CHF
Australia's
Health Panel

Experiences of dignity and respect among health consumers across different healthcare settings

REPORT

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Consumers Health Forum of Australia (2026).
Experiences of dignity and respect among health consumers across different healthcare settings.
Canberra, Australia

P: 02 6176 0000
E: info@chf.org.au

twitter.com/CHFofAustralia
facebook.com/CHFofAustralia

Office Address
Level 5, 15 Moore St
Canberra ACT 2601

Postal Address
PO Box 308
Collins Street West VIC 8007

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SUMMARY

Australians want healthcare that treats them with dignity, respect and as partners in decisions about their care. Throughout this report, dignity and respect are described using consumers' own experiences and language, focusing on how their care felt and what made a difference to their care interactions.

In this Australia's Health Panel survey, **243 consumers** described care that is often courteous, but their experiences of dignity and respect were inconsistent. About one in four consumers reported negative care experiences, particularly those with disability, chronic or mental health conditions, and those navigating complex or hospital-based care. These are not isolated interpersonal issues, but they reflect structural problems related to time, continuity, accountability and coordination within current models of care.

Key insights

Respect was common, but inconsistent, especially for people with complex needs. Most consumers reported positive care experiences of dignity and respect, but more than one in four had negative care experiences, particularly among people with disability, chronic or mental health conditions, LGBTQIA+ consumers, older people, and those in regional and rural areas.

How care was delivered mattered more than where it occurred, but complexity increased risk. While primary care was associated with more consistently positive care experiences, negative care experiences were most common in tertiary settings, and mixed experiences were more likely when care involved multiple providers, highlighting the impact of time pressure, coordination and continuity in care.

Involvement in decisions was central to trust and engagement. Consumers who felt involved in decisions were far more likely to report positive care experiences, trust and confidence. Negative care experiences were associated with exclusion from decision-making, reduced trust and avoidance of future care.

System and personal pressures shape experiences beyond the consultation. Consumers' experiences of dignity and respect were shaped by broader system-level and personal factors beyond clinical interactions. This highlighted respectful care depends not only on individual behaviour, but on a system that supports time, coordination and continuity.

Recommendations

Together, these insights show the importance of aligning funding, accreditation and models of care with the time, continuity and coordination needed to deliver dignified, respectful care consistently

To strengthen dignity and respect in healthcare, we recommend:

1. **Embed meaningful and consistent consumer involvement in decisions as a core accreditation requirement.** Require health services to demonstrate shared decision-making in practice, particularly in specialist and complex care settings, and show how consumers' views influence care decisions.

2. **Align accredited models of care with the time and coordination required for respectful care.** Incentivise models of care that support adequate consultation time, continuity of care, and effective coordination across providers, especially for consumers navigating multi-provider or complex care.

3. **Strengthen accountability for dignity and respect.** Require routine monitoring of consumer feedback on dignity and respect, with clear escalation pathways and evidence that feedback is used to drive service improvement.

4. **Ensure accreditation explicitly addresses equity and cultural safety.** Strengthen accreditation standards to clearly require culturally-safe, inclusive and adaptive care for diverse populations, including consumers who experience greater health and social disadvantage or require additional support.

5. **Strengthen workforce capability for respectful communication.** Support ongoing workforce development in respectful communication, shared decision-making and trauma-informed care, embedded within supervision, reflective practice and continuing professional development.

6. **Improve visibility and use of consumer experience data on dignity and respect.** Require routine collection, reporting and use of consumer experiences of dignity and respect to support benchmarking, transparency and improvement across services.

BACKGROUND

Consumer-centric care is an approach to healthcare that places consumers at the centre of their own healthcare decisions by recognising their experiences, values and needs. It involves treating consumers with dignity and respect, clearly sharing information, and working in partnership with their healthcare provider so that consumers are supported in making informed decisions about their healthcare. It has been recognised as a key component of high-quality healthcare, supporting better engagement, trust, and outcomes for consumers [1,2].

In Australia, expectations for consumer-centric care are embedded in national standards and rights-based frameworks. For example, the National Safety and Quality Health Service (NSQHS) Partnering with Consumers Standard requires health services to actively involve consumers in their own healthcare as well as in service planning, delivery and evaluation [1]. Similarly, the Australian Charter of Healthcare Rights affirms consumers' rights to dignity and respect, to be informed, and to participate in decisions about their healthcare [2].

Dignity and respect are essential to consumer-centric care. Research consistently shows that respectful communication and partnership are critical to building trust in healthcare providers and institutions [3]. However, experiences of poor communication, lack of involvement in decision-making, or feeling dismissed or judged can undermine consumers' confidence in health services and contribute to disengagement from care. Findings from the National Consumer Sentiment Surveys showed that about in 3 in 4 consumers felt they had received the best possible care, and were involved in decisions about their care, yet many reported being rushed during their most recent appointment which can lead to unmet needs [4, 5].

Although national standards endorse consumer-centric care [1, 6], more evidence examining could increase understanding of how dignity and respect are experienced by consumers across healthcare settings. This can support policymakers to identify strengths and opportunities for improvement.

Aim

This report aims to address this gap and present insights from an online survey conducted between 16th March to 7th April 2026, which captured consumers' experiences of dignity and respect (see **Appendix B** for details on our study methodology).

FINDINGS

Demographics

A total of 243 consumers completed the survey. Most were aged 65 years or younger (58.0%), identified as women or female (83.1%), and lived in metropolitan areas (73.8%). A substantial proportion also identified with one or more priority populations, including LGBTQIA+ individuals (9.1%), people from culturally and linguistically diverse (CALD) backgrounds (10.3%), people living with disability (31.3%), those with chronic conditions (58.4%), and those with mental health experience (32.9%).

While Australia's Health Panel surveys are designed to provide a policy-relevant snapshot of consumer experience rather than a nationally representative sample, consumers to this survey were geographically diverse, with representation from all Australian states and territories.[1]

From primary to tertiary care: complexity, not setting, shapes experience

Multi-provider care emerged as a key feature of consumer experiences, with around one in two (48.1%) involving multiple providers. The involvement of multiple providers highlights how consumers' experiences can be shaped across interactions, which help explain why some consumers are more likely to report mixed or inconsistent care experiences.

Almost half of consumers saw a GP or family doctor (48.6%), followed by specialist doctors (39.1%) (**Figure 1**). Many also interacted with reception or administrative staff, nurses or midwives, and hospital-based services, while allied health professionals and pharmacists were less frequently involved.

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[1] Victoria (34.9%), New South Wales (24.1%), Queensland (13.7%), Western Australia (8.7%), South Australia (8.7%), Australian Capital Territory (5.8%), Tasmania (3.3%), and the Northern Territory (0.8%).

Providers involved in most recent healthcare experience

Type	48.6%	39.1%	31.7%	25.1%
	GP/family doctor	Specialist doctor	Admin staff	Nurse/midwife
	19.3%	17.7%	16.5%	9.1%
	Hospital staff	ED staff	Allied Health	Pharmacist

Figure 1. *Most consumers interacted with multiple providers during their most recent healthcare experience*

Positive care experiences were most common in primary care (66.0%), while negative care experiences were most common in tertiary care settings (44.0%) (**Table 1**). Consumers navigating multiple providers were more likely to report a combination of positive and negative care experiences (mixed experiences) (22.9%).

Table 1. *Provider involvement by experience type*

Provider involved	Overall N = 239*	Positive *n* = 136	Negative *n* = 64	Mixed *n* = 39
Total % for settings	**100.00%**	**56.9%**	**26.8%**	**16.3%**
Primary health	43.1%	66.0%	20.4%	13.6%
Tertiary health	27.6%	42.4%	44.0%	13.6%
Multiple/mixed	29.3%	57.1%	20.0%	22.9%

*Four responses were excluded because they did not fit the aforementioned categories or were unclear

Taken together, these findings show that tertiary and multi-provider care settings are key points where care experiences were often negative or inconsistent. As care becomes more complex, system pressures, particularly time constraints and coordination challenges, increase, reducing meaningful involvement and increasing the risk of inequitable and disrespectful care. Fragmentation also creates variability in dignity and respect across interactions, which means consumers experience the system inconsistently.

