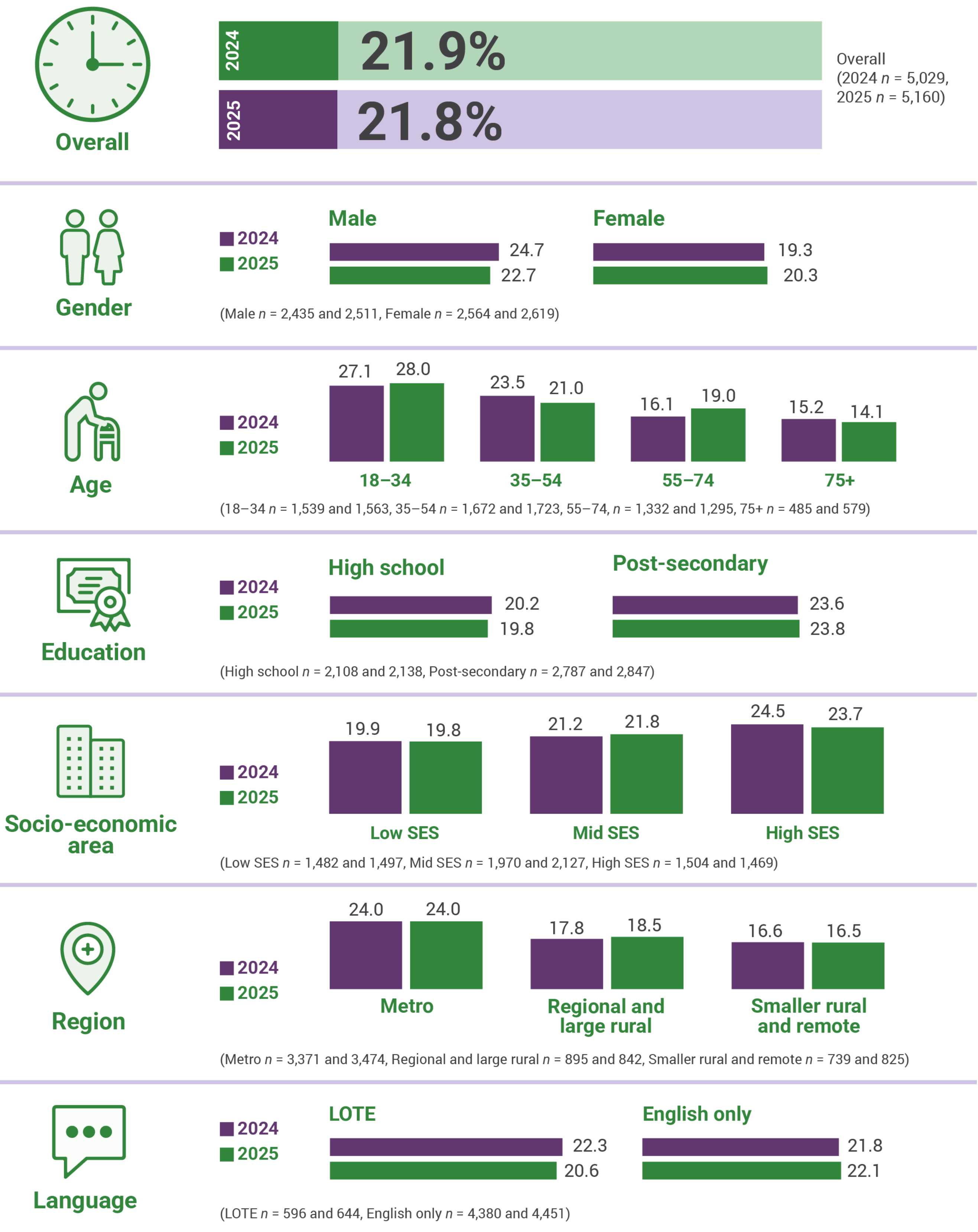
↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

Note: “I don’t know” and “Other” responses are not shown in the chart.

Ease of access to after-hours care

Figure 20 shows differences in ease of access to after-hours care according to respondents' socio-demographic characteristics. Compared to 2024, ease of access to after-hours medical care remained consistent across demographic groups, with no statistically significant differences observed.

Figure 20: Ease of access to after-hours healthcare services across demographic groups



Overall
(2024 *n* = 5,029,
2025 *n* = 5,160)

(Male *n* = 2,435 and 2,511, Female *n* = 2,564 and 2,619)

(18–34 *n* = 1,539 and 1,563, 35–54 *n* = 1,672 and 1,723, 55–74, *n* = 1,332 and 1,295, 75+ *n* = 485 and 579)

(High school *n* = 2,108 and 2,138, Post-secondary *n* = 2,787 and 2,847)

(Low SES *n* = 1,482 and 1,497, Mid SES *n* = 1,970 and 2,127, High SES *n* = 1,504 and 1,469)

(Metro *n* = 3,371 and 3,474, Regional and large rural *n* = 895 and 842, Smaller rural and remote *n* = 739 and 825)

(LOTE *n* = 596 and 644, English only *n* = 4,380 and 4,451)

Factors significantly associated with perceived ease of access to after-hours care

Our analysis showed that age and income were the strongest predictors of perceived after-hours healthcare access, with additional disparities linked to geography, insurance, language and affordability, suggesting uneven perceived access across population groups.

Key findings from our 2025 data (see Appendix B6) were as follows.

- Younger adults (18 to 34) perceived after-hours care easier to access than all older age groups (35 to 54 years: OR = 0.70; 55 to 74 years: OR = 0.65; ≥ 75 years: OR = 0.51).
- Compared to the lowest income group, higher income groups perceived after-hours care easier to access; that is, those earning $2,000 to $3,999 weekly (OR = 1.40) and > $4,000 weekly (OR = 1.51). Compared to metropolitan residents, those in regional or large rural towns (OR = 0.74) or in medium/small rural towns and remote areas (OR = 0.67) perceived after-hours services harder to access.
- Those without PHI had perceived after-hours care harder to access than those with PHI (OR = 0.80), highlighting insurance status as an access facilitator.
- English-only speakers perceived after-hours care easier to access than those speaking other languages at home (OR = 1.29), suggesting potential language or navigation barriers for CALD communities.
- Those using internet twice daily perceived after-hours care easier to access (OR = 1.47) compared to those who use internet more than 3 or more times daily.
- Individuals who reported difficulty affording healthcare were less likely to perceive after-hours care as easy to access compared to those without affordability issues (OR = 0.75). This suggests that concerns about affordability may extend to after-hours care as well.

Summary and reflections

Healthcare experiences

Positive experiences with healthcare services can play a key role in building trust, motivating people to seek care promptly and supporting continued engagement with providers.[68] In 2025, patterns of navigating healthcare and interacting with providers were largely consistent with 2024, with most respondents accessing in-person care and similar preferences for GP services. Use of telehealth, home-based care and after-hours care, as well as satisfaction with these options, remained stable, with the majority rating telehealth quality comparable to in-person care.

Compared to 2024, the slight, though statistically non-significant, increase in consumer-centred care in 2025 suggests a stable trend in healthcare experiences rather than a marked improvement. With 75.6% of respondents reporting that providers often or always ensured they received the best care, and 72.6% feeling included in health decisions, the results indicate a generally positive perception of care quality and shared decision-making. However, the lack of significant change suggests a plateau in progress, where further efforts may be needed to embed consumer-centred practices more consistently across the healthcare system.[69] These findings highlight the importance of investing in communication, continuity of care and provider training to ensure that all consumers feel heard, respected and actively involved in their care.

High satisfaction with in-person healthcare services in 2025 remains a strong point in the Australian healthcare system, particularly for GPs (86.4%), pharmacists (89.0%) and dentists (88.5%). Given that 95.8% of respondents accessed at least one service, suggests that in-person care continues to be both accessible and valued. Additionally, the preference for continuity of care remains evident, with 62.6% of respondents consistently seeing the same GP. This continuity is a key component of quality primary care and can contribute to better health outcomes, stronger consumer–provider relationships and more coordinated care.[70] These findings reinforce the importance of maintaining and supporting in-person services, even as digital health options expand.

The uptake of telehealth and home-based services reflects a growing diversification in how Australians access care in 2025, with 43.1% using telehealth and 7.5% using home-based services. Satisfaction with telehealth remains high, 86.5% for telephone and 81.5% for video consultations, indicating that these options are meeting many consumers' needs. However, while 59.9% found telehealth more convenient, 40.8% felt it was less effective for building relationships with providers, suggesting that these alternatives may be complementary and should not replace in-person consultations.[71] After-hours care was accessed by nearly a third of respondents (31.7%), with emergency departments being the most common option (3 in 5 went to an emergency department in person), potentially reflecting limited availability of other after-hours care.

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[68] Abukari Kwame and Pammla M. Petrucka, "A Literature-Based Study of Patient-Centered Care and Communication in Nurse-Patient Interactions: Barriers, Facilitators, and the Way Forward," BMC Nursing 20, no. 1 (2021): 158, https://doi.org/10.1186/s12912-021-00684-2.

[69] A. Parkinson et al., "Putting the Consumer First: Creating a Consumer-Centred Health System for a 21st Century Australia. A Health Policy Report, April 2016," The George Institute for Global Health and the Consumers Health Forum of Australia (2016).

[70] Centaine L. Snoswell et al., "How Do Consumers Prefer Their Care Delivered: In-Person, Telephone or Videoconference?," *Journal of Telemedicine and Telecare* (England) 30, no. 10 (2024): 1555–62, https://doi.org/10.1177/1357633X231160333.

[71] Sara Javanparast et al., "The Experience of Australian General Practice Patients at High Risk of Poor Health Outcomes with Telehealth during the COVID-19 Pandemic: A Qualitative Study," *BMC Family Practice* 22, no. 1 (2021): 69, https://doi.org/10.1186/s12875-021-01408-w.

Our adjusted analysis found that respondents who were younger, had higher income, lived in metropolitan areas or used the internet twice daily (compared to 3 or more times daily) had significantly less difficulty accessing after-hours care. The findings suggest barriers accessing after-hours healthcare services for older adults,[72] lower income earners[73] and those in rural or regional areas,[74] highlighting structural inequities in service availability and accessibility that may require targeted strategies to ensure equitable access. Interestingly, respondents who reported using the internet twice daily experienced less difficulty accessing after-hours care compared to those using it 3 or more times daily This unexpected result may reflect a non-monotonic relationship between use of internet and ease of after-hours access. We anticipate that moderate users (twice daily) may use it more purposefully for tasks such as booking appointments, whereas heavier users (3 or more times daily) might include those who use the internet for social or entertainment purposes. As our survey did not capture the specific purposes of their internet use, this interpretation remains speculative.[75]

We also found that those without PHI or who spoke a language other than English at home perceived after-hours care as more difficult to access, which further highlights equity challenges in healthcare. Lack of PHI may limit options for timely care, while language barriers can hinder navigation of available services, particularly when information and booking systems are primarily in English.[76] These disparities reinforce the need for culturally and linguistically appropriate communication strategies and affordable care pathways to ensure that after-hours healthcare services are accessible to all population groups.

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[72] Miia Rahja et al., "What Is Important to Older People When Accessing Urgent Health Care: Key Considerations and Recommendations From Consumer Consultations," *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy* 28, no. 3 (2025): e70311, https://doi.org/10.1111/hex.70311.

[73] Margaret Kelaher et al., "Effects of Financial Disadvantage on Use and Non-Use of After Hours Care in Australia," *Health Policy* 79, no. 1 (2006): 16–23, https://doi.org/10.1016/j.healthpol.2005.11.017.

[74] Kathryn Zeitz et al., "Australian Issues in the Provision of After-Hours Primary Medical Care Services in Rural Communities," *Australian Journal of Rural Health* 14, no. 3 (2006): 99–104, https://doi.org/10.1111/j.1440-1584.2006.00781.x.

[75] Bernard C. K. Choi and Anita W. P. Pak, "A Catalog of Biases in Questionnaires," *Preventing Chronic Disease* (United States) 2, no. 1 (2005): A13.

[76] Khatri and Assefa, "Access to Health Services among Culturally and Linguistically Diverse Populations in the Australian Universal Health Care System: Issues and Challenges."

Quality of healthcare

The quality of healthcare can influence consumer trust, engagement and outcomes. When individuals feel confident in the care they receive, they are more likely to follow medical advice, attend follow-up appointments and maintain long-term relationships with providers.[77] Satisfaction also reflects the effectiveness, safety and responsiveness of the healthcare system.[78] Respect in healthcare fosters trust between consumers and providers, encouraging honest communication and shared decision-making.[79] It ensures that individuals feel valued, heard and safe.

We asked respondents to rate their satisfaction with the quality of healthcare they received, and whether they experienced any discrimination or disrespect from healthcare providers in the past 12 months.

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[77] Cathal Doyle et al., "A Systematic Review of Evidence on the Links between Patient Experience and Clinical Safety and Effectiveness," *BMJ Open* 3, no. 1 (2013): e001570, https://doi.org/10.1136/bmjopen-2012-001570.

[78] Sofia Xesfingi and Athanassios Vozikis, "Patient Satisfaction with the Healthcare System: Assessing the Impact of Socio-Economic and Healthcare Provision Factors," *BMC Health Services Research* 16, no. 1 (2016): 94, https://doi.org/10.1186/s12913-016-1327-4.