Respect alone is not enough: gaps remain in safety, inclusion and understanding

> ***"Treating patients with respect and making sure everyone feel listened and heard."***
>
> ***"Some nurses seemed to treat me condescendingly, talked over me and did not consider my questions from my perspective."***

Building on this, consumers' experiences show that respect is often present at a surface level, but less consistent in practice. Consumers were clear that respectful communication and being genuinely listened to are essential to care, yet their needs were not consistently met. While most respondents reported being treated with courtesy and respect (73.0%), fewer experienced the elements that define meaningful respect, such as being listened to without rushing, feeling recognised beyond their clinical needs, or having their cultural background understood (**Figure 2**).

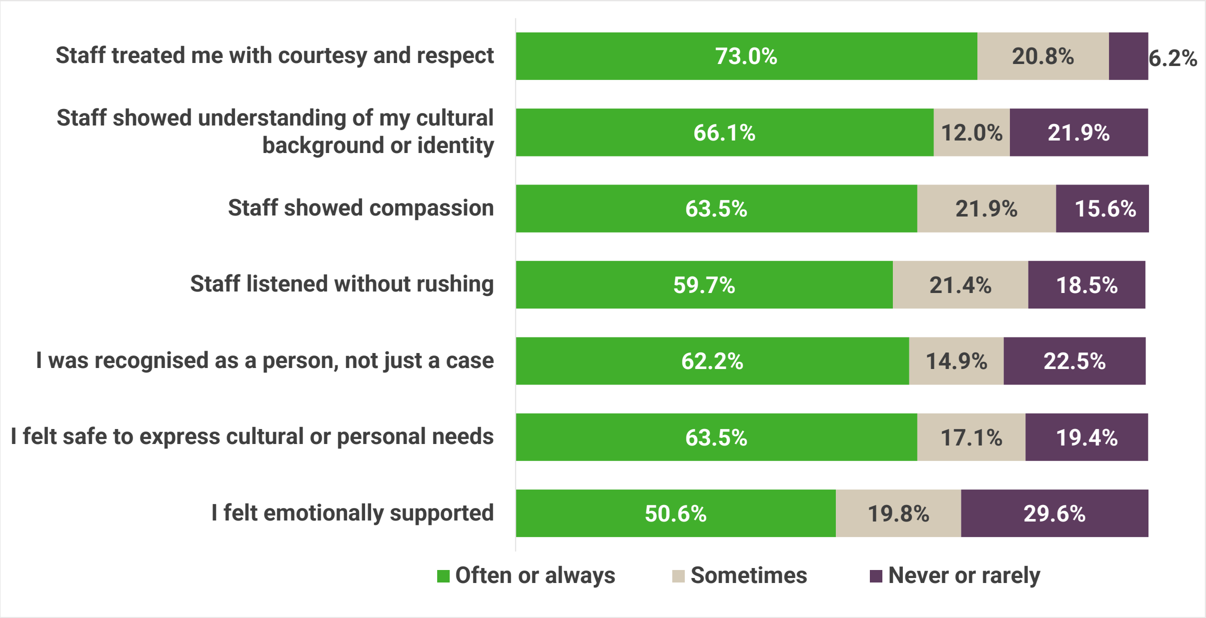

Figure 2. *Courtesy and respect were common, but emotional support and cultural understanding were less consistent*

A notable proportion experienced care that undermined dignity and respect (**Figure 3**). Around one in five reported often or always feeling spoken down to or not taken seriously (22.0%) or having incorrect assumptions made about them, while 13.0% felt judged or blamed. Experiences of unfair treatment based on culture, background or personal characteristics were less common but still present, with 8% reporting that this often or always occurred.

These findings suggest that gaps in respectful care reflect not only workforce capability, but also the systems in which such care is delivered, where time pressure and fragmented models of care can constrain quality of practice and amplify biases. Courtesy is no substitute for consumer dignity and respect, where a gap widens every time, they are denied the time and inclusion they deserve.

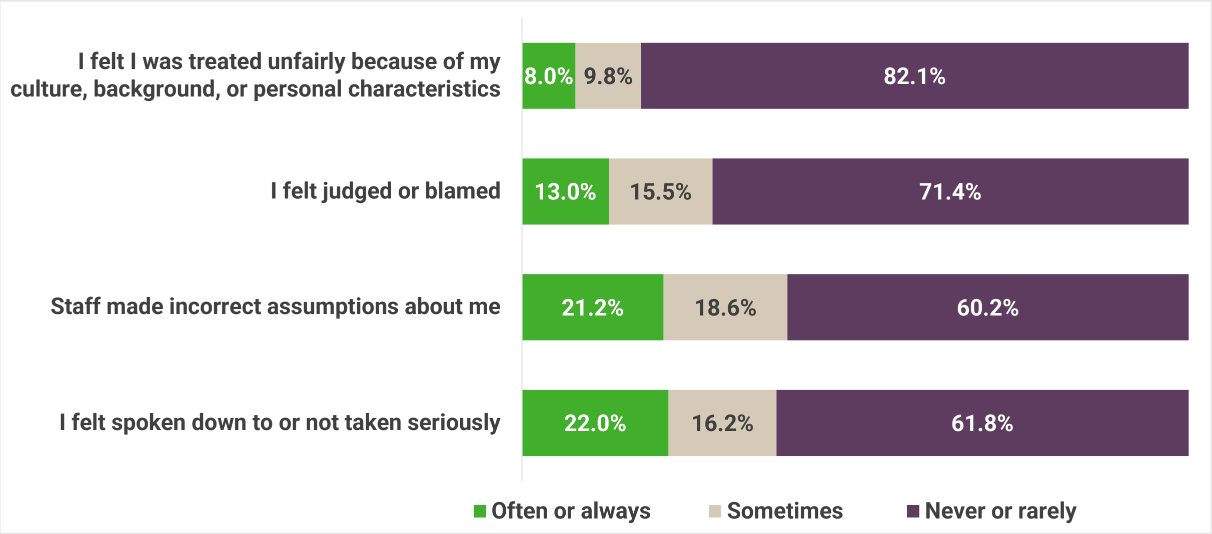

Figure 3. *Consumers experienced dismissive, judgmental or unfair treatment*

Meaningful involvement depends on time, listening and engagement

Being involved drives trust, confidence and ongoing engagement with care

> ***"The opportunity to be involved in the decision making regardless of age and/or not making assumptions about persons of different age groups, etc."***
>
> ***"Offer solutions and have the patient decide which is the best or most workable for them. I need to be involved"***

One key way this gap can become visible is through how decisions are made. Consumers consistently described involvement in decisions as a defining feature of respectful care. Being included, listened to and able to shape decisions was seen as central to feeling respected, confident and willing to engage with care. While national data from the 2025 NCSS findings showed that most consumers felt included in decisions about their care (72.9%) [5], our current findings paint a different picture. Our survey showed that many consumers described only partial or unclear involvement, with decisions sometimes made for them or without meaningful discussion (**Figure 4**).

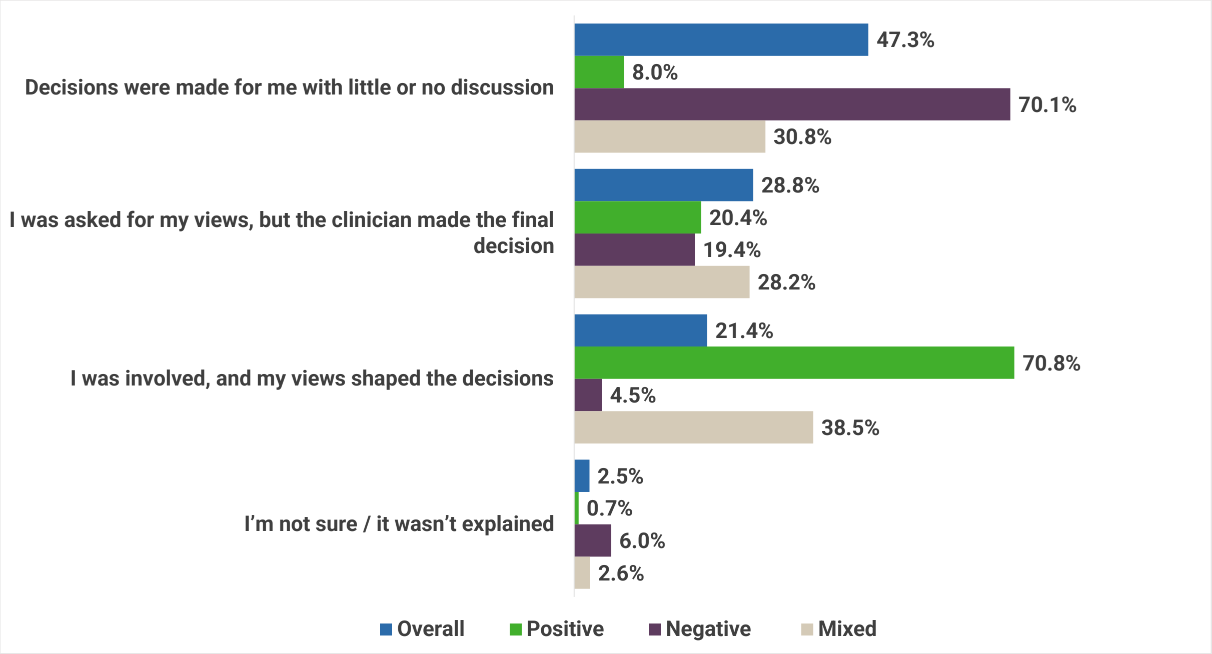

Figure 4. *Consumers were often involved in decisions, a substantial proportion reported limited or no involvement, particularly those with overall negative experiences*

This is a critical pivot in the care experience. Where consumers felt genuinely involved in decisions), they were more likely to describe their experience as positive, with stronger trust in healthcare professionals and greater confidence in managing their health (**Figure 5)**. In contrast, negative experiences were strongly linked with exclusion from decision-making, where consumers felt their views were not heard or did not influence outcomes.

These findings suggest that shared decision-making is about creating meaningful participation. When consumers are treated as partners in their care, this supports trust, engagement and continuity, and when they are not, the impact contributes to reduced confidence and a greater likelihood of disengagement from care.

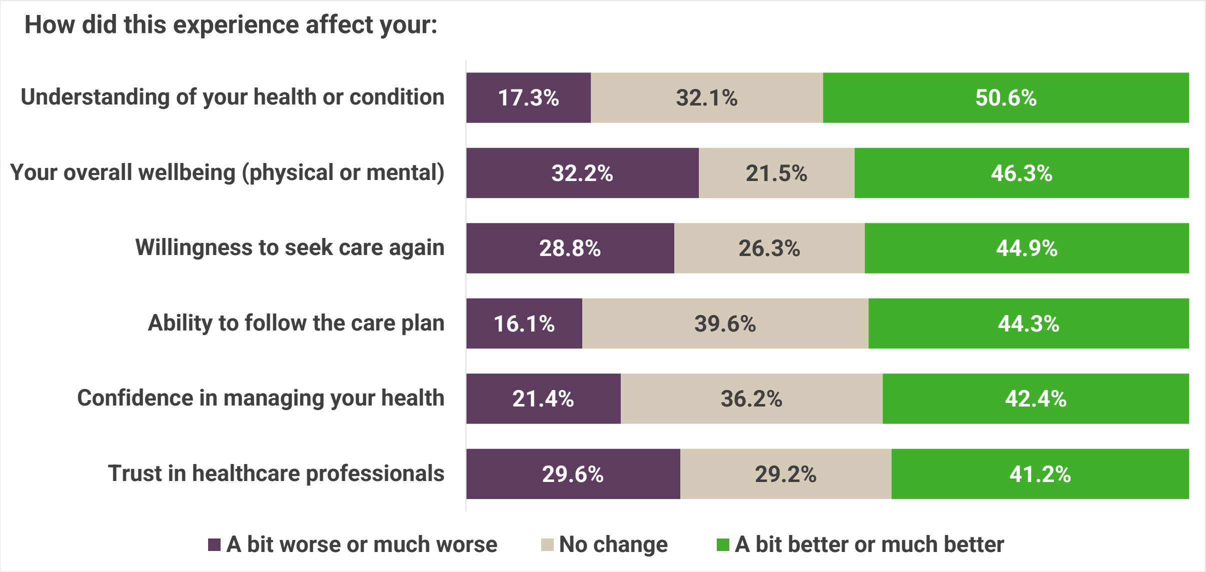

Figure 5. *Experiences of dignity and respect influenced trust, confidence and engagement with care*

Feeling heard and not being rushed defines respectful care

> ***"If clinicians had more time to do their work with patients and did not feel so rushed…patients would be able to ask more questions, feel more involved and make informed choices"***
>
> ***"Listen to the patient as they know their body and probably know what has worked in the past."***

Achieving this level of involvement requires the conditions for respectful care; time, listening and engagement. While data from the 2025 NCSS indicates broad consumer satisfaction with the care they received [5], our findings show that the reality for some was more demanding. For roughly one-third of consumers in our survey, the benchmark for respectful care was a concrete experience of being listened to having concerns taken seriously, and given enough time with the clinician. (**Figure 6**).

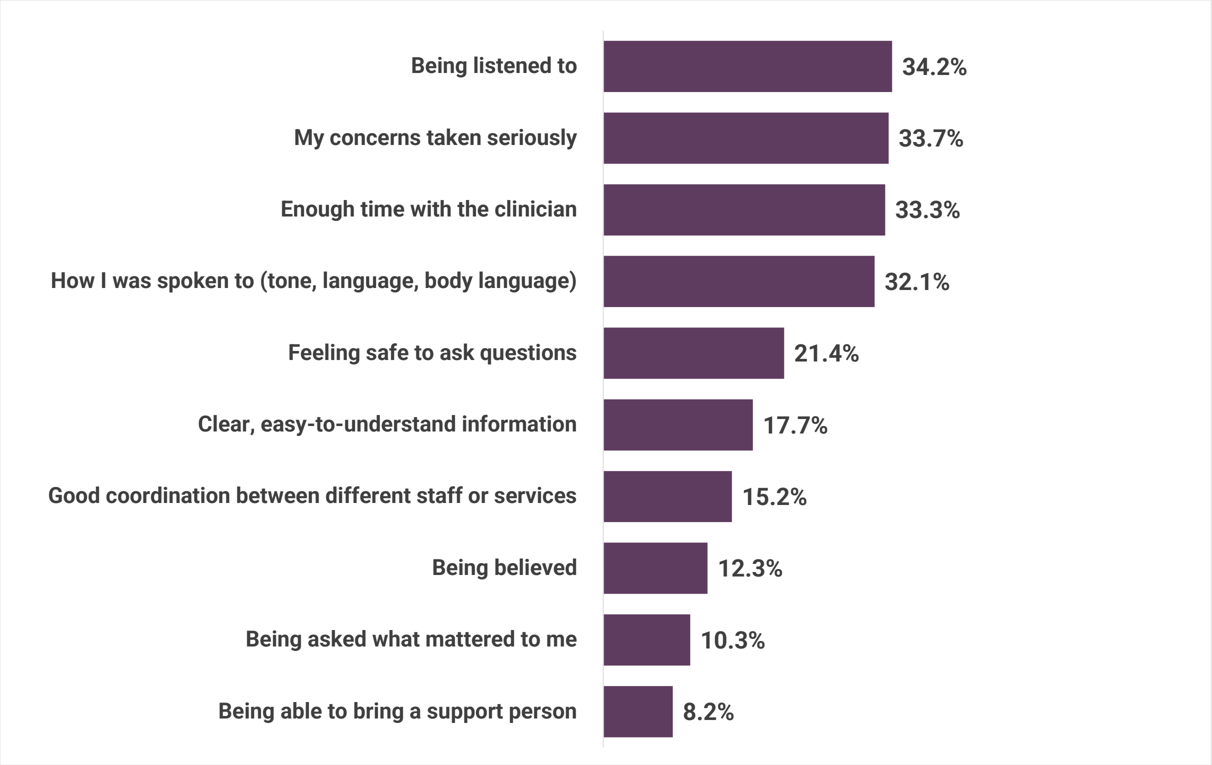

Figure 6. *Feeling listened to, taken seriously and not rushed were the top ten contributors to consumers feeling respected*

When these elements were missing, however, the impact was immediately negative. Consumers described feeling dismissed, not believed, or rushed through interactions (**Figure 7, Appendix A2**). One in five reported often or always feeling spoken down to or not taken seriously, and many linked this directly to limited time and poor coordination between providers.