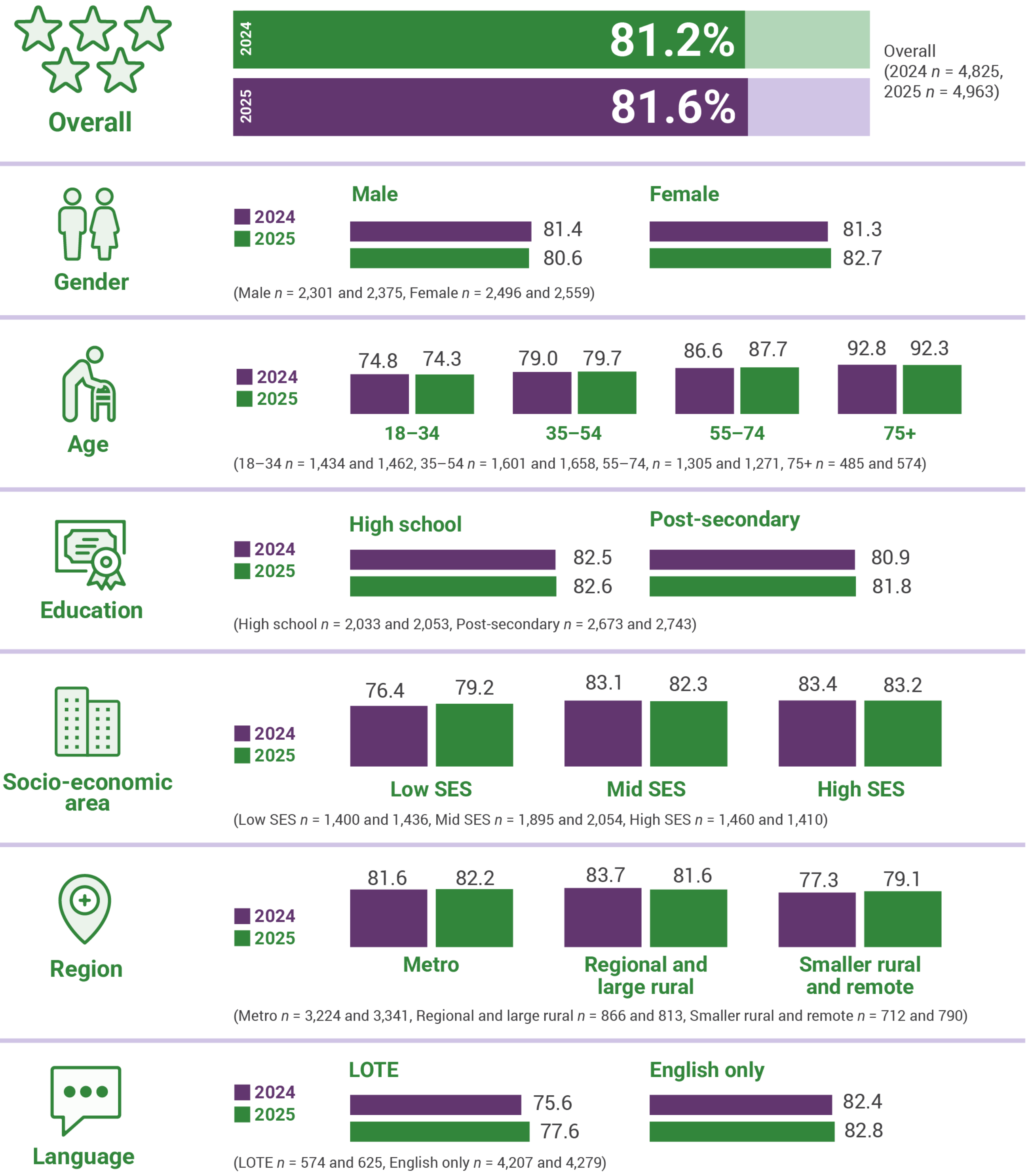
[79] Tara Montgomery et al., "Transparency as a Trust-Building Practice in Physician Relationships With Patients," *JAMA* 324, no. 23 (2020): 2365–66, https://doi.org/10.1001/jama.2020.18368.

Satisfaction with quality of healthcare

Among respondents who attended healthcare services in 2025, 4 in 5 (81.6%) were either somewhat or very satisfied with the quality of healthcare they received, which is similar to the rate reported in 2024 (81.2%).

Figure 21 shows respondents' satisfaction with the quality of healthcare they received according to their socio-demographic characteristics, and health and PHI status. Compared to 2024, satisfaction with the quality of healthcare received remained consistent across demographic groups, with no statistically significant differences observed.

Figure 21: Overall satisfaction with the quality of healthcare received across demographic groups (base: those who attended healthcare services in the past 12 months)



(Male *n* = 2,301 and 2,375, Female *n* = 2,496 and 2,559)

(18–34 *n* = 1,434 and 1,462, 35–54 *n* = 1,601 and 1,658, 55–74, *n* = 1,305 and 1,271, 75+ *n* = 485 and 574)

(High school *n* = 2,033 and 2,053, Post-secondary *n* = 2,673 and 2,743)

(Low SES *n* = 1,400 and 1,436, Mid SES *n* = 1,895 and 2,054, High SES *n* = 1,460 and 1,410)

(Metro *n* = 3,224 and 3,341, Regional and large rural *n* = 866 and 813, Smaller rural and remote *n* = 712 and 790)

(LOTE *n* = 574 and 625, English only *n* = 4,207 and 4,279)

Factors associated with overall satisfaction with healthcare

Our analysis showed that age and financial stress were the strongest predictors of overall healthcare satisfaction, with additional disparities linked to income, geography, gender and digital access, highlighting uneven satisfaction across population groups.

Key findings from our 2025 data (see Appendix B7) were as follows.

- Compared to younger adults (18 to 34 years), satisfaction increased with age (35 to 54 years: OR = 1.38; 55 to 74 years: OR = 2.11; ≥ 75 years: OR = 3.28).
- Individuals with financial stress were less satisfied with the healthcare they received compared to those without financial stress (OR = 0.55). Higher income groups showed greater satisfaction: $2,000 to $3,999 weekly (OR = 1.45) and > $4,000 weekly (OR = 1.64) compared to those earning under $1,000 weekly.
- Rural residents in medium or small towns and remote areas had significantly lower satisfaction (OR = 0.68) compared to metropolitan residents.
- Women reported higher healthcare satisfaction than men (OR = 1.24), while less-frequent internet users (once daily or less) had substantially lower satisfaction than frequent users (3 or more times daily) (OR = 0.54).

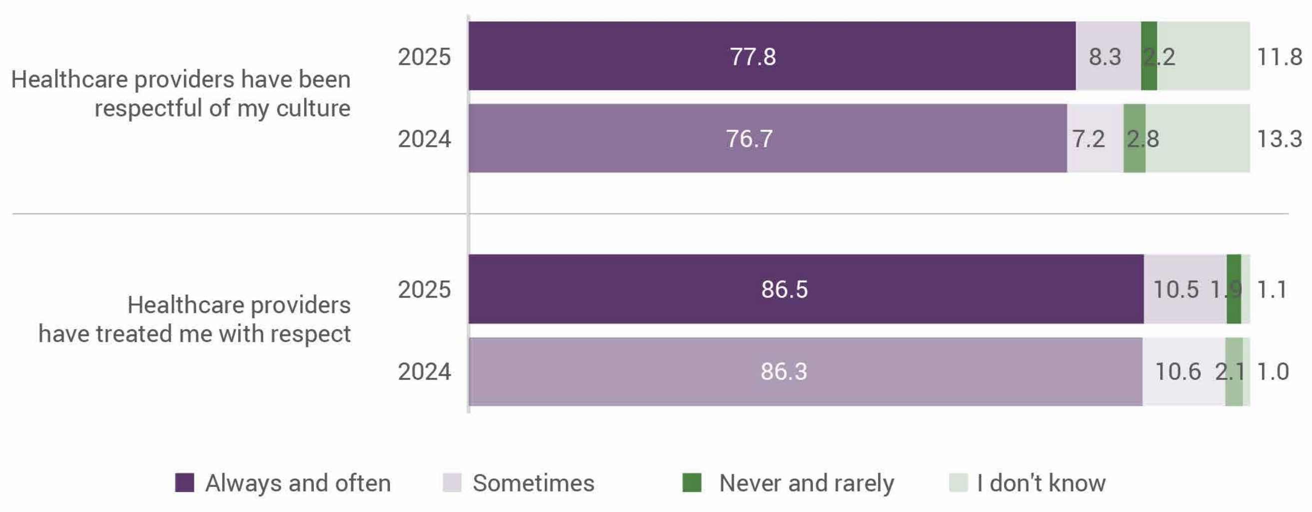
Respectful healthcare

Respondents' experiences with respectful healthcare in 2025 were similar to those reported in 2024 (Figure 22).

Among those who accessed healthcare services in 2025:

- 77.8% (nearly 8 in 10) reported that their healthcare providers were often or always respectful of their culture (versus 76.7% in 2024)
- 2.2% reported that their healthcare providers were rarely or never respectful of their culture (versus 2.8% in 2024).
- 86.5% (nearly 9 in 10) were often or always treated with respect by their healthcare providers (versus 86.3% in 2024)
- 1.9% reported that their healthcare providers rarely or never treated them with respect (versus 2.1% in 2024).

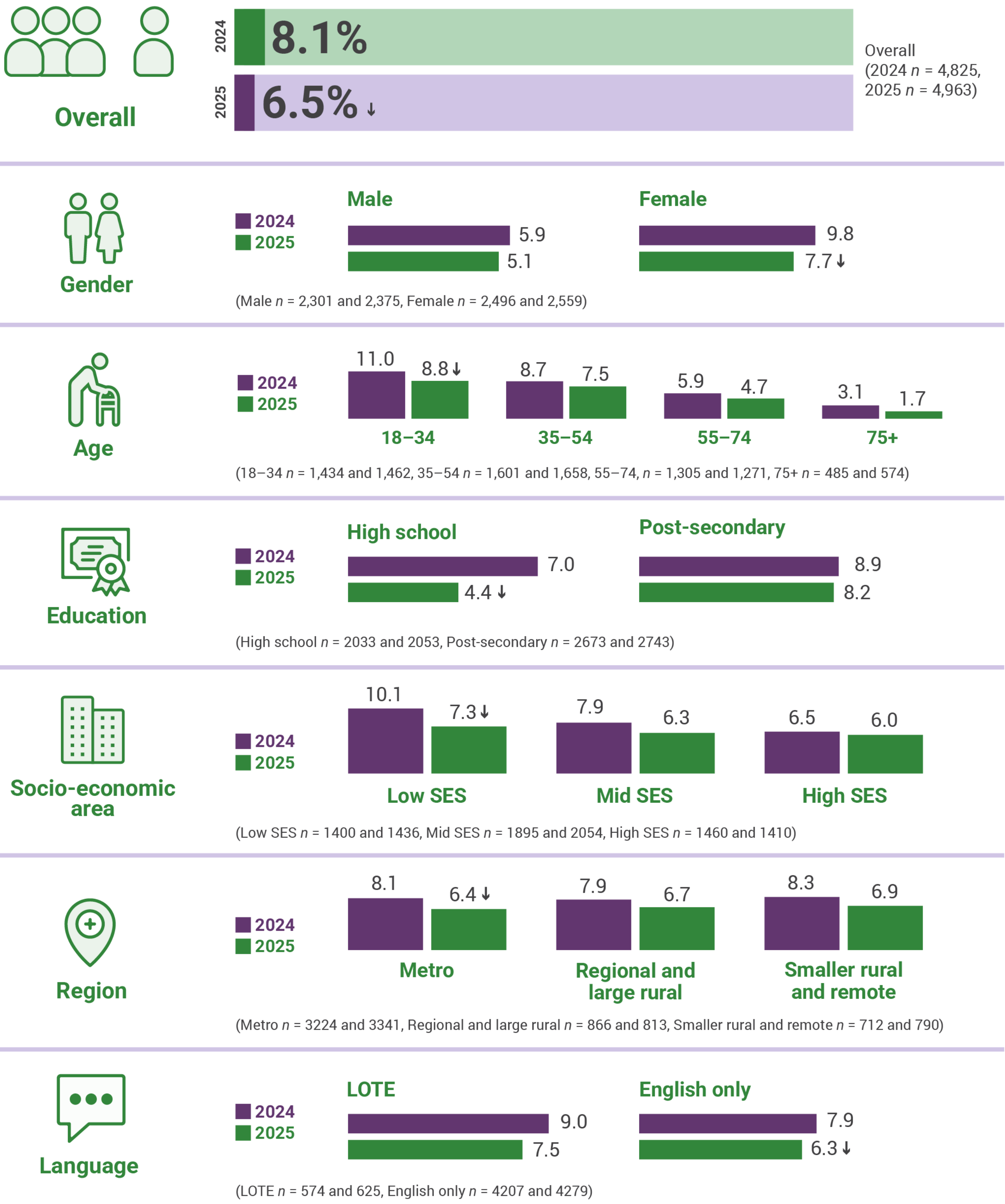
Figure 22: The vast majority of 2024 and 2025 respondents reported that their healthcare providers usually treated them with respect. Only a small proportion said they were rarely or never treated with respect, or that their cultural needs were not respected



Base: Overall (2024 *n* = 4,825, 2025 *n* = 4,963)

Figure 23 shows the proportions of respondents' experiences of discrimination or disrespect when receiving healthcare. Among respondents in 2025, 6.5% experienced discrimination or disrespect when they received healthcare. Compared to 2024, this showed a statistically significant decline in the proportion of respondents reporting experiences of discrimination or disrespect when receiving healthcare, including women, metropolitan residents, people who had secondary school education or below, and English-only speakers.