These experiences were not isolated communication issues. They reflected system pressures, including time constraints, fragmented care, and competing demands, which can shape what happens during consultations. This suggests that dignity and respect rely on conditions that enable meaningful interaction, not just individual provider behaviour.

Consumers with greater needs face more negative and inequitable care experiences

> ***"Doctors should never be questioning the 'quality of life' of a person with a disability I felt like my life did not matter to this doctor I left the hospital because I was afraid that they were going to let me die"***

Where these conditions are not met, negative experiences are not evenly distributed. Consumers with greater needs face more inconsistent and inequitable care. Consistent with findings from the NCSS, most consumers report positive experiences of care. However, experiences are not consistent, with important gaps for those with greater needs. Our survey showed that most care experiences for consumers were positive (56.4%), but bias and lack of respect can lead to feeling dismissed, undervalued, and unsafe during care. One in four reported negative care experiences (27.6%). Consumers living with disability (35.5%), those with mental health experience (37.5%), or chronic illness (32.4%) were more likely to have negative care experiences (**Table 2, Appendix A2**).

> ***"Doctors are highly dismissive of women, women's health issues, still to this day, not believing us, not giving us options, and not being up to date on current research"***
>
> ***"Treat people with respect and the same regardless of age, culture, etc. Be aware of unconscious biases"***

Higher proportions of negative care experiences were also reported by women, older adults (75 years and older), consumers living in regional and rural areas and LGBTQIA+ individuals (**Table 2, Appendix A2**). together, this highlights that inequities in dignity and respect are shaped by both individual experiences and broader system constraints.

System and personal pressures shape experiences beyond the consultation

> ***"Ensuring accountability within systems, ensuring all staff know they will be held accountable for their actions."***
>
> ***"There seems to be such massive time pressures, so you feel that nobody is that interested, let alone willing to attend to any needs.***

These patterns are reinforced by broader system and personal pressures that shape experiences beyond the consultation. Our survey shows that many consumers experienced pressures, particularly related to mental health conditions, chronic illness, or disability, which influenced how supported they felt irrespective of whether their care was positive or negative (**Figure 8**). Despite consumers experiencing positive care, they still described systemic and personal pressures, including anxiety, time pressures, access barriers and costs. In contrast, negative care experiences were a direct result of systemic exclusion. We found that when consumers are forced to navigate language barriers or were fearful of consequences of speaking up, their dignity and respect was not preserved.

These findings show that, even when faced with significant structural and personal challenges, experiences of dignity and respect were strongly shaped by what happens within the consultation.

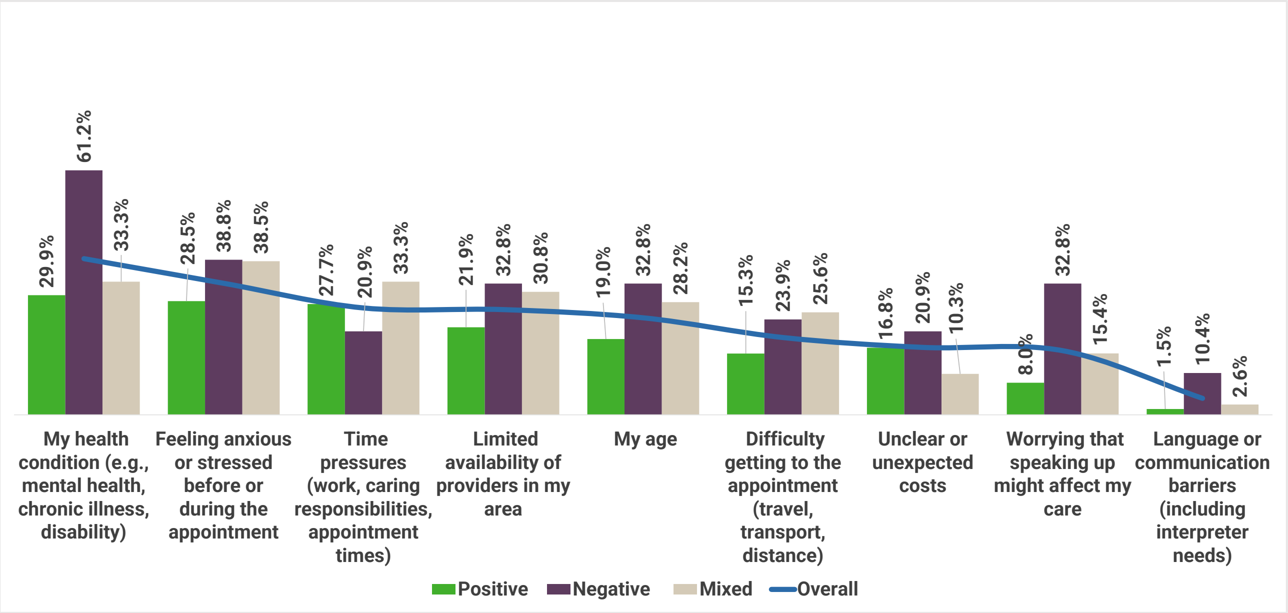

Figure 8. *Consumers' experiences of dignity and respect were shaped by personal, practical and system-level factors*

Respectful care builds trust and engagement and poor care drives avoidance

> ***"The respect is the byproduct of continuity and advocacy. Giving every patient a dedicated guide transforms the system from a confusing, impersonal maze into a supportive partnership."***
>
> ***"Health services have worked hard to make people feel more respected. However, it only takes one person to destroy the hard work. I think that it is a matter of working together with the patient towards a good outcome."***

These experiences have clear downstream effects on how consumers engage with care. Respectful care relies on sustained partnership and continuity, and yet it can quickly be undermined when interactions do not consistently support trust and shared decision-making. While the 2025 NCSS found a staggering 50% of consumers of consumers with unmet needs[5], our findings suggest that a lack of dignity is a primary driver of this gap. When respect is absent, consumers not only feel unheard, but they also actively avoid the system. We found that the presence of dignity and respect has a measurable impact emotionally and on future care-seeking behaviour, proving that respectful care is a necessity (**Figures 9 and10, Appendix A2**).

Positive care experiences do more than provide consumer comfort, they push consumers to build trust and confidence, follow advice and take an active role in their health. Conversely, negative experiences act as a barrier. Poor interactions trigger anxiety and care avoidance, creating a cycle of delayed treatment and fragmented care that the system cannot afford to ignore.

Consumers' priorities for change: more time, better communication and shared decisions

> ***"Communicate clearly and respectfully about what is happening and why, using plain language and checking that people feel informed. Building in simple shared-decision-making steps—such as asking about preferences, outlining options, and inviting people to co-decide the next steps—helps consumers feel genuinely included in their care."***

Consumers' priorities for improvement reflect these experiences, focusing on the conditions that enable respectful care. Consumers want more time in consultations (42.4%), to be more involved in decisions (40.3%) and better coordination between services (38.7%) (**Figures 11a and 11b, Appendix A2**). Many also stressed the importance of clearer explanations of options and risks (35.8%) and stronger communication skills among staff (32.1%), while one in five identified greater accountabilities when disrespect occurs. Around 7% identified the need for more culturally-safe care and 8% for being able to bring a support person.

Again, even where care was generally respectful, those with positive care experiences were more likely to support most of these expectations, except for accountability in cases of disrespect, and they held stronger expectations about respectful behaviour overall compared to consumers with negative care experiences.

In their own words, consumers described how feeling heard, involved and not rushed determined whether care felt respectful. These priorities reinforce the core drivers of respectful care: time, communication, coordination and meaningful involvement in decisions (**Appendix A**).

RECOMMENDATIONS

Many consumers reported positive care experiences, but negative care experiences were more common among people with greater health and social disadvantages and in those navigating complex, multi-provider and/or tertiary care. Dignity and respect are strongly shaped by time pressures, quality of communication, involvement in decisions, and the way care is coordinated across healthcare providers.

Dignity and respect are not simply matters of consumers' experiences, but are fundamental to their safety, adherence and equity in healthcare. When consumers are listened to, involved and supported, they are more likely to engage with care and follow advice; when they are not, reduced trust and avoidance of future care are common outcomes.