Figure 23: Experiences of discrimination and disrespect when receiving healthcare across demographic groups (base: those who attended health services in the past 12 months)



Overall (2024 *n* = 4,825, 2025 *n* = 4,963)

(Male *n* = 2,301 and 2,375, Female *n* = 2,496 and 2,559)

(18–34 *n* = 1,434 and 1,462, 35–54 *n* = 1,601 and 1,658, 55–74, *n* = 1,305 and 1,271, 75+ *n* = 485 and 574)

(High school *n* = 2033 and 2053, Post-secondary *n* = 2673 and 2743)

(Low SES *n* = 1400 and 1436, Mid SES *n* = 1895 and 2054, High SES *n* = 1460 and 1410)

(Metro *n* = 3224 and 3341, Regional and large rural *n* = 866 and 813, Smaller rural and remote *n* = 712 and 790)

(LOTE *n* = 574 and 625, English only *n* = 4207 and 4279)

↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

Factors associated with experiencing discrimination or disrespect when receiving healthcare

The low rate (6.5%) of individuals experiencing discrimination when receiving healthcare suggests that these experiences, while serious when they occur, are reported by a relatively small proportion of healthcare users. Our analysis showed that chronic illness and financial stress were the strongest predictors of healthcare discrimination, with additional disparities linked to being younger (18 to 34 years), higher education and low income, highlighting intersecting vulnerabilities in consumer experiences.

Key findings from our 2025 data (see Appendix B8) were as follows.

- Compared to younger adults aged 18 to 34, older adults experienced less discrimination when receiving healthcare (55 to 74 years: OR = 0.57; ≥ 75 years: OR = 0.29). The age protection effect may reflect generational differences in expectations or reporting behaviours.
- Individuals with post-secondary education experienced more discrimination when receiving healthcare than those with high school education (OR = 2.05), possibly reflecting greater awareness of discriminatory behaviour or higher expectations of respectful care.
- Individuals with chronic illness had experienced more discrimination when receiving healthcare than those without chronic illness (OR = 2.10), highlighting systemic issues in how healthcare providers treat consumers with ongoing health needs.
- Those experiencing financial stress (OR = 1.96) and difficulties affording care (OR = 1.67) had significantly higher odds of discrimination, suggesting that financial vulnerability intersects with poor treatment when receiving healthcare.
- Those earning $2,000 to $3,999 weekly had experienced less discrimination (OR = 0.54) compared to the lowest income group, while other income levels showed non-significant effects.

Summary and reflections

Quality of healthcare

Quality and respect in healthcare are essential for trust, engagement and better outcomes, fostering confidence, adherence to care and meaningful consumer–provider relationships. In 2025, overall satisfaction and respectful care patterns were largely unchanged from 2024, with most respondents reporting high levels of satisfaction (> 80%) and respect from providers (> 85%). Cultural respect remained strong, with nearly 8 in 10 respondents feeling their culture was acknowledged during care. While discrimination during healthcare declined to 6.5%, these experiences were more concentrated among young people (< 35 years), those experiencing financial stress, those living with chronic illness, higher income earners ($2,000 to $3,999 weekly) and individuals with post-secondary education.

Our adjusted analysis indicated that higher satisfaction with healthcare quality was associated with being older (≥ 35 years), earning a high weekly income (> $2,000 weekly), being female and frequent internet use (3 or more times daily). These groups may have experienced more interactions with the healthcare system, better access to services or greater familiarity with navigating care, which could contribute to their higher levels of satisfaction.[80] We found that lower satisfaction with healthcare quality was associated with experiencing financial stress, or living in rural or remote areas, indicating that both socio-economic and geographic factors may shape perceptions of healthcare quality.

Respectful care continues to be a strong feature of the healthcare experience, with 86.5% of respondents in 2025 feeling respected by their providers (versus 86.3% in 2024) and 77.8% reporting culturally respectful interactions (versus 76.7% in 2024). These results suggest that most healthcare professionals are maintaining high standards of interpersonal care, which is essential for building trust, improving communication and supporting positive health outcomes.[81] However, the slight gap between general respect and cultural respect indicates room for improvement in ensuring that care is inclusive and responsive to diverse cultural backgrounds.

Discrimination in healthcare was reported by 6.5% of respondents in 2025, reflecting a slight but statistically significant decrease from 2024 (8.1%). Reports of discrimination were more common among individuals experiencing financial stress, those living with chronic illness and those with post-secondary education, suggesting that health and socio-economic factors may shape perceptions of treatment in several ways. For example, individuals under financial stress may feel judged for their inability to afford certain services or perceive inequities in care options. Those with chronic illnesses often require frequent or complex care, which can lead to feelings of being dismissed or stereotyped.[82] Similarly, people with higher education levels may be more attuned to communication quality and perceive condescension or lack of respect.

Reports of discrimination were less common among older adults and higher income earners. Older adults may be perceived as more deserving of care due to age-related health needs,[83] and they often have more frequent interactions with the healthcare system, which can foster familiarity and trust with providers.[84] They may also have access to specific services that reduce barriers and improve their experiences. For higher income earners, financial stability often translates into better access to private healthcare, shorter wait times and more choice in providers.[85] These advantages can reduce exposure to discriminatory practices, as they may be treated more favourably or have the option to avoid services where discrimination is more likely to occur.

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[80] Kwon and Kwon, "Patterns of Health Literacy and Influencing Factors Differ by Age: A Cross-Sectional Study."; Sara N. Bleich et al., "How Does Satisfaction with the Health-Care System Relate to Patient Experience?," *Bulletin of the World Health Organization* 87, no. 4 (2009): 271–78, https://doi.org/10.2471/blt.07.050401; Ezeamii et al., "Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care."; Sun and Chen, "Is Financial Capability a Determinant of Health? Theory and Evidence."

[81] Montgomery et al., "Transparency as a Trust-Building Practice in Physician Relationships With Patients."

[82] Joo, "Fragmented Care and Chronic Illness Patient Outcomes: A Systematic Review"; Neville Millen and Christine Walker, "Overcoming the Stigma of Chronic Illness: Strategies for Normalisation of a 'Spoiled Identity,'" *Health Sociology Review* 10, no. 2 (2001): 89–97.

[83] Neil Jeyasingam et al., "Attitudes to Ageing Amongst Health Care Professionals: A Qualitative Systematic Review," *European Geriatric Medicine* 14, no. 5 (2023): 889–908, https://doi.org/10.1007/s41999-023-00841-7.

[84] Alison M. Mudge et al., "Qualitative Analysis of Challenges and Enablers to Providing Age Friendly Hospital Care in an Australian Health System," *BMC Geriatrics* 21, no. 1 (2021): 147, https://doi.org/10.1186/s12877-021-02098-w.

[85] Sun and Chen, "Is Financial Capability a Determinant of Health? Theory and Evidence."

Views and attitudes towards the healthcare system

Views and attitudes towards the healthcare system play a crucial role in shaping public engagement, policy support and health outcomes.[86] When individuals hold positive attitudes and informed views, they are more likely to seek care proactively, adhere to medical advice and participate in public health initiatives.[87] These perceptions also influence how people evaluate reforms, trust healthcare providers and advocate for equity and improvement.[88]

Having confidence in the healthcare system is essential because it encourages individuals to seek timely medical care, follow public health advice and participate in preventive measures.[89]

Respondents were provided with 3 statements about the healthcare system in Australia and asked to select which best reflected their overall view. They were also asked to rate how confident they would be in the Australian healthcare system if they were to become seriously ill based on 4 different scenarios, and whether their confidence in the system changed in the past 12 months.

Views about the Australian healthcare system

Respondents' views about the Australian healthcare system in 2025 remained relatively unchanged since 2024. Among respondents in 2025:

- 55.6% (1 in 2) felt that "There are some good things about our healthcare in Australia, but major changes are needed to make it work better" (versus 55.8% in 2024)
- 34.4% (1 in 3) felt that "It usually works pretty well, and only minor changes are needed" (versus 34.0% in 2024)
- 7.2% felt that "Healthcare in Australia has so much wrong with it, that we need to completely rebuild it" (versus 7.2% in 2024)
- 2.8% believed that none of the statements matched their view of the healthcare system in Australia (versus 3.1% in 2024).

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86 Louise A. Ellis et al., "Changes in Public Perceptions and Experiences of the Australian Health-care System: A Decade of Change," *Health Expectations* 24, no. 1 (2021): 95–110.

87 Sunil K. Dixit and Murali Sambasivan, "A Review of the Australian Healthcare System: A Policy Perspective," *SAGE Open Medicine* 6 (2018): 2050312118769211.

88 Louise A. Ellis et al., "Public Perceptions of the Australian Health System During COVID-19: Findings From a 2021 Survey Compared to Four Previous Surveys," *Health Expectations* 27, no. 4 (2024): e14140.

89 M. W. Calnan and E. Sanford, "Public Trust in Health Care: The System or the Doctor?," *Quality and Safety in Health Care* 13, no. 2 (2004): 92, https://doi.org/10.1136/qshc.2003.009001; Ho Fai Chan et al., "How Confidence in Health Care Systems Affects Mobility and Compliance during the COVID-19 Pandemic," *PLoS ONE* 15, no. 10 (2020): e0240644, https://doi.org/10.1371/journal.pone.0240644; Margaret E. Kruk et al., "Population Confidence in the Health System in 15 Countries: Results from the First Round of the People's Voice Survey," *The Lancet Global Health* 12, no. 1 (2024): e100–111, https://doi.org/10.1016/S2214-109X(23)00499-0.

Confidence in the healthcare system

Respondents' confidence in the Australian healthcare system in 2025 was similar to the level reported in 2024 (Figure 24). Respondents in 2025 were asked how confident they would be in the Australian healthcare system if they were to become ill:

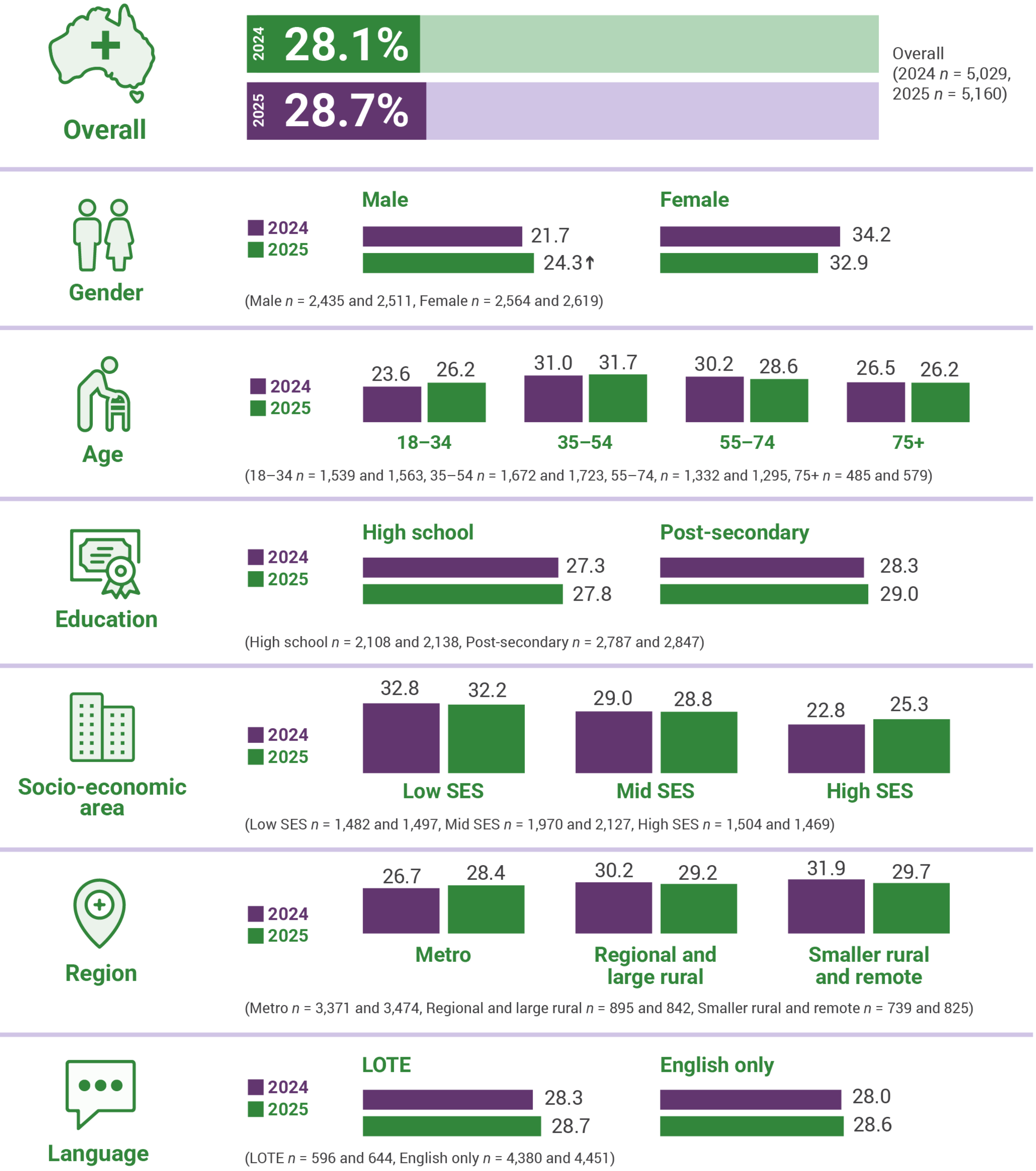
- 1 in 2 (50.6%) were either very or extremely confident they would get quality and safe medical care (versus 51.3% in 2024)
- nearly half (47.0%) were either very or extremely confident they would receive the most effective medication (versus 47.0% in 2024)
- 9 in 20 (44.6%) were either very or extremely confident they would receive the best medical technology (versus 44.0% in 2024)
- 1 in 3 (32.3%) were either very or extremely confident they would be able to afford the care they need (versus 32.0% in 2024).