Primary and tertiary care operate under different funding, governance and accountability structures that shape consultation time, continuity and coordination. The settings which better enable these conditions (more commonly primary care) are associated with more consistent dignity and respect, which then reinforces the need for aligned accreditation and service models, especially in complex and tertiary settings.

The recommendations below[2] were informed by consumers' experiences of dignity and respect across healthcare settings.

Recommendation 1 (lead responsibility: accreditation authorities/standard-setting bodies): Embed meaningful and consistent consumer involvement in decisions as a core accreditation requirement.

> ***Short-term (0-12 months).*** Progress consultation and development of strengthened accreditation requirements that embed shared decision-making.
>
> ***Medium-term (1-3 years).*** Implement updated standards requiring services to demonstrate how consumer views influence care decisions, particularly in complex and specialist care settings.
>
> ***Why:*** Many consumers reported being only partially involved or excluded from decisions about their care, highlighting a gap between accreditation expectations and lived experience.

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[2] These recommendations reflect the experiences of consumers in our sample and should be interpreted in light of the study's scope and limitations, as outlined in **Appendix A**.

Recommendation 2: Align accredited models of care that enable respectful communication in practice, including adequate time, continuity and coordination, rather than relying solely on individual clinician behaviour, particularly in complex and tertiary care settings where negative care experiences are more common.

> ***Short-term (0-12 months).*** Develop guidance and pilot funding and service models that support adequate consultation time, continuity of care and coordination across care providers.
>
> ***Medium-term (1-3 years).*** Align accreditation and funding frameworks to incentivise models of care that consistently enable respectful, coordinated care, especially for consumers with complex needs.
>
> ***Why:*** Consumers consistently reported that feeling rushed, poorly coordinated care and lack of continuity undermined experiences of dignity and respect, especially when navigating multiple providers.

Recommendation 3: Strengthen system-level accountability for dignity and respect.

> ***Short-term (0-12 months).*** Clarify expectations within accreditation standards for monitoring and responding to consumer feedback on dignity and respect.
>
> ***Medium-term (1-3 years).*** Require services to demonstrate clear escalation pathways and evidence that consumer feedback drives service improvement.
>
> ***Why:*** Consumers reported that when disrespect occurs, there are often few visible or effective pathways for raising concerns or seeing meaningful improvement, undermining trust in the health system.

Recommendation 4: Ensure accreditation explicitly addresses equity and cultural safety.

> ***Short-term (0-12 months).*** Strengthen accreditation to clearly articulate expectations for culturally-safe, inclusive and adaptive care.
>
> ***Medium-term (1-3 years).*** Require accredited services to demonstrate how care is adapted to meet the needs of diverse populations, including support for consumers who require additional assistance or advocacy.
>
> ***Why:*** Consumers from priority populations reported less consistent experiences of dignity and respect, highlighting the need for accreditation standards that explicitly require services to demonstrate culturally-safe and equitable care in practice.

Recommendation 5: Strengthen workforce capability for respectful communication.

Short-term (0-12 months). Update accreditation and professional standards to embed expectations for respectful communication, shared decision-making and trauma-informed care.

Medium-term (1-3 years). Require services to demonstrate ongoing workforce development supported by supervision, reflective practice and continuous professional development, rather than one-off training.

Why: Consumers frequently described feeling rushed, dismissed or not listened to, highlighting the need for sustained investment in communication skills that support dignity, respect and partnership in care.

Recommendation 6: Improve visibility and use of consumer experience data on dignity and respect.

Short-term (0-12 months). Establish requirements for routine collection and reporting of consumer-reported experiences of dignity and respect, including evidence that consumer feedback is used to address issues that contribute to anxiety, avoidance or delay of care following negative care experiences.

Medium-term (1-3 years). Use consumer experience data to support benchmarking, transparency and continuous improvement across healthcare services.

Why: Consumers' feedback on feeling respected or disrespected is not always acted on, reducing confidence that their experiences lead to meaningful change.

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Appendix A1. Supplementary table

Theme (*n* = 228) n, %	Theme description	Example quote
Time, rushing, and capacity 56, 25%	Concerns about inadequate consultation time, rushed interactions, and staffing pressures.	"More time available so patients don't feel rushed."
Respect, dignity, and compassion 47, 20%	Being treated kindly, respectfully, and as an individual across all interactions.	"Treating patients with respect and making sure everyone feel listened and heard."
Being listened to and believed 45, 19%	Patients feel heard, trusted, and validated in their experiences and symptoms.	"Listen to the patient as they know their body and probably know what has worked in the past."
Bias, discrimination, and cultural safety 44, 19%	Experiences of bias related to age, gender, culture, disability or background, and the need for cultural safety.	"Believe women when they talk about pain and symptoms."
Clear, plain communication 30, 13%	Use of clear, simple, and accessible language so information is understood.	"Use simple language instead of terminology."
Shared decision-making 26, 11%	Patients being actively involved in choices about their care and treatment options.	"Offer solutions and have the patient decide which is the best/most workable for them."

Theme ($n = 228$) n, %	Theme description	Example quote
System coordination and accountability 25, 11%	Need for better coordination between services, follow-up, and accountability when things go wrong.	“Coordination between services could be improved.”
Consumer preparedness 8, 4%	Supporting patients to prepare for consultations through questions, notes, or support people.	“Encouraging people to arrive with written questions and take notes during consultations.”
Clinical safety 3, 1%	Ensuring safe, appropriate, and evidence-based clinical care.	“Not forcing you to be discharged when you are unable to walk or feed yourself.”

Appendix A2. Table 2

Table 2. *Characteristics of consumers by experiences of dignity and respect*

Details		n	Positive	Negative	Mixed
	Overall	**243**	**56.4%**	**27.6%**	**16.0%**
Age group	**Under 65 years****	140	52.9%	30.0.%	17.1%
	65-74	66	65.1%	18.2%	16.7%
	≥75	36	52.8%	36.1%	11.1%
Gender*	**Woman or female**	202	56.4%	27.2%	16.3%
	Man or male	33	57.6%	24.2%	18.2%
Region	**Metropolitan areas**	177	58.2%	27.1%	14.7%
	Regional & large rural towns	43	48.8%	32.6%	18.6%
	Medium & small rural / remote	20	60.0%	20.0%	20.0%
LGBTQIA+	**Yes**	22	50.0%	36.4%	13.6%
	No	221	57.0%	26.7%	16.3%
CALD	**Yes**	25	60.0%	24.0%	16.0%
	No	218	56.0%	28.0%	16.1%
Disability	**Yes**	76	46.1%	35.5%	18.4%
	No	167	61.1%	24.0%	15.0%
Chronic illness	**Yes**	142	52.1%	15.5%	32.4%
	No	101	62.4%	16.8%	20.8%
Mental health experience	**Yes**	80	40.0%	37.5%	22.5%
	No	163	64.4%	22.7%	12.9%

*Note: *The non-binary (n=8) and ATSI (n=5) categories were not included due to small cell sizes.*

***One consumer did not provide their age details*

LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Intersex, Asexual, and other sexual orientations, gender identities and sex characteristics.
CALD: Culturally and Linguistically Diverse
ATSI: Aboriginal and/or Torres Strait Islander

Appendix A2. Figures 7-9, 11a, and 11b

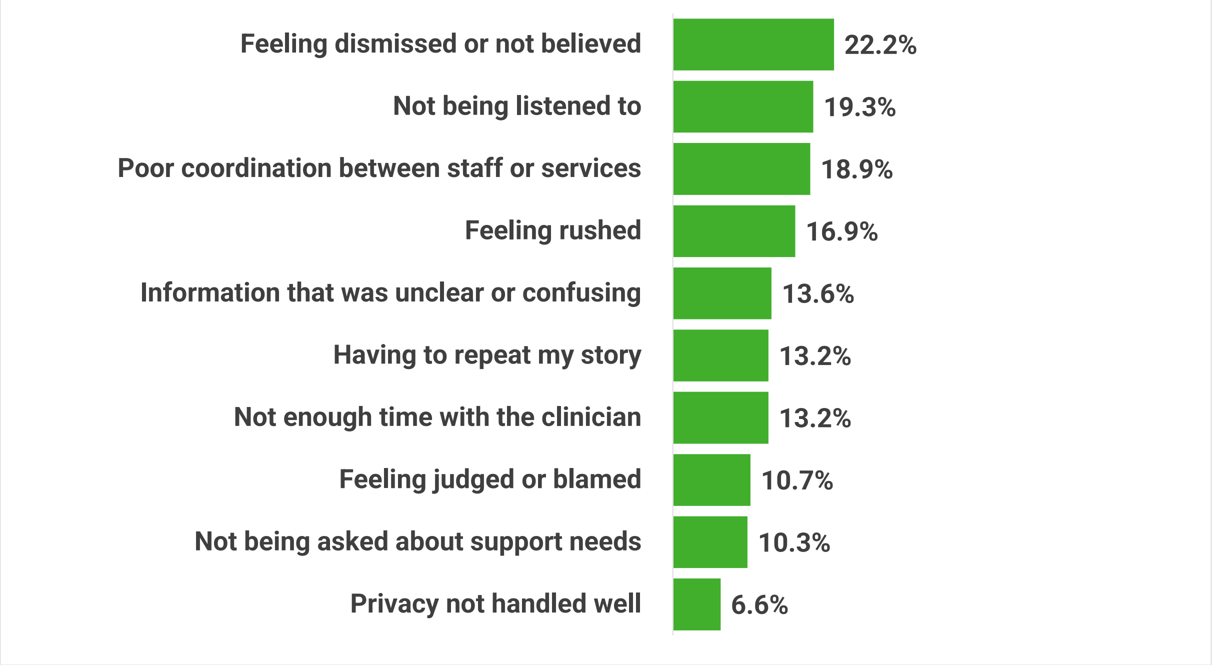

Figure 7. *Dismissive communication, time pressure and poor coordination undermined consumers' sense of respect the most among top ten contributors*

Appendix A2 continued. Figures 7-9, 11a, and 11b

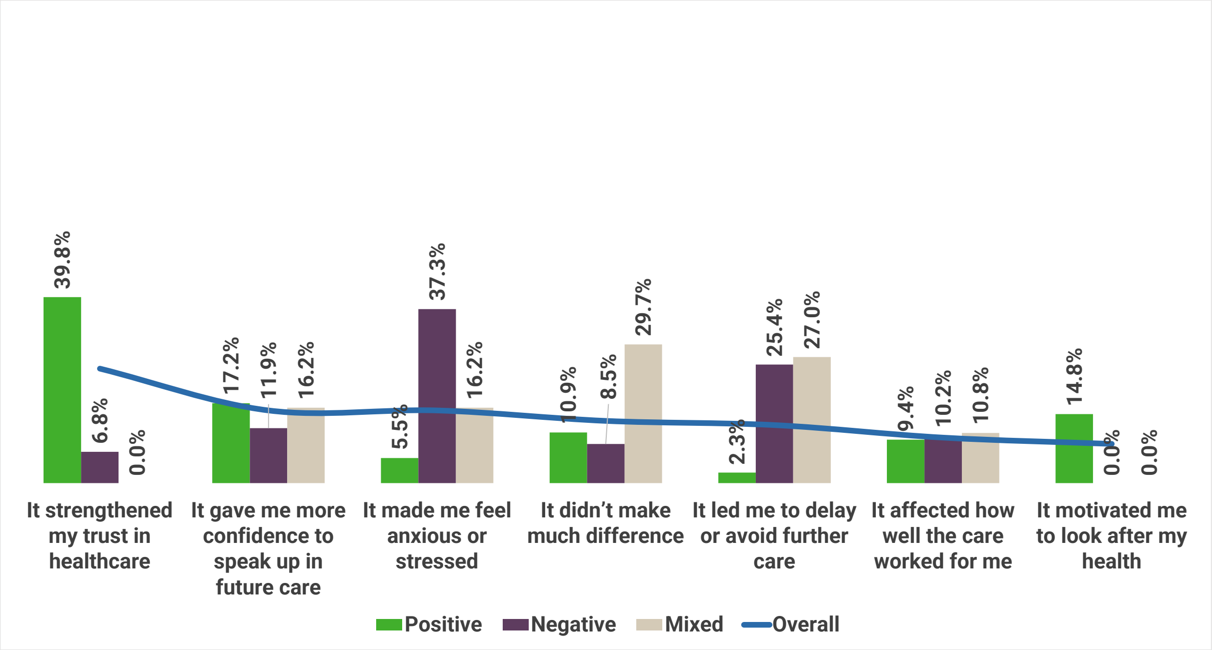

Figure 9. *Experiences of dignity and respect shape whether healthcare builds trust and motivation or leads to anxiety, avoidance and disengagement*

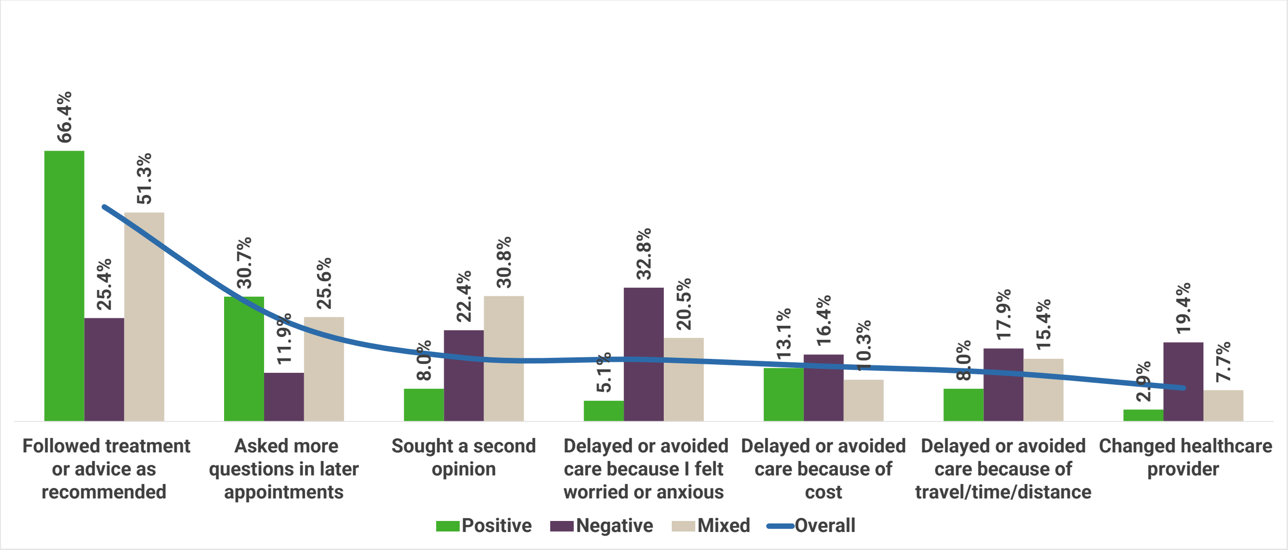

Figure 10. *When consumers feel respected and involved, they engage with care; when they don't, they disengage*