Figure 24: More healthcare consumers in 2024 and 2025 are extremely or very confident they will be able to get quality and safe medical care than being able to afford the care they need

Base: Overall (2024 *n* = 5,029, 2025 *n* = 5,160)

As shown in Figure 25, confidence in the Australian healthcare system had decreased since 2024.

Figure 25: Decline in confidence in the Australian healthcare system across demographic groups



(Male *n* = 2,435 and 2,511, Female *n* = 2,564 and 2,619)

(18–34 *n* = 1,539 and 1,563, 35–54 *n* = 1,672 and 1,723, 55–74, *n* = 1,332 and 1,295, 75+ *n* = 485 and 579)

(High school *n* = 2,108 and 2,138, Post-secondary *n* = 2,787 and 2,847)

(Low SES *n* = 1,482 and 1,497, Mid SES *n* = 1,970 and 2,127, High SES *n* = 1,504 and 1,469)

(Metro *n* = 3,371 and 3,474, Regional and large rural *n* = 895 and 842, Smaller rural and remote *n* = 739 and 825)

(LOTE *n* = 596 and 644, English only *n* = 4,380 and 4,451)

↑↓ 2025 result is significantly higher or lower than the 2024 result, $p < 0.05$

When asked whether their confidence in the Australian healthcare system had changed in the past 12 months:

- 61.8% (3 in 5) reported that their confidence had stayed the same (versus 62.3% in 2024)
- 28.7% (almost 3 in 10) reported that their confidence had decreased (versus 28.1% in 2024)
- 6.9% said that their confidence had increased (versus 6.4% in 2024)
- 2.6% were unsure (versus 3.2% in 2024).

Factors associated with confidence in the healthcare system

Our analysis showed that financial hardship was the strongest predictor of decreased confidence in the healthcare system, with additional disparities linked to gender, age, chronic illness and income, highlighting trust gaps among those with greater health and financial vulnerabilities.

The following are the key findings from our 2025 data (see Appendix B9).

- Respondents who had difficulties in affording healthcare had less confidence in the healthcare system than those who did not (OR = 2.00), while individuals with financial stress also showed less confidence than those without financial stress (OR = 1.58).
- Women had less confidence in the healthcare system compared to men (OR = 1.35), indicating potential gender-specific experiences or expectations.
- Compared to younger adults (18 to 34), middle-aged adults (35 to 54 years) showed less confidence in the healthcare system (OR = 1.30), while other older groups showed similar but non-significant trends.
- Individuals with chronic illness has less confidence than those without chronic illness (OR = 1.35), indicating that those with the greatest healthcare needs are experiencing diminished trust in the system.
- The highest income group (> $4,000 weekly) had more confidence in the healthcare system (OR = 0.68), demonstrating how financial resources can buffer against system-related frustrations.

Areas for improvement

Suggestions for improvement in the healthcare system can foster innovation, enhance consumer care and address inefficiencies that may compromise outcomes. By encouraging feedback, systems can evolve to meet changing needs, reduce disparities and adopt best practices. These insights help identify gaps in service delivery, improve resource allocation and ensure that healthcare remains responsive, equitable and sustainable.

We asked respondents for their views on government spending in Australian healthcare, and which aspects of the system they believe require improvement.

Healthcare funding

Views on government spending in Australian healthcare in 2025 were similar to those reported in 2024. Among respondents in 2025:

- 57.1% (1 in 2) considered government spending on healthcare was too low (versus 56.3% in 2024)
- 24.7% (1 in 4) considered government spending on healthcare to be the right amount (versus 24.5% in 2024)
- 3.4% considered government spending on healthcare to be too high (versus 3.5% in 2024)
- 14.8% did not have an opinion on government spending on healthcare (versus 15.7% in 2024).

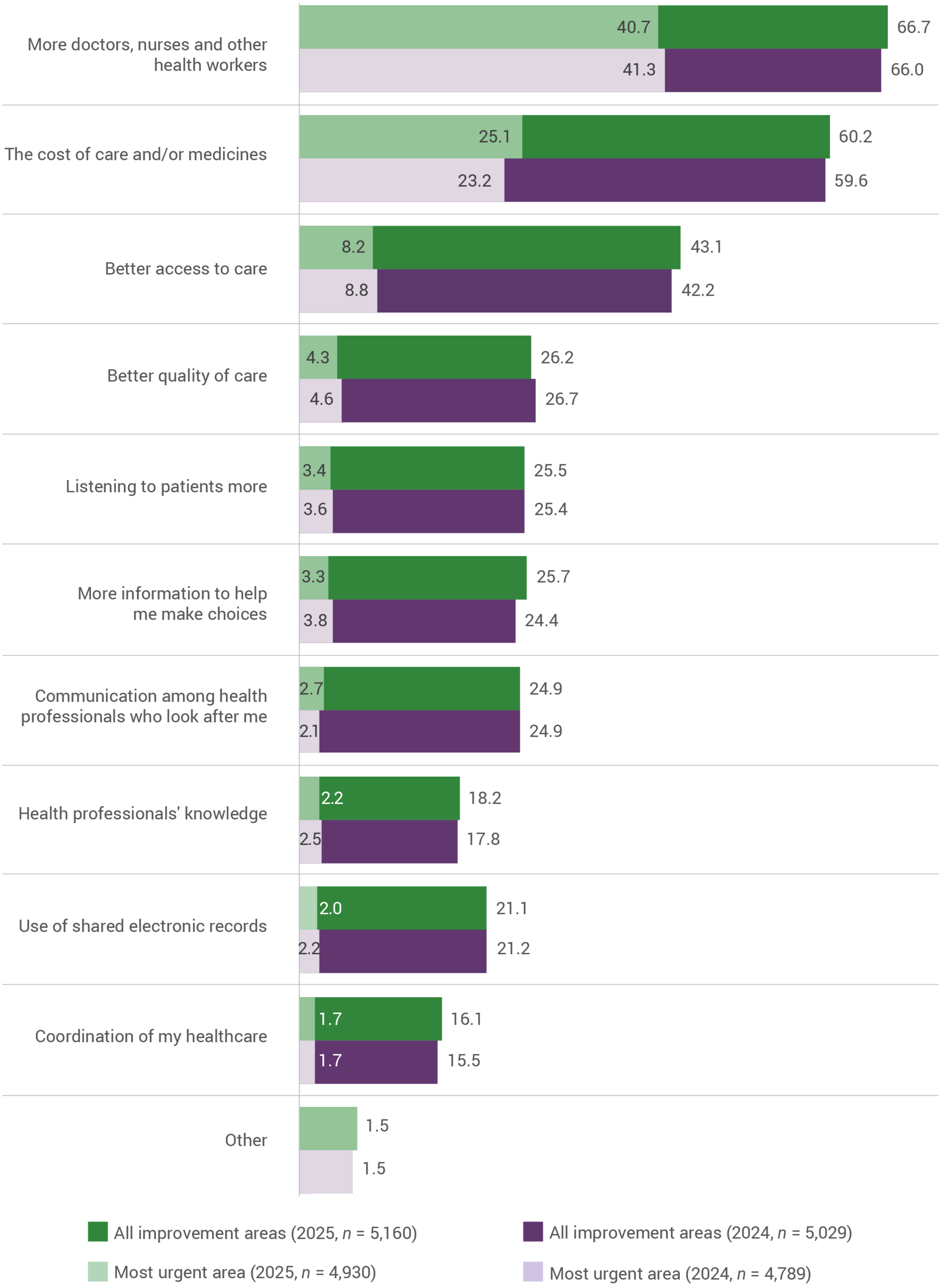
Key areas to focus improvements to the healthcare system

In 2025, 95.6% of respondents indicated at least one area for improvement, which is similar to the rate in 2024 (95.2%). Respondents highlighted the following 3 areas as the most in need of improvement within the healthcare system:

- more doctors, nurses and other health workers (2024 = 66.0%; 2025 = 66.7%)
- the cost of care and/or medicines (2024 = 59.6%; 2025 = 60.2%)
- better access to care (2024 = 42.2%; 2025 = 43.1%).

Respondents were asked to select the areas of the healthcare system that need improvement. Those who selected more than one area were then asked to indicate which area needs improvement most urgently. Figure 26 lists all the areas that need improvements and the areas that need improvement most urgently.

Figure 26: Health consumers commonly note the health workforce, cost of care and medicines, and access to care as the key areas to focus improvements to the healthcare system



Summary and reflections

Views and attitudes towards the healthcare system

Public perceptions of the healthcare system can influence engagement, policy backing and overall health outcomes. Confidence in healthcare drives timely care, adherence to public health advice and preventive action. Suggestions for system improvements can unlock innovation, strengthen consumer care and address gaps that limit effectiveness. In 2025, views on the Australian healthcare system, confidence in its performance and views on government spending remained unchanged from 2024.

In 2025, a majority of respondents (55.6%) acknowledged that while the system has strong foundations, it requires major changes rather than a complete overhaul. Meanwhile, 34.4% believed only minor changes are needed, reflecting a segment of the population that is relatively satisfied with the healthcare system.

There was moderate confidence in receiving quality care if respondents became ill, with just over half (50.6%) expressing confidence in the quality of care they would receive, and only 32.3% confident in being able to afford the care they would need. While the majority (61.8%) reported no change in their confidence in the healthcare system, a notable 28.7% reported that their confidence has declined, suggesting growing concerns among a significant portion of the population. The gap between perceived quality and affordability also highlights the challenge of maintaining high standards of care while ensuring it remains accessible to all Australians.

Our adjusted analysis showed that experiencing financial stress was the strongest predictor of having reduced confidence in receiving quality care, reinforcing its role in shaping healthcare perceptions and experiences.[90] Other contributing factors included chronic illness, low weekly income and being female, suggesting that both health and social factors can influence how confident individuals feel about accessing care. These findings highlight the need for strategies that address financial barriers and systemic inequities[91] among groups who may feel less assured about accessing affordable, quality care, particularly when seriously ill.

In 2025, most respondents (57.1%) believed government spending on healthcare to be too low. Lower government spending can limit subsidies, reduce service coverage and constrain investment in workforce and infrastructure, all of which increase out-of-pocket costs and make healthcare less affordable.[92]

Respondents identified clear priorities for improving the healthcare system, with the most frequently cited areas being increasing the health workforce (66.7%), reducing costs (60.2%) and improving access (43.1%). These priorities align closely with the broader concerns highlighted throughout the findings, particularly around affordability, availability of services and equitable access. The emphasis on workforce expansion reflects public awareness of strain on healthcare providers and the need for timely, high-quality care. Together, these insights point to a strong public demand for investment and reform to enhance the capacity, affordability and accessibility of healthcare in Australia.

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[90] Korda et al., "Income-Related Inequalities in Chronic Conditions, Physical Functioning and Psychological Distress among Older People in Australia: Cross-Sectional Findings from the 45 and up Study."

[91] Korda et al., "Income-Related Inequalities in Chronic Conditions, Physical Functioning and Psychological Distress among Older People in Australia: Cross-Sectional Findings from the 45 and up Study."

[92] Emily J. Callander, "Out-of-Pocket Fees for Health Care in Australia: Implications for Equity," *Medical Journal of Australia* (Australia) 218, no. 7 (2023): 294–97, https://doi.org/10.5694/mja2.51895.

Discussion

Representing the voices of health consumers is central to CHF's mission, especially as Australia faces the challenges of a growing, ageing and increasingly diverse population. Ensuring that consumer perspectives are heard is not only a matter of equity, but also essential in shaping a responsive, inclusive and effective healthcare system. The findings in our 2025 NCSS report presented not only a range of healthcare perspectives and experiences from a health consumer lens but also highlighted concerning gaps within the Australian healthcare system, where healthcare needs are often unmet, especially in populations with multiple barriers to healthcare.

Encouragingly, our 2025 survey saw slight but meaningful improvements in consumer-centred care and respectful treatment compared to the 2024 survey. Reports of discrimination declined in 2025, particularly among women, metropolitan residents and English-only speakers. In 2025, more respondents perceived that their healthcare providers ensured they received the best care and included them in decisions about their health, with both measures showing slight improvements from 2024. Engagement with digital health platforms remained steady, with consistently high ease of accessing and sharing their health information among users of MHR, and ease of registering for MyMedicare users. However, gaps in awareness persisted, especially among non-English speakers and individuals with lower levels of education. Telehealth continued to be valued for its convenience, despite ongoing concerns about its impact on building client–provider trust.

Our findings from the 2025 NCSS revealed a healthcare landscape in which social determinants continue to shape access, experience and outcomes. Most notably, our multivariable analyses found financial stress was the most consistent predictor across nearly all indicators. We found that individuals experiencing financial hardship were significantly more likely to report unmet healthcare needs, lower satisfaction with healthcare quality, reduced ability to navigate the healthcare system and diminished confidence in its effectiveness. They were also more likely to experience discrimination when receiving care. These findings are consistent with research showing that cost-of-living pressures are increasingly driving Australians to defer care and experience poorer health outcomes.[93]

Closely linked to financial stress was income and ability to afford healthcare. We found that those with the highest income (≥ $4,000 weekly) consistently reported better health, greater satisfaction with healthcare quality and greater awareness of MyMedicare and MHR, while individuals with difficulties affording care were less likely to report positive outcomes across these domains. Compared to 2024, the 2025 results showed a slight but concerning increase in cost-related barriers to care. In 2025, more respondents reported that the reason they did not fill a prescription for medicine when needed was being unable to afford it (increasing from 46.7% in 2024 to 54.2%). Financial barriers were also a key reason provided by those who skipped medical tests or appointments when needed (increasing from 43.8% in 2024 to 48.7%). Despite moderate confidence in the healthcare system, only 1 in 3 respondents expressed confidence that they could afford care if they become seriously ill. These patterns highlight the need for policies that address healthcare affordability and reduce financial barriers to care.[94]

Our findings suggest that having PHI may serve as a proxy indicator for socio-economic advantage, improving healthcare experiences and enabling greater engagement with the healthcare system. Individuals with PHI were more likely to report good health, have greater awareness of MyMedicare and MHR, experience fewer unmet healthcare needs and report more difficulty accessing after-hours healthcare services. Despite stable Medicare coverage and the availability of PHI, affordability remained a key reason for not having PHI. While having PHI can improve consumers' healthcare experiences, increased reliance on PHI may unintentionally reinforce health inequities, particularly for those unable to afford coverage.[95]

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[93] Patrick O'Keeffe, "Economic Inequality and the 'Cost of Living' Crisis," in *Power, Privilege and Place in Australian Society*, ed. Patrick O'Keeffe (Springer Nature Singapore, 2024), https://doi.org/10.1007/978-981-97-1144-4_5; Callander, "Out-of-Pocket Fees for Health Care in Australia: Implications for Equity."

[94] Callander, "Out-of-Pocket Fees for Health Care in Australia: Implications for Equity."

[95] Tam et al., "Determinants of Attitude and Intention towards Private Health Insurance: A Comparison of Insured and Uninsured Young Adults in Australia."

Another critical theme is the experience of CALD communities. We found that individuals who speak languages other than English at home were less likely to be aware of MyMedicare and MHR, were less able to navigate the healthcare system and perceived after-hours care as less accessible. They were also more likely to report unmet healthcare needs than English-only speakers. These disparities suggest potential language-related access barriers for CALD communities and highlight the importance of culturally responsive services that adapt to cultural values, beliefs and contexts to ensure understanding and effectiveness, including but not limited to multilingual services that focus on language translation.[96]

Healthcare experiences varied notably by age, indicating that age was a key determinant in how individuals engaged with the system. We found that older adults generally reported higher satisfaction and better navigation, likely reflecting accumulated experience with the healthcare system.[97] However, they also perceived after-hours care as less accessible and were less likely to report good health. These findings suggest that while older Australians may be more familiar with the system, service design may not fully meet their needs, particularly in terms of flexibility and timely access.[98]

Gender and sexual orientation shaped people's healthcare experiences. We found that compared to men, women reported higher satisfaction with healthcare quality and awareness of MHR and MyMedicare, yet reported lower confidence in the healthcare system. Individuals who do not identify as heterosexual were more likely to report poor health and unmet healthcare needs, despite higher awareness of MyMedicare and MHR. These findings suggest that while engagement may be high among these 2 groups, it does not necessarily translate into equitable or affirming care. Therefore, targeted efforts to improve inclusivity and responsiveness within healthcare settings are essential.[99]

Area of residence also shaped healthcare experiences. We found that, compared to metropolitan residents, those living in rural or remote areas reported significantly lower satisfaction with healthcare quality, greater difficulty navigating the healthcare system and more challenges accessing after-hours care.

Our findings confirm existing concerns regarding the urban–rural divide in Australian healthcare, where facilities, equipment and services in rural areas may be lacking or outdated. Reliable internet and digital tools (like telehealth) may be less available or effective in rural regions due to infrastructure limitations and digital literacy challenges.[100] Additionally, there are fewer healthcare professionals working in rural areas, leading to shortages and reduced access to care.[101] These findings highlight the need for sustained investment in rural health infrastructure, digital access and workforce distribution.

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96 Khatri and Assefa, "Access to Health Services among Culturally and Linguistically Diverse Populations in the Australian Universal Health Care System: Issues and Challenges."

97 Guogui Huang et al., "Quality of Life and Quality of Care Experience in Australian Residential Aged Care: A Retrospective Cohort Study of 1,772 Residents," *BMC Geriatrics* 24, no. 1 (2024): 1006, https://doi.org/10.1186/s12877-024-05472-6; Breanne Hobden et al., "Experiences of Patient-Centered Care Among Older Community-Dwelling Australians," *Frontiers in Public Health* (Switzerland) 10 (2022): 912137, https://doi.org/10.3389/fpubh.2022.912137.

98 Kwon and Kwon, "Patterns of Health Literacy and Influencing Factors Differ by Age: A Cross-Sectional Study."

99 James J. Lucas et al., "When Primary Healthcare Meets Queerstory: Community-Based System Dynamics Influencing Regional/Rural LGBTQ+People's Access to Quality Primary Healthcare in Australia," *BMC Public Health* 23, no. 1 (2023): 387, https://doi.org/10.1186/s12889-023-15289-4.

100 Krahe et al., "Factors That Influence Digital Health Implementation in Rural, Regional, and Remote Australia: An Overview of Reviews and Recommended Strategies."; Supriya Mathew et al., "Telehealth in Remote Australia: A Supplementary Tool or an Alternative Model of Care Replacing Face-to-Face Consultations?," *BMC Health Services Research* 23, no. 1 (2023): 341, https://doi.org/10.1186/s12913-023-09265-2.

101 Colin H. Cortie et al., "The Australian Health Workforce: Disproportionate Shortfalls in Small Rural Towns," *The Australian Journal of Rural Health* (Australia) 32, no. 3 (2024): 538–46, https://doi.org/10.1111/ajr.13121.

Limitations

While the 2025 NCSS provides insights into the healthcare experiences of Australians, several limitations should be acknowledged. First, the survey offers a snapshot of health consumers' perspectives at a single point in time. Moreover, the timing of data collection differed between years: the 2024 survey was conducted in October and November, whereas the 2025 survey took place in February and March. Differences in healthcare demand, service availability and/or consumer priorities may influence responses. As such, caution is warranted when interpreting changes between 2024 and 2025, as these may not reflect long-term trends. The self-reported nature of the data also introduces potential for recall bias and social desirability bias, which may influence the accuracy of responses. Although multivariable regression analyses were used to control for confounding variables, the findings reflect associations rather than causal relationships. Unmeasured confounders may still have influenced the results.

Additionally, although the survey is nationally representative, certain subpopulations (such as people experiencing homelessness, those without internet access or individuals with limited English proficiency) may be underrepresented, potentially limiting the generalisability of findings. Survey mode effects may also have shaped responses, depending on whether participants completed the survey online or via phone. External factors such as media coverage or policy changes during the survey period may have influenced perceptions of healthcare system performance.[102] Non-response bias may also be present, as individuals who chose not to participate may differ systematically from respondents. Finally, due to differences in research methods, we were unable to compare 2024 and 2025 NCSS data on sexual orientation, disability and carer status with ABS estimates.

Conclusion

The 2025 NCSS findings reveal a healthcare system that is gradually evolving towards more consumer-centred care yet continues to be shaped by persistent inequities. While improvements in respectful healthcare and reduced discrimination are encouraging, the data highlights ongoing challenges for disadvantaged populations, particularly those facing financial stress, language barriers and geographic isolation. Financial stress emerged as the most consistent predictor of poor healthcare outcomes, highlighting the urgent need for policies that address affordability and reduce cost-related barriers to care. Additionally, disparities in awareness and navigation among CALD communities, older adults and individuals without PHI point to systemic gaps in inclusivity and accessibility.

To build a more equitable and responsive healthcare system, Australia must invest in structural reforms that prioritise affordability, cultural competence and workforce development, especially in rural and remote areas. Enhancing multilingual services, improving digital access and tailoring healthcare design to meet the diverse needs of consumers will be critical. The 2025 NCSS provides a robust evidence base for guiding these efforts, emphasising that meaningful progress requires targeted, inclusive strategies that ensure all Australians can access and benefit from high-quality, respectful and effective care.

Next steps

The 2024 and 2025 NCSSs built a strong foundation for documenting healthcare needs, perceptions and use of services among Australians, as the Strengthening Medicare measures take effect. The consistency in key questions, methodology and stratified sampling of Australian adults between the 2024 and 2025 NCSSs enables meaningful comparisons and insights into people's healthcare experiences.

As healthcare priorities evolve, such as improving affordability, reducing wait times, expanding mental health support and ensuring equitable access, it is essential to ensure the NCSS captures the issues and expectations that matter most to consumers. Therefore, CHF, in partnership with the Department and a representative group of health consumers, has reviewed the 2025 NCSS to ensure that it remains a relevant, trusted tool for shaping policies that respond to real-world needs ahead of the 2026 survey launch.

CHF looks forward to the views of health consumers and to publishing the findings from the next NCSS in late 2026.

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[102] Lewis et al., "Healthcare in the News Media: The Privileging of Private over Public."

Appendix A. Methodology

A1. Data collection and weighting

Data collection for the 2025 NCSS was undertaken online between 26 February and 25 March 2025. Following a data-cleaning process to remove responses (*n* = 122), where there was evidence of duplication, straight lining or speeding, 5,160 responses remained. On average, the survey took just under 15 minutes to complete.

Ethics approval for the study was obtained (reference: 2024-07-939-A-1) from the Bellberry Human Research Ethics Committee.

A1.1. Survey development

Given the proximity of the 2024 and 2025 surveys (approximately 4 months), the 2025 NCSS was almost identical to the 2024 NCSS (14 October and 13 November 2024).

The 2024 NCSS was developed from an initial review of the 2021 NCSS questionnaire and other government surveys early in 2024 by CHF. The 2024 NCSS survey contents were reviewed during 3 workshops with consumers and Department staff to obtain priority themes for data collection and reporting and to avoid duplication with existing data sources, where possible. Department staff reviewed the survey and provided feedback before it was finalised.

The survey 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 smartphones, it was programmed to work effectively and clearly on 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.

A1.2. Soft launch

Given the similarity of the 2024 and 2025 surveys, a pilot that took place in 2024 to source feedback from respondents was not repeated in 2025. Instead, a soft launch of the survey with a total of 74 respondents confirmed that there were technical issues with the survey and the survey was fully launched on 26 February 2025.

A1.3. Sampling and recruitment

All survey respondents were recruited using 1 of 3 market research panels. First, respondents from the Roy Morgan Single Source panel were invited. Once this sample was exhausted, the Pureprofile panel was activated, followed by the Octopus Group panel. The supplementary panels were used to ensure that quotas relating to population groups that were smaller and/or potentially harder to reach, such as young adults in regional or less-populous locations, could be fulfilled in this 2025 wave as well as future waves of the survey. Respondents were issued points that could be redeemed at major retailers as an incentive for their participation.

The 2025 sample was limited to respondents who did not participate in the 2024 survey. To achieve a representative sample of the broader Australian population, interlocking quotas were applied based on a matrix comprising of the following.

- Gender
- Six age groups – 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, ≥ 65
- 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

These quotas reflected the Australian adult population in each interlocking cell according to the most recently available ABS Labour Force Survey data (ABS 2025a) at the time of the survey. Appropriate numbers of panellists were recruited to fulfil the proportional quota in each cell.

A1.4. Recruitment

To be eligible to participate, individuals needed to live in Australia and be aged 18 years or older. Eligibility requirements did not change between the 2024 and 2025 surveys. Participation in the survey was voluntary. Consent was obtained via a check box at the end of the introductory script.

To ensure that our cohort of respondents also included people who are not engaged online, a range of recruitment methods were employed, 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 and Octopus Group panellists through their online portals and was visible to the those who met the study eligibility criteria and quota requirements. Pureprofile and Octopus Group panellists did not receive targeted invitations or reminders.