Appendix A2 continued. Figures 7-9, 11a, and 11b

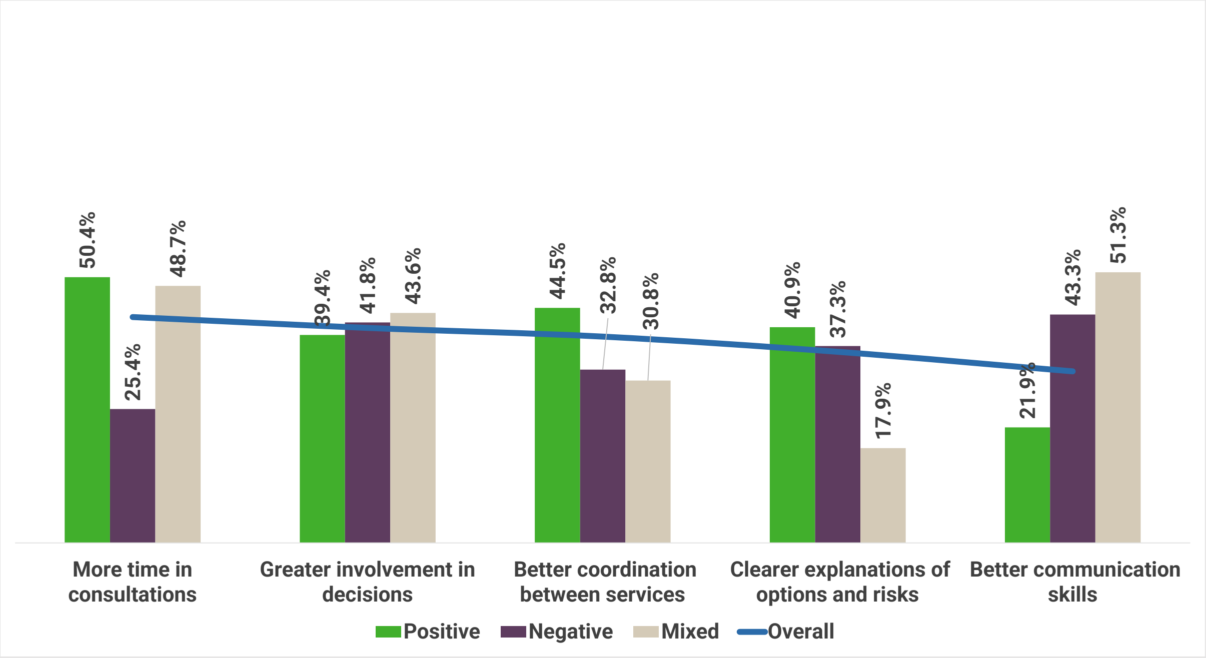

Figure 11a. *Improving dignity and respect in healthcare requires more time, better communication and genuine involvement in decisions*

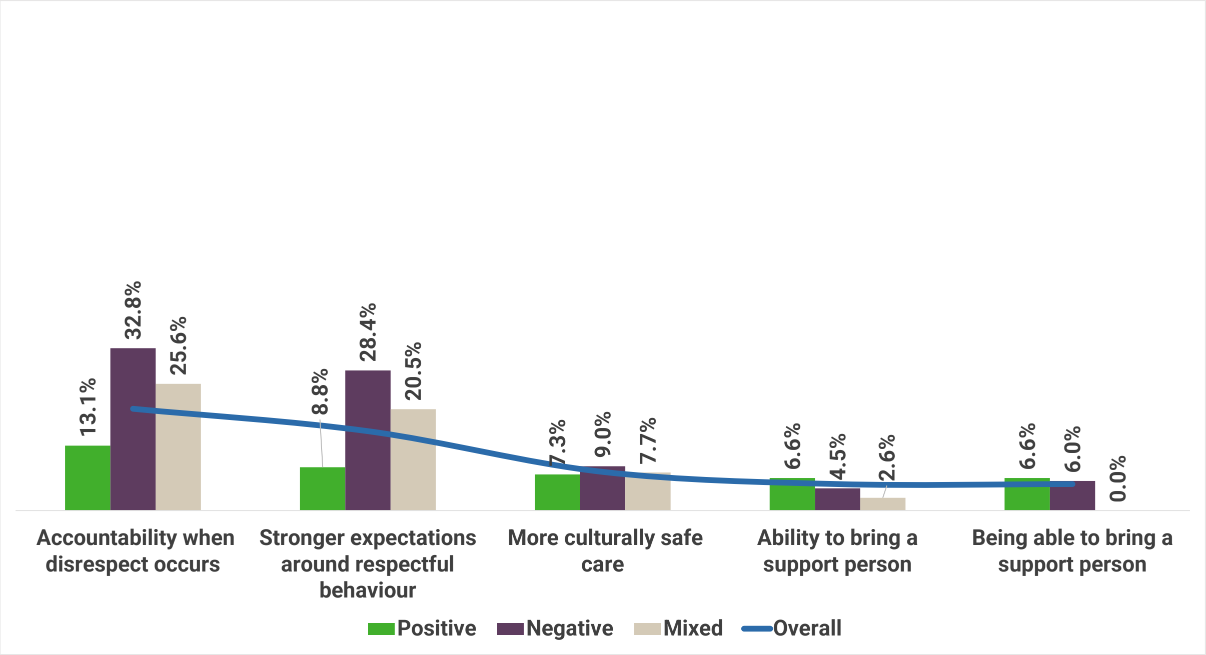

Figure 11b. *Support for accountability, respectful behaviour, cultural safety and support persons was strongest among consumers reporting negative care experiences*

Appendix B. Methods

Australia's Health Panel is a growing group of health consumers who regularly complete surveys on health issues. The project is run by the Consumers Health Forum of Australia (CHF), and surveys from 2025 onwards are delivered through LimeSurvey, an open-source online survey platform for survey creation, distribution and analysis.

We conducted an online survey from 16th March 2026 to 7th April 2026 to explore consumers' experiences of experiences of dignity and respect in healthcare (please see full survey attached as **Appendix B**).

CHF invited Australia's Health Panel as well members of. In total, 243 consumers completed[3] the survey after receiving an invite, which included consumers from:

- AHP (*n* = 233)
- Members Policy Network (n=4)
- People with Disability Australia (PWDA) (n=4)
- Australian Research Alliance for Children and Youth (ARACY) (n=2)

Because multiple invitation platforms were used, some participants could have completed the survey more than once, and therefore, any duplicate surveys were identified and removed using a combination of demographic information (i.e., age, gender and postcode) and IP address.

Text responses from participants who selected the 'Other' option were recoded into one or more existing response categories when appropriate. We anticipate that this may have occurred when participants misunderstood the question or misread the available response options.

We summarised the data using the means, frequencies and percentages and only surveys completed were included in our final analysis. We categorised location of residence at the States or Territory level based on the postcodes or area of residence provided by consumers.

To analyse the qualitative data, we applied coding frames using keyword patterns allowing a response to match multiple themes.

Our tables and figures report findings for 243 consumers, unless stated otherwise. We removed "Not applicable", "No answer" or "Prefer not to say" answer options, and therefore, total *n (subsample size)* throughout this report may vary.

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[3] For clarity, "complete" surveys are defined as those finished up to and including Q12

Response classifications

- **Experience type (Q1a):** Response options of “Very positive” and “Somewhat positive” were recoded as “Positive”, while “Very negative” and “Somewhat negative” were recoded as “Negative”. Responses of “Mixed” were retained as “Mixed”.
- **Q2:** Response options for provider involvement were recoded into three categories: Primary health, Tertiary health and Multiple/mixed.
- **Q4a and Q4b:** Response options of “Never” and “Rarely” were combined into a “Never or rarely”, while “Often” and “Always” were combined into “Often or always”. Responses of “Sometimes” were retained.
- **Q7:** Response options of “Much worse” and “A bit worse” were combined into “A bit worse or much worse”, while “A bit better” and “Much better” were combined into “A bit better or much better”. Responses of “No change” were retained.

Demographic classifications

- **Region of residence:** Consumers were grouped into three categories, metropolitan areas, regional and large rural towns, and medium and small rural or remote areas, based on the postcode of their home address. Postcodes were mapped to the Modified Monash Model (MMM), which classifies areas according to remoteness and population size[4]. The three categories used in this report correspond to:
    - Metropolitan areas: MMM 1
    - Regional and large rural towns: MMM 2-3
    - Medium and small rural and remote areas: MMM 4-7
- **Age groups:** consumers were grouped into the following age bands for reporting:
    - Under 65
    - 65-74
    - 75-84
    - 85 or over
- **Other classifications:** For LGBTQIA+, CALD, ATSI, disability, mental health experience, and chronic illness, consumers who answered “Yes” were classified as belonging to that group. Those who answered “No” were classified as not belonging to the group, and “Don’t know” or missing responses were recorded as “Unknown”.

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[4] Australian Government Department of Health and Aged Care, “Modified Monash Model (MMM).”

Limitations

This survey is based on 243 responses, which may limit the generalisability of findings. A substantial proportion of consumers reported disability, chronic illness, or mental health experience. Therefore, the findings may be most relevant to groups with higher levels of healthcare use.

The sample size may not fully capture demographic diversity, and some subgroup analyses involve small cell sizes and should be interpreted with caution. As participants were recruited through Australia's Health Panel and partner consumer networks, our sample may over-represent individuals who are more engaged with the healthcare system or who have stronger views or experiences, which can introduce potential self-selection bias.