A1.5. Data handling

Survey data were checked and those completed in an unrealistically quick timeframe or where straight lining occurred (i.e. respondents sped through the survey without thought) were deleted. Duplicates based on IP address, age, gender and postcode were also deleted. The survey was conducted online using a programmed script that guided respondents through each question sequentially, ensuring all items were completed and no data was missing. If a respondent dropped out without completing the survey, their responses were not analysed.

Responses of “I don’t know” or “Prefer not to say” are reported alongside other response categories in this report except in the demographic group charts. Survey responses of people from small groups, such as the respondents who identified as non-binary or a different gender, are not shown as separate categories but are included in the overall results.

A1.6. Data weights

The same weighting procedure applied in 2024 was also used in 2025 to process the second wave of data. Although the survey employed quota controls, it was still necessary to weight the data to align with the target population due to minor discrepancies in the achieved quotas. 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 daily).[103]

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

- **Gender**: Male or female (respondents who selected non-binary or use a different term were randomly allocated to 1 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
- **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 & IV, secondary education and below
- **Internet usage**: 3 or more times daily, twice daily, once daily or less

Data on gender, age, location and education were extracted from the 2025 ABS Labour Force Survey data.[104] Internet usage data was extracted from Roy Morgan’s Single Source data,[105] 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.

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[103] Roy Morgan, *National Consumer Sentiment Survey 2025: Wave 2 Technical Report. Prepared for the Consumers Health Forum of Australia* (Canberra, 2025).

[104] Australian Bureau of Statistics, “Labour Force, Australia, Detailed.”

[105] Roy Morgan, “Single Source,” June 2024, https://www.roymorgan.com/products-and-tools/single-source.

A2. Respondent classifications

A2.1. Metropolitan areas, regional and large rural centres, small and medium rural centres and remote areas classification

Area of residence (metropolitan areas, regional and large rural centres, small and medium rural centres and remote areas) was allocated based on the Modified Monash Model (MMM).[106] The MMM is used to define whether a location is metropolitan, rural, remote or very remote based on remoteness and population size. Some government programs, particularly those associated with health workforce distribution, use the MMM to classify locations in Australia. Respondents from the NCSS were grouped into metropolitan area (corresponding to MM 1 on the MMM classification), regional and large rural centres (corresponding to MM 2 and MM 3) or small and medium rural centres and remote areas (corresponding to MM 4 – MM 7). Using this classification, the categories in the NCSS are defined as follows.

- Metropolitan areas equals major cities (e.g. capital cities excluding Darwin and Hobart).
- Regional and large rural centres equals those within or less than 15 km from a town with a population of at least 15,000; this includes Darwin and Hobart.
- Small and medium rural centres and remote areas equals more than 15 km from the closest town with a population of at least 15,000.

The 2025 report is the first time MMM has been used to categorise respondents, with the 2024 report basing the categorisation on the Australian Statistical Geography Standard (ASGS) Remoteness Area framework.

A2.2. Socio-economic status

This survey used one of ABS' socio-economic indices for areas (SEIFA); specifically, the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). The IRSAD includes both relative advantage and disadvantage across measures relating to economic and social conditions of people living within an area. We categorised respondents' postcodes into IRSAD deciles before these were combined to create SES values for each individual.[107] 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.

A2.3. Chronic conditions

For consistency in reporting across the sector, the questionnaire derived a question on chronic conditions from the Patient Experience Survey.[108] 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.

A2.4. 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 "High school" group. Respondents who reported certificate-level, diploma-level, undergraduate or postgraduate qualifications were allocated to the "Post-secondary" group.

A2.5. Language other than English spoken at home (LOTE) and other cultural background indicators

Several measures in the 2024 and 2025 NCSS collect information to profile respondents' language or cultural backgrounds. The primary measure used to group responses is LOTE based on the question "Do you speak a language other than English at home?" For analysis and reporting, "Yes" responses were classified as LOTE and "No" responses were classified as Only English. Respondents were also asked "Were you born in Australia?" and "When did you first arrive in Australia to live?" Information about cultural identity or ethnicity was collected for those identifying as being of Aboriginal and/or Torres Strait Islander origin to ensure the final results were inclusive of a representative sample of Australian First Nations peoples.

A2.6. Private health insurance

Respondents were asked "Do you have private health insurance?" to profile responses based on having or not having PHI.

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[106] Australian Government Department of Health and Aged Care, "Modified Monash Model (MMM)," April 10, 2025, https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en.

[107] Andrzej S. Januszewski et al., "Online Tool for Cross-Sectional and Longitudinal Comparison of Socio-Economic Status Indices Based on Postcodes in Australia," *Internal Medicine Journal* 55, no. 8 (2025): 1360–66, https://doi.org/10.1111/imj.70117.

[108] Australian Bureau of Statistics, "Patient Experiences," November 18, 2025, https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#cite-window1.

A2.7. Self-rated health

In the NCSS, respondents provided a subjective indication of their overall health using the question "In general, would you say your health is …?" and providing a response of "Excellent", "Very good", "Good", "Fair" or "Poor". Respondents could also indicate "I don't know" or "Prefer not to say," but only a very small proportion of respondents did so in 2024 and 2025 (0.2% both years). Self-rated or self-assessed health is a common measure of health status used to predict various health outcomes.[109] The NCSS combined proportions of adult respondents rating their health as excellent or very good was 39.2% in 2024 and 38.2% in 2025. The NCSS results were 10 to 15 percentage points lower than other commonly reported results for Australians, including those aged 15 years and over as part of the National Health Survey.[110]

A2.8. Financial stress and afford care difficulties

Financial stress was assessed using an adapted version questions from the Menzies-Nous Australian Health Survey (2008)[111] that had previously been used in the 2018 and 2021 NCSSs. Respondents were shown 8 statements and were asked to indicate if any had happened in the past 12 months because of a shortage of money. For analysis and reporting purposes, financial stress was coded as "Yes" if at least 1 of the 8 statements was selected.

Respondents were also asked if their healthcare needs were not met for 4 different healthcare types in the past 12 months, including not visiting a dentist, not visiting a doctor, not attending recommended testing and treatment, and not filling a prescription or taking medication. On a follow-up question, respondents were able to indicate if they did not take these actions for their health due to affordability. For analysis and reporting purposes, respondents were coded as having difficulties affording care if they indicated that their healthcare needs were not met due to affordability to at least 1 of the 4 questions.

A2.9. Navigating the healthcare system

Respondents' ability to navigate the healthcare system was assessed using scale 7 of the HLQ, "Navigating the healthcare system".[112] 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. The scale comprised 6 questions with 5-point Likert-response options ranging from 1 ("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.

A2.10 LGBTQIA+

Sexual orientation was grouped into 3 categories: Heterosexual (if participants identified as straight or heterosexual), LGBTQIA+ (if they identified as gay or bisexual or used another term) and Unknown orientation (if they selected "I don't know" or "Prefer not to say").

A2.11 Internet usage

Internet usage frequency was categorised into 3 groups to assess digital access: 3 or more times daily, twice daily and once daily or less (if reported usage was once daily or a few times a week or less).

A2.12 Income groups

Income was categorised into 5 groups to reflect reported weekly earnings per household: lowest income group < $1,000 per week, low income $1,000 to $1,999, middle income $2,000 to $3,999, highest income > $4,000 per week, and "Prefer not to say".

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[109] Thomas F. Crossley and Steven Kennedy, "The Reliability of Self-Assessed Health Status," *Journal of Health Economics* 21, no. 4 (2002): 643–58, https://doi.org/10.1016/S0167-6296(02)00007-3.

[110] Australian Bureau of Statistics, National Health Survey (n.d.), https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release.

[111] Menzies Centre for Health Policy, *The Menzies-Nous Australian Health Survey 2008* (MCHP, 2008).

[112] Osborne et al., "The Grounded Psychometric Development and Initial Validation of the Health Literacy Questionnaire (HLQ)."

A3. Statistics used in this report

- **Counts**: Weighted numbers and percentages are presented throughout the report. See A1.6 Data weights for more information.
- **Base size**: The base size refers to the number of respondents to the survey question or filtered result. Throughout this report, the base size is reported as the number enclosed in brackets, following an *n* and equals sign: (*n* =), unless the base consists of the entire sample, in which case the base size is not shown. Respondents who indicated “Prefer not to say” and “I don’t know”, are **not** excluded from the calculation of statistics and tabulation of results for that question. In most cases, “Prefer not to say” and “I don’t know” responses were a small proportion of the overall result and as such not shown in charts and tables within this report.
- **Percentage**: A percentage is the ratio or fraction of the response, divided by the base size. In this report, where percentages are used, a % sign is used in text but not displayed in the charts. The percentages are rounded to one decimal point.
- **Average**: An average, or mean, for the HLQ measure is calculated by dividing the sum of the response values by the base size. “I don’t know” and “Prefer not to say” values are excluded from average calculations. This number is reported to 2 decimal places.
- **Rounding**: Data percentages displayed throughout the report are rounded to the nearest whole number. As such, not all percentages stated will add up to 100%.
- **Net figures**: For the purposes of summarising survey responses, response categories are sometimes collapsed by combining 2 or more response options.

Significance and other statistical analyses

- **Statistical significance**: Statistical tests were used in this report to determine if differences were likely due to a real effect or chance. The 2024 and 2025 surveys were conducted using independent samples; respondents in 2025 were not the same individuals surveyed in 2024. This distinction means all comparisons between years are based on separate groups rather than repeated measures. Consequently, the statistical methods applied, such as t-tests and chi-square tests, are appropriate for independent samples.
  - **Chi-square test**: This test was used to examine whether there were differences between groups in the distribution of categorical responses (e.g. comparing response patterns for the proportion indicating “Excellent” in 2024 compared to 2025). It tests whether the observed differences are larger than what would be expected by chance.
  - **t-test**: This test was used to compare the average scores of 2 groups (e.g. comparing the mean HLQ score in 2024 compared to 2025). It shows whether any difference between the 2 group averages is statistically significant, rather than due to random variation.
- **Regression**: Regression methods were used in this report to explore associations between socio-demographic characteristics and survey responses. These analyses allowed us to identify whether certain groups were more or less likely to give particular responses, or whether scores varied systematically across groups. Non-significant predictors were retained in these analyses for completeness and that their exclusion does not affect the interpretation of significant predictors. Two types of regression were used.
  - **Binomial logistic regression**: This method was used when the outcome being analysed had 2 possible values (e.g. “Yes” or “No”). It allowed us to compare the likelihood of responses between different socio-demographic groups.
  - **Linear regression**: This method was used when the outcome being analysed was a continuous score, such as scale 7 of the HLQ. It allowed us to see how responses varied across socio-demographic groups.
- **Survey design**: All analyses took account of the survey design, including the use of weights to reflect the Australian population. The “survey” package in RStudio was used to ensure that stratification and weighting were correctly incorporated for significance testing. Binomial logistic regressions and linear regressions were also conducted in RStudio using the “survey” package.
- **Statistical significance**: Differences between groups were only reported when results were statistically significant at $p < 0.05$.

Appendix B: Logistic and linear regression results

B1. Self-rated health

A binomial logistic regression examined predictors of self-rated health (very good or excellent versus other categories). The overall model was significant ($p < 0.001$), with moderate explained variance (McFadden's $R^2 = 0.144$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.02 to 1.19 across predictors, indicating minimal multicollinearity.

Model fit statistics (N = 5,160):

- Nagelkerke pseudo R^2: 0.237
- Model deviance: 5,877
- Akaike information criterion (AIC): 5,961
- Mean predicted probability: 0.425 (proportion rating health as excellent/very good)
- Predicted probability range: 0.033 - 0.819

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	0.084	0.208	0.40	0.687	1.088	Non-significant
Age, 35–54 vs 18–34	−0.418	0.099	−4.20	< 0.001	0.658	***
Age, 55–74 vs 18–34	−0.376	0.119	−3.17	0.002	0.687	**
Age, ≥ 75 vs 18–34	−0.100	0.172	−0.59	0.559	0.905	Non-significant
Gender, Female vs Male	−0.037	0.081	−0.46	0.646	0.963	Non-significant
Gender, Other/Non-binary vs Male	−1.048	0.682	−1.54	0.124	0.351	Non-significant
Income, $1,000–$1,999 vs < $1,000	−0.065	0.127	−0.51	0.609	0.937	Non-significant
Income, $2,000–$3,999 vs < $1,000	0.207	0.126	1.65	0.100	1.230	Non-significant
Income > $4,000 vs < $1,000	0.517	0.159	3.24	0.001	1.678	**
Income, Prefer not to say vs < $1,000	0.259	0.148	1.75	0.080	1.296	Non-significant
Education, High school vs Post-secondary	0.531	0.092	5.74	< 0.001	1.701	***
Chronic conditions, Yes vs No	−1.011	0.086	−11.77	< 0.001	0.364	***
Regional vs Metropolitan	−0.117	0.120	−0.98	0.328	0.890	Non-significant
Rural/Remote vs Metropolitan	0.133	0.123	1.08	0.279	1.142	Non-significant
PHI, No vs Yes	−0.197	0.091	−2.18	0.029	0.821	*
PHI, Don't know vs Yes	−0.178	0.531	−0.34	0.737	0.837	Non-significant
English only vs LOTE spoken at home	0.097	0.119	0.82	0.414	1.102	Non-significant
Prefer not to say vs LOTE spoken at home	−0.825	0.579	−1.42	0.155	0.438	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	−0.549	0.148	−3.70	< 0.001	0.577	***
Sexual orientation, Prefer not to say vs Heterosexual	0.062	0.237	0.26	0.795	1.064	Non-significant
Mid SES vs Low SES	0.148	0.103	1.43	0.153	1.159	Non-significant
High SES vs Low SES	0.177	0.121	1.46	0.145	1.193	Non-significant
Internet use, twice daily vs 3 or more times daily	−0.286	0.160	−1.79	0.073	0.751	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.231	0.182	−1.27	0.205	0.794	Non-significant
Financial stress, Yes vs No	−0.220	0.101	−2.17	0.030	0.803	*
Difficulties affording care, Yes vs No	−0.412	0.109	−3.79	< 0.001	0.662	***

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B2. MyMedicare awareness

A binomial logistic regression examined predictors of MyMedicare awareness (aware versus not aware). The overall model was significant ($p < 0.001$), with modest explained variance (McFadden's $R^2 = 0.071$). Adjusted GVIF values ranged from 1.01 to 1.22, indicating minimal multicollinearity.

Model fit statistics (N = 5,160):

- Nagelkerke pseudo R^2: 0.117
- Model deviance: 5,888
- AIC: 5,972
- Mean predicted probability: 0.326 (proportion aware of MyMedicare)
- Predicted probability range: 0.102 - 0.610

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	−0.437	0.208	−2.10	0.036	0.646	*
Age, 35–54 vs 18–34	−0.205	0.101	−2.03	0.042	0.815	*
Age, 55–74 vs 18–34	−0.018	0.120	−0.15	0.881	0.982	Non-significant
Age, ≥ 75 vs 18–34	0.276	0.170	1.62	0.106	1.317	Non-significant
Gender, Female vs Male	0.213	0.083	2.57	0.010	1.237	*
Gender, Other/Non-binary vs Male	−0.393	0.575	−0.68	0.494	0.675	Non-significant
Income, $1,000–$1,999 vs < $1,000	−0.074	0.123	−0.61	0.544	0.928	Non-significant
Income, $2,000–$3,999 vs < $1,000	−0.088	0.130	−0.68	0.499	0.916	Non-significant
Income, > $4,000 vs < $1,000	0.335	0.156	2.14	0.032	1.398	*
Income, Prefer not to say vs < $1,000	−0.392	0.155	−2.53	0.012	0.676	*
Education, High school vs Post-secondary	−0.069	0.090	−0.77	0.443	0.933	Non-significant
Chronic conditions, Yes vs No	0.158	0.088	1.81	0.071	1.172	Non-significant
Regional vs Metropolitan	0.022	0.119	0.19	0.852	1.022	Non-significant
Rural/Remote vs Metropolitan	−0.053	0.127	−0.42	0.675	0.948	Non-significant
PHI, No vs Yes	−0.330	0.094	−3.50	< 0.001	0.719	***
PHI, Don’t know vs Yes	−0.043	0.503	−0.09	0.931	0.958	Non-significant
English only vs LOTE spoken at home	−0.247	0.119	−2.07	0.039	0.781	*
Prefer not to say vs LOTE spoken at home	0.088	0.438	0.20	0.842	1.091	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	−0.032	0.146	−0.22	0.826	0.968	Non-significant
Sexual orientation, Prefer not to say vs Heterosexual	0.105	0.243	0.43	0.667	1.110	Non-significant
Mid SES vs Low SES	−0.001	0.103	−0.01	0.993	0.999	Non-significant
High SES vs Low SES	−0.085	0.122	−0.69	0.489	0.919	Non-significant
Internet use, twice daily vs 3 or more times daily	0.024	0.155	0.15	0.877	1.024	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.304	0.182	−1.67	0.094	0.738	Non-significant
Financial stress, Yes vs No	0.249	0.103	2.41	0.016	1.282	*
Difficulties affording care, Yes vs No	−0.295	0.110	−2.69	0.007	0.744	**

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B3. MHR awareness

A binomial logistic regression examined predictors of MHR awareness (aware versus not aware). The overall model was significant ($p < 0.001$), with moderate explained variance (McFadden's $R^2 = 0.129$). Adjusted GVIF values ranged from 1.03 to 1.21, indicating minimal multicollinearity.

Model fit statistics (N = 5,030):

- Nagelkerke pseudo R^2: 0.206
- Model deviance: 5,474
- AIC: 5,560
- Mean predicted probability: 0.726 (proportion aware of MHR)
- Predicted probability range: 0.132–0.946

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	−0.765	0.214	−3.58	< 0.001	0.465	***
Age, 35–54 vs 18–34	0.708	0.102	6.97	< 0.001	2.029	***
Age, 55–74 vs 18–34	1.165	0.129	9.04	< 0.001	3.203	***
Age ≥ 75 vs 18–34	1.086	0.196	5.54	< 0.001	2.962	***
Gender, Female vs Male	0.630	0.089	7.11	< 0.001	1.878	***
Gender, Other/Non-binary vs Male	0.111	0.428	0.26	0.795	1.118	Non-significant
Income, $1,000–$1,999 vs < $1,000	0.174	0.130	1.34	0.181	1.190	Non-significant
Income, $2,000–$3,999 vs < $1,000	0.227	0.138	1.64	0.100	1.255	Non-significant
Income, > $4,000 vs < $1,000	0.380	0.161	2.37	0.018	1.463	*
Income, Prefer not to say vs < $1,000	−0.013	0.153	−0.09	0.932	0.987	Non-significant
Education, High school vs Post-secondary	0.324	0.095	3.40	< 0.001	1.382	***
Chronic conditions, Yes vs No	0.433	0.093	4.65	< 0.001	1.543	***
Regional vs Metropolitan	0.146	0.129	1.13	0.260	1.157	Non-significant
Rural/Remote vs Metropolitan	0.140	0.135	1.04	0.299	1.150	Non-significant
PHI, No vs Yes	−0.212	0.098	−2.17	0.030	0.809	*
PHI, Don't know vs Yes	−0.964	0.477	−2.02	0.043	0.381	*
English only vs LOTE spoken at home	0.252	0.122	2.06	0.040	1.287	*
Prefer not to say vs LOTE spoken at home	0.096	0.524	0.18	0.854	1.101	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	0.438	0.166	2.63	0.009	1.549	**
Sexual orientation, Prefer not to say vs Heterosexual	−0.311	0.246	−1.26	0.206	0.733	Non-significant
Mid SES vs Low SES	0.150	0.108	1.39	0.165	1.162	Non-significant
High SES vs Low SES	−0.149	0.125	−1.19	0.234	0.862	Non-significant
Internet use, twice daily vs > 3 times daily	−0.251	0.165	−1.52	0.129	0.778	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.678	0.170	−3.98	< 0.001	0.508	***
Financial stress, Yes vs No	−0.003	0.105	−0.03	0.975	0.997	Non-significant
Difficulties affording care, Yes vs No	0.059	0.114	0.52	0.605	1.061	Non-significant

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B4. Unmet healthcare needs

A binomial logistic regression examined predictors of having at least one unmet healthcare need (yes versus no). The overall model was significant ($p < 0.001$), with good explained variance (McFadden's $R^2 = 0.216$). Adjusted GVIF values ranged from 1.02 to 1.21, indicating minimal multicollinearity.

Model fit statistics (N = 5,031):

- Nagelkerke pseudo R^2: 0.346
- Model deviance: 5,605
- AIC: 5,691
- Mean predicted probability: 0.486 (proportion with unmet healthcare needs)
- Predicted probability range: 0.063–0.942

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	−0.481	0.210	−2.29	0.022	0.618	*
Age, 35–54 vs 18–34	−0.155	0.104	−1.50	0.135	0.856	Non-significant
Age, 55–74 vs 18–34	−0.670	0.122	−5.48	< 0.001	0.512	***
Age ≥ 75 vs 18–34	−1.440	0.204	−7.08	< 0.001	0.237	***
Gender, Female vs Male	0.116	0.084	1.38	0.169	1.123	Non-significant
Gender, Other/Non-binary vs Male	−0.107	0.490	−0.22	0.828	0.899	Non-significant
Income, $1,000–$1,999 vs < $1,000	−0.289	0.126	−2.29	0.022	0.749	*
Income, $2,000–$3,999 vs < $1,000	−0.281	0.133	−2.12	0.035	0.755	*
Income, > $4,000 vs < $1,000	−0.250	0.158	−1.58	0.114	0.779	Non-significant
Income, Prefer not to say vs < $1,000	−0.482	0.161	−2.99	0.003	0.618	**
Education, High school vs Post-secondary	0.244	0.097	2.51	0.012	1.276	*
Chronic conditions, Yes vs No	0.415	0.092	4.50	< 0.001	1.515	***
Regional vs Metropolitan	0.111	0.122	0.91	0.363	1.117	Non-significant
Rural/Remote vs Metropolitan	0.161	0.131	1.23	0.220	1.175	Non-significant
PHI, No vs Yes	0.508	0.095	5.37	< 0.001	1.662	***
PHI, Don't know vs Yes	0.799	0.588	1.36	0.174	2.223	Non-significant
English only vs LOTE spoken at home	−0.260	0.122	−2.13	0.034	0.771	*
Prefer not to say vs LOTE spoken at home	−0.016	0.568	−0.03	0.977	0.984	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	0.326	0.146	2.24	0.025	1.385	*
Sexual orientation, Prefer not to say vs Heterosexual	0.510	0.284	1.80	0.072	1.666	Non-significant
Mid SES vs Low SES	0.154	0.106	1.46	0.146	1.167	Non-significant
High SES vs Low SES	0.064	0.126	0.51	0.608	1.066	Non-significant
Internet use, twice daily vs 3 or more times daily	−0.303	0.159	−1.90	0.057	0.739	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.270	0.206	−1.31	0.189	0.763	Non-significant
Financial stress, Yes vs No	1.505	0.096	15.66	< 0.001	4.503	***

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B5. Health navigation

A linear regression examined predictors of HLQ scores. The overall model was significant ($p < 0.001$), with modest explained variance ($R^2 = 0.103$, adjusted $R^2 = 0.098$). Adjusted GVIF values ranged from 1.03 to 1.29, indicating minimal multicollinearity.

Model fit statistics ($N = 5{,}030$):

- Residual standard error: 0.639
- Model deviance: 2,042
- AIC: 9,732
- Mean HLQ score: 3.481
- Mean predicted HLQ score: 3.503
- Predicted score range: 2.551–4.094

Coefficients and effects

Predictor	Estimate (β)	SE	t	p	Effect Size	Significance
(Intercept)	3.493	0.066	53.04	< 0.001	–	***
Age, 35–54 vs 18–34	−0.002	0.031	−0.08	0.936	No effect	Non-significant
Age, 55–74 vs 18–34	0.155	0.036	4.31	< 0.001	Small–Medium	***
Age ≥ 75 vs 18–34	0.363	0.053	6.80	< 0.001	Medium	***
Gender, Female vs Male	0.004	0.025	0.17	0.868	No effect	Non-significant
Gender, Other/Non-binary vs Male	−0.323	0.139	−2.33	0.020	Small–Medium	*
Income, $1,000–$1,999 vs < $1,000	0.063	0.037	1.71	0.087	Small	Non-significant
Income, $2,000–$3,999 vs < $1,000	0.081	0.039	2.08	0.038	Small	*
Income, > $4,000 vs < $1,000	0.146	0.045	3.23	0.001	Small–Medium	**
Income, Prefer not to say vs < $1,000	0.018	0.046	0.39	0.693	No effect	Non-significant
Education, High school vs Post-secondary	−0.026	0.026	−1.00	0.320	No effect	Non-significant
Chronic conditions, Yes vs No	−0.034	0.027	−1.26	0.208	Small	Non-significant
Regional vs Metropolitan	−0.066	0.033	−2.01	0.044	Small	*
Rural/Remote vs Metropolitan	−0.146	0.037	−3.93	< 0.001	Small–Medium	***
PHI, No vs Yes	−0.019	0.028	−0.69	0.488	No effect	Non-significant
PHI, Don't know vs Yes	−0.124	0.173	−0.72	0.473	Small	Non-significant
English only vs LOTE spoken at home	0.087	0.040	2.17	0.030	Small	*
Prefer not to say vs LOTE spoken at home	0.011	0.144	0.08	0.937	No effect	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	−0.118	0.051	−2.32	0.021	Small	*
Sexual orientation, Prefer not to say vs Heterosexual	−0.134	0.080	−1.68	0.092	Small	Non-significant
Mid SES vs Low SES	0.049	0.030	1.61	0.107	Small	Non-significant
High SES vs Low SES	0.031	0.035	0.90	0.367	Small	Non-significant
Internet use, twice daily vs 3 or more times daily	0.006	0.043	0.13	0.898	No effect	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.136	0.054	−2.50	0.012	Small–Medium	*
Financial stress, Yes vs No	−0.197	0.032	−6.10	< 0.001	Small–Medium	***
Difficulties affording care, Yes vs No	−0.259	0.033	−7.89	< 0.001	Medium	***

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$
- Effect sizes: small (0.05–0.15), small–medium (0.15–0.25), medium (> 0.25)

B6. Ease of accessing care after-hours

A binomial logistic regression examined predictors of finding after-hours healthcare somewhat or very easy to access (easy versus difficult). The overall model was significant ($p < 0.001$), with modest explained variance (McFadden's R^2 = 0.071). Adjusted GVIF values ranged from 1.02 to 1.23, indicating minimal multicollinearity.