Non-response and incomplete answers could introduce bias, and as the data are self-reported, findings may be subject to recall and social desirability bias. In addition, collapsed responses for reporting can obscure variation in experiences. Finally, the cross-sectional design provides a snapshot in time and cannot establish causality. The findings presented in this report reflect the experiences of consumers and are intended to provide a policy relevant overview of these experiences, rather than present population-level estimates or draw any causal conclusions.

Appendix C. Survey

Consumer-centric healthcare

We are conducting a short 10-minute survey about people's experiences of dignity and respect in healthcare in Australia. People's experiences can be positive, negative, or mixed.

Your responses will help us understand what makes people feel respected in healthcare, and how these experiences affect confidence, wellbeing, and health outcomes.

This information will be used to identify opportunities to improve care for everyone.

Your responses are anonymous and will only be used for research and advocacy purposes.

There are no right or wrong answers. Please answer honestly based on your own experience.

There are 21 questions in this survey.

Section 1: About your experience

Q01. Thinking about the last 12 months, please choose one healthcare experience that stands out most to you (for any reason).

To help you remember it through the survey, please briefly describe the experience in the text box below (e.g., "GP visit about back pain" or "hospital stay after injury").

Please do not include names or personal details.

Please write your answer here:

Q01a. Overall, how would you describe that experience?

Please choose **only one** of the following:

- Very positive
- Somewhat positive
- Mixed
- Somewhat negative
- Very negative
- Prefer not to say

Q02. Who was involved in this experience?

Please choose **all** that apply:

- GP / family doctor
- Specialist doctor (e.g., psychiatrist (mental health), cardiologists (heart), dermatologists (skin))
- Nurse / midwife
- Allied health (e.g., physio, occupational therapist, dietitian)
- Pharmacist
- Reception / admin / practice staff
- Emergency department staff
- Hospital ward or outpatient clinic staff
- Other:

Section 2: What influenced how respected you felt

These questions ask about what shaped how respected you felt, in either a positive or negative way during your experience: {Q1}.

Q03a. What made you feel <u>more</u> respected during this experience?

Please select from 1 to 3 answers.

- Being listened to
- My concerns taken seriously
- How I was spoken to (tone, language, body language)
- Being believed
- Clear, easy-to-understand information
- Being asked what mattered to me

- Feeling safe to ask questions
- Respect for my cultural or personal background
- My privacy handled well
- Not having to repeat my story
- Being asked about my support needs (e.g., interpreter, mobility, sensory, communication)
- Being able to bring a support person
- Good coordination between different staff or services
- Enough time with the clinician
- Other:

Q03b. What made you feel less respected?

Please select from 1 to 3 answers.

- Not being listened to
- Feeling dismissed or not believed
- Information that was unclear or confusing
- Feeling judged or blamed
- Feeling rushed
- Lack of cultural understanding or sensitivity
- Feeling unsafe to ask questions
- Privacy not handled well
- Having to repeat my story
- Not being asked about support needs
- Not being able to bring a support person
- Poor coordination between staff or services
- Not enough time with the clinician
- Other:

Section 3: How staff treated you

These questions are about the behaviour of anyone you interacted with (clinical - such as doctors and nurses or administrative - such as the receptionist) during your experience: {Q1}.

Q04a. Thinking about staff during this experience, how often did each of the following happen?

Please choose the appropriate response for each item:

	Never	**Rarely**	**Sometimes**	**Often**	**Always**	**Don't know**
Staff treated me with courtesy and respect						
Staff listened without rushing						
Staff made incorrect assumptions about me						
Staff showed understanding of my cultural background or identity						
Staff showed compassion						

Q04b. And how often did you feel the following?

Please choose the appropriate response for each item:

	Never	Rarely	Sometimes	Often	Always	Don't know
I was recognised as a person, not just a case						
I felt spoken down to or not taken seriously						
I felt judged or blamed						
I felt I was treated unfairly because of my culture, background, or personal characteristics						
I felt safe to express cultural or personal needs						
I felt emotionally supported						

Section 4: Practical things that made the experience easier or harder

This section asks about practical or logistical factors, not staff behaviour, during your experience: {Q1}.

Q05. Which of the following affected your experience?

They may have helped or made things harder.

Please choose **all** that apply:

- Difficulty getting to the appointment (travel, transport, distance)
- Time pressures (work, caring responsibilities, appointment times)
- Limited availability of providers in my area
- Language or communication barriers (including interpreter needs)
- Unclear or unexpected costs
- Feeling anxious or stressed before or during the appointment
- Worrying that speaking up might affect my care
- My age
- My health condition (e.g., mental health, chronic illness, disability)
- None of these
- Other:

Section 5: How decisions were made

Q06. Thinking about decisions during this experience: {Q1}, which best describes what happened?

Please choose **only one** of the following:

- I was involved, and my views shaped the decisions
- I was asked for my views, but the clinician made the final decision
- Decisions were made for me with little or no discussion
- I'm not sure / it wasn't explained

Section 6: How the experience affected you

This section asks about how you felt after your experience: {Q1}.

Q07. How did this experience affect your: *

Please choose the appropriate response for each item:

	Much worse	A bit worse	No change	A bit better	Much better	Don't know
Understanding of your health or condition						
Confidence in managing your health						
Trust in healthcare professionals						
Willingness to seek care again						
Ability to follow the care plan						
Your overall wellbeing (physical or mental)						

Q08. Thinking about feeling respected (or not), which ONE of the following best describes its main impact on you?

Please choose **only one** of the following:

- It motivated me to look after my health
- It gave me more confidence to speak up in future care
- It strengthened my trust in healthcare
- It affected how well the care worked for me
- It made me feel anxious or stressed
- It led me to delay or avoid further care
- It didn’t make much difference
- None of these
- Other

Q09. Since this experience, have you done any of the following?

Please choose **all** that apply:

- Followed treatment or advice as recommended
- Asked more questions in later appointments
- Sought a second opinion
- Changed healthcare provider
- Delayed or avoided care because of cost
- Delayed or avoided care because of travel/time/distance
- Delayed or avoided care because I felt worried or anxious
- None of the above
- Other:

Section 7: Fairness and improvements

Q10. Do you think people like you (e.g., in your age group, location, background, health condition) are treated with the same level of dignity and respect as others?

Please choose **only one** of the following:

- Yes, mostly
- Yes, sometimes
- No
- Don't know

Q11. Which of the following would make the biggest difference to dignity and respect in healthcare?

Please select from 1 to 3 answers.

- More time in consultations
- Better communication skills
- Stronger expectations around respectful behaviour
- Greater involvement in decisions
- Better coordination between services
- More culturally-safe care
- Clearer explanations of options and risks
- Ability to bring a support person
- Accountability when disrespect occurs
- Being able to bring a support person
- Other:

Q12. What is one realistic change health services could make to help people feel more respected?

Please write your answer here:

Demographics

In this part of the survey, we ask a few questions about you—such as your age, gender, postcode and other general characteristics.

These questions help us understand who is participating in the panel and allow us to analyse the results of this and future surveys in meaningful ways.

Your responses will be kept **confidential** and used only for research purposes. You can skip any question you're not comfortable answering. Thank you for helping us ensure our research reflects a diverse range of perspectives.

D1. What is your age?

Please choose **only one** of the following:

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85 or over

D2. How do you describe your gender?

Note: Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents

Please choose **only one** of the following:

- Man or male
- Woman or female
- Non-binary
- I use a different term (please specify)

D3a. Where do you live?

	Please enter a four digit number	I don't know
Postcode		

D3b. Where do you live?

Only answer this question if the following conditions are met:

- I don’t know is selected at D3a

Please choose **only one** of the following:

- Sydney
- Rest of New South Wales
- Melbourne
- Rest of Victoria
- Brisbane
- Rest of Queensland
- Adelaide
- Rest of South Australia
- Perth
- Rest of Western Australia
- Tasmania
- Northern Territory
- Australian Capital Territory
- Outside Australia

D4. Do you identify as any of the following?

Please choose **all** that apply:

- Aboriginal and/or Torres Strait Islander
- Person with a disability
- Person with a chronic condition
- Person with a mental health experience
- Culturally and linguistically diverse (CALD)
- LGBTQIA+ person
- None of the above

Thank you for your feedback — it will directly shape how we run our future surveys. We'll share a short summary of what we hear with everyone who responds.

Thank you for completing this survey.