Model fit statistics (*N* = 5,030):

- Nagelkerke pseudo R^2: 0.111
- Model deviance: 5,028
- AIC: 5,111
- Mean predicted probability: 0.230 (proportion finding after-hours care easy)
- Predicted probability range: 0.029–0.498

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	−1.116	0.235	−4.75	< 0.001	0.327	***
Age, 35–54 vs 18–34	−0.363	0.105	−3.45	< 0.001	0.695	***
Age, 55–74 vs 18–34	−0.426	0.132	−3.23	0.001	0.653	**
Age ≥ 75 vs 18–34	−0.672	0.205	−3.28	0.001	0.511	**
Gender, Female vs Male	0.036	0.092	0.39	0.699	1.036	Non-significant
Gender, Other/Non-binary vs Male	0.685	0.486	1.41	0.159	1.983	Non-significant
Income, $1,000–$1,999 vs < $1,000	0.157	0.142	1.10	0.270	1.170	Non-significant
Income, $2,000–$3,999 vs < $1,000	0.337	0.144	2.34	0.019	1.401	*
Income, > $4,000 vs < $1,000	0.413	0.169	2.44	0.015	1.512	*
Income, Prefer not to say vs < $1,000	−0.174	0.178	−0.98	0.328	0.840	Non-significant
Education, High school vs Post-secondary	0.066	0.101	0.65	0.513	1.069	Non-significant
Chronic conditions, Yes vs No	−0.090	0.092	−0.98	0.327	0.914	Non-significant
Regional vs Metropolitan	−0.301	0.133	−2.26	0.024	0.740	*
Rural/Remote vs Metropolitan	−0.396	0.146	−2.72	0.007	0.673	**
PHI, No vs Yes	−0.217	0.105	−2.07	0.038	0.805	*
PHI, Don't know vs Yes	−1.013	0.634	−1.60	0.110	0.363	Non-significant
English only vs LOTE spoken at home	0.255	0.130	1.96	0.050	1.291	*
Prefer not to say vs LOTE spoken at home	−0.770	0.594	−1.30	0.195	0.463	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	0.086	0.167	0.52	0.605	1.090	Non-significant
Sexual orientation, Prefer not to say vs Heterosexual	−0.290	0.302	−0.96	0.337	0.748	Non-significant
Mid SES vs Low SES	−0.020	0.115	−0.18	0.860	0.980	Non-significant
High SES vs Low SES	−0.123	0.129	−0.95	0.342	0.884	Non-significant
Internet use, twice daily vs 3 or more times daily	0.384	0.157	2.44	0.015	1.468	*
Internet use, once daily or less vs 3 or more times daily	−0.035	0.209	−0.17	0.869	0.966	Non-significant
Financial stress, Yes vs No	0.108	0.113	0.96	0.336	1.114	Non-significant
Difficulties affording care, Yes vs No	−0.291	0.121	−2.40	0.017	0.747	*

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B7. Overall satisfaction with quality of healthcare

A binomial logistic regression examined predictors of healthcare satisfaction (satisfied versus not satisfied). The overall model was significant ($p < 0.001$), with modest explained variance (McFadden's $R^2 = 0.131$). Adjusted GVIF values ranged from 1.03 to 1.24), indicating minimal multicollinearity.

Model fit statistics (*N* = 5,160):

- Nagelkerke pseudo R^2: 0.189
- Model deviance: 4,116
- AIC: 4,201
- Mean predicted probability: 0.830

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	1.242	0.248	5.00	< 0.001	3.462	***
Age, 35–54 vs 18–34	0.319	0.119	2.69	0.007	1.376	**
Age, 55–74 vs 18–34	0.746	0.161	4.63	< 0.001	2.108	***
Age ≥ 75 vs 18–34	1.189	0.288	4.13	< 0.001	3.284	***
Gender, Female vs Male	0.218	0.105	2.09	0.037	1.244	*
Gender, Other/Non-binary vs Male	0.353	0.508	0.70	0.487	1.423	Non-significant
Income, $1,000–$1,999 vs < $1,000	0.238	0.150	1.58	0.114	1.268	Non-significant
Income, $2,000–$3,999 vs < $1,000	0.369	0.157	2.35	0.019	1.447	*
Income, > $4,000 vs < $1,000	0.493	0.205	2.41	0.016	1.638	*
Income, Prefer not to say vs < $1,000	0.203	0.183	1.11	0.266	1.225	Non-significant
Education, High school vs Post-secondary	−0.103	0.114	−0.91	0.365	0.902	Non-significant
Chronic conditions, Yes vs No	0.039	0.112	0.35	0.729	1.040	Non-significant
Regional vs Metropolitan	−0.059	0.151	−0.39	0.696	0.943	Non-significant
Rural/Remote vs Metropolitan	−0.388	0.150	−2.59	0.010	0.678	**
PHI, No vs Yes	−0.128	0.115	−1.12	0.265	0.880	Non-significant
PHI, Don't know vs Yes	−0.298	0.498	−0.60	0.550	0.742	Non-significant
English only vs LOTE spoken at home	0.127	0.144	0.89	0.376	1.135	Non-significant
Prefer not to say vs LOTE spoken at home	−1.397	0.564	−2.48	0.013	0.247	*
Sexual orientation, LGBTQIA+ vs Heterosexual	−0.092	0.175	−0.53	0.597	0.912	Non-significant
Sexual orientation, Prefer not to say vs Heterosexual	−0.646	0.268	−2.41	0.016	0.524	*
Mid SES vs Low SES	0.129	0.123	1.05	0.294	1.138	Non-significant
High SES vs Low SES	0.083	0.152	0.55	0.586	1.086	Non-significant
Internet use, twice daily vs 3 or more times daily	−0.106	0.195	−0.55	0.585	0.899	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.618	0.202	−3.06	0.002	0.539	**
Financial stress, Yes vs No	−0.601	0.124	−4.86	< 0.001	0.548	***
Difficulties affording care, Yes vs No	−0.224	0.128	−1.74	0.081	0.799	Non-significant

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B8. Discrimination or disrespect

A binomial logistic regression examined predictors of experiencing discrimination or disrespect in healthcare settings (yes versus no). The overall model was significant ($p < 0.001$), with modest explained variance (McFadden's $R^2 = 0.133$). Adjusted GVIF values ranged from 1.08 to 1.39, indicating minimal multicollinearity.

Model fit statistics (*N* = 4,872):

- Nagelkerke pseudo R^2: 0.161
- Model deviance: 2,069
- AIC: 2,142
- Mean predicted probability: 0.072 (proportion experiencing discrimination/disrespect)
- Predicted probability range: 0.004–0.422

Coefficients and Odds Ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	−3.403	0.372	−9.14	< 0.001	0.030	***
Age, 35–54 vs 18–34	−0.293	0.172	−1.70	0.089	0.746	Non-significant
Age, 55–74 vs 18–34	−0.571	0.217	−2.63	0.009	0.565	**
Age ≥ 75 vs 18–34	−1.254	0.527	−2.38	0.017	0.285	*
Gender, Female vs Male	0.241	0.155	1.56	0.120	1.273	Non-significant
Gender, Other/Non-binary vs Male	0.278	0.585	0.47	0.635	1.320	Non-significant
Income, $1,000–$1,999 vs < $1,000	−0.377	0.201	−1.87	0.061	0.686	Non-significant
Income, $2,000–$3,999 vs < $1,000	−0.608	0.218	−2.79	0.005	0.544	**
Income, > $4,000 vs < $1,000	−0.151	0.266	−0.57	0.571	0.860	Non-significant
Income, Prefer not to say vs < $1,000	−0.210	0.269	−0.78	0.434	0.811	Non-significant
Education, High school vs Post-secondary	0.716	0.191	3.74	< 0.001	2.046	***
Chronic conditions, Yes vs No	0.743	0.188	3.96	< 0.001	2.101	***
Regional vs Metropolitan	0.099	0.204	0.48	0.629	1.104	Non-significant
Rural/Remote vs Metropolitan	0.199	0.218	0.92	0.360	1.221	Non-significant
PHI, No vs Yes	−0.202	0.169	−1.20	0.230	0.817	Non-significant
PHI, Don't know vs Yes	−1.199	1.064	−1.13	0.260	0.301	Non-significant
English only vs LOTE spoken at home	−0.152	0.203	−0.75	0.456	0.859	Non-significant
Prefer not to say vs LOTE spoken at home	−0.882	0.935	−0.94	0.345	0.414	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	0.306	0.234	1.31	0.191	1.358	Non-significant
Sexual orientation, Prefer not to say vs Heterosexual	−0.016	0.390	−0.04	0.967	0.984	Non-significant
Mid SES vs Low SES	−0.216	0.172	−1.26	0.209	0.806	Non-significant
High SES vs Low SES	−0.204	0.211	−0.97	0.333	0.815	Non-significant
Internet use, twice daily vs 3 or more times daily	0.046	0.255	0.18	0.856	1.047	Non-significant
Internet use, once daily or less vs 3 or more times daily	−0.370	0.428	−0.87	0.387	0.691	Non-significant
Financial stress, Yes vs No	0.674	0.184	3.66	< 0.001	1.961	***
Difficulties affording care, Yes vs No	0.512	0.179	2.87	0.004	1.669	**

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

B9. Confidence in healthcare system

A binomial logistic regression examined predictors of decreased confidence in the healthcare system over the past year (decreased versus maintained/increased). The overall model was significant ($p < 0.001$), with modest explained variance (McFadden's $R^2 = 0.106$). Adjusted GVIF values ranged from 1.02 to 1.24, indicating minimal multicollinearity.

Model fit statistics (*N* = 5,030):

- Nagelkerke pseudo R^2: 0.171
- Model deviance: 5,525
- AIC: 5,612
- Mean predicted probability: 0.280 (proportion with decreased healthcare confidence)
- Predicted probability range: 0.052 – 0.758

Coefficients and odds ratios

Predictor	Estimate (β)	SE	z	p	Odds ratio	Significance
(Intercept)	−1.721	0.218	−7.89	< 0.001	0.179	***
Age, 35–54 vs 18–34	0.264	0.107	2.46	0.014	1.302	*
Age, 55–74 vs 18–34	0.254	0.131	1.95	0.051	1.290	Non-significant
Age ≥ 75 vs 18–34	0.249	0.197	1.26	0.207	1.283	Non-significant
Gender, Female vs Male	0.299	0.087	3.44	< 0.001	1.348	***
Gender, Other/Non-binary vs Male	−0.361	0.538	−0.67	0.503	0.697	Non-significant
Income, $1,000–$1,999 vs < $1,000	−0.022	0.122	−0.18	0.855	0.978	Non-significant
Income, $2,000–$3,999 vs < $1,000	−0.117	0.135	−0.86	0.388	0.890	Non-significant
Income, > $4,000 vs < $1,000	−0.382	0.157	−2.43	0.015	0.682	*
Income, Prefer not to say vs < $1,000	0.071	0.150	0.48	0.634	1.074	Non-significant
Education, High school vs Post-secondary	0.142	0.094	1.51	0.132	1.152	Non-significant
Chronic conditions, Yes vs No	0.302	0.095	3.19	0.001	1.352	**
Regional vs Metropolitan	−0.110	0.125	−0.89	0.376	0.896	Non-significant
Rural/Remote vs Metropolitan	−0.035	0.127	−0.28	0.780	0.965	Non-significant
PHI, No vs Yes	0.094	0.095	0.99	0.323	1.098	Non-significant
PHI, Don't know vs Yes	−0.777	0.513	−1.52	0.129	0.460	Non-significant
English only vs LOTE spoken at home	−0.069	0.127	−0.54	0.591	0.934	Non-significant
Prefer not to say vs LOTE spoken at home	0.610	0.631	0.97	0.333	1.840	Non-significant
Sexual orientation, LGBTQIA+ vs Heterosexual	−0.055	0.153	−0.36	0.718	0.946	Non-significant
Sexual orientation, Prefer not to say vs Heterosexual	0.271	0.269	1.01	0.314	1.312	Non-significant
Mid SES vs Low SES	−0.131	0.105	−1.26	0.210	0.877	Non-significant
High SES vs Low SES	−0.223	0.128	−1.75	0.081	0.800	Non-significant
Internet use, twice daily vs 3 or more times daily	−0.098	0.158	−0.62	0.536	0.907	Non-significant
Internet use, once daily or less vs 3 or more times daily	0.199	0.180	1.11	0.269	1.220	Non-significant
Financial stress, Yes vs No	0.459	0.107	4.29	< 0.001	1.582	***
Difficulties affording care, Yes vs No	0.694	0.106	6.54	< 0.001	2.002	***

Notes:

- Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
- Non-significant results have $p > 0.05$

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