Consumers Health Forum of Australia

Speaking Up for Health:

Findings from the 2026 National Consumer Sentiment Survey



Consumers Health Forum of Australia (2026)
Speaking Up for Health: Findings from the 2026 National Consumer Sentiment Survey.

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Executive summary

The 2026 National Consumer Sentiment Survey is a nationally representative online survey of 5,178 Australian adults, conducted between 23 February and 23 March 2026.

Mind the gap: Australians experience a 'two-speed' health system

While Australians are generally positive about our health system, the results of CHF's 2026 National Consumer Sentiment Survey reveal a 'two-speed' experience of healthcare.

Those who can afford healthcare report greater trust and confidence in the system and are better able to access health services when and where they need it.

In contrast, respondents experiencing financial stress had substantially higher odds of reporting an unmet healthcare need after adjustment for other measured characteristics.

Cost was the most commonly reported reason for delaying or forgoing healthcare including nearly half of all respondents who did not fill prescriptions, 41 per cent of those who missed tests or treatment, 33 per cent of those who did not see a doctor when needed and 67 per cent of those who delayed dental care.

Differences in respondents' experience of accessing healthcare were associated not only with income, but also with:

- Age: younger adults (aged between 18 and 54 years) were more likely to have unmet needs compared with adults aged 55 years and over.
- Health status: people with one or more chronic condition were more likely to report unmet healthcare needs than those without a chronic condition.
- Private health insurance (PHI): respondents without PHI were more likely to report unmet healthcare needs than those with PHI.
- Geographic location: respondents living in rural, regional and remote locations reported lower access to services, such as after-hours care, and greater difficulty navigating the health system than those living in metropolitan areas.

Overall, respondents who experienced difficulty affording healthcare (38.9%) were substantially more likely to report decreased confidence in the health system than those who did not face affordability barriers (21.3%).

Compared with the 2024 and 2025 NCSS findings, socio-demographic disparities in healthcare access and experiences have persisted. Some measures showed modest improvement, including the proportion of respondents who reported usually seeing the same GP and perceived ease of accessing after-hours care.

The persistence of these disparities highlights an important equity challenge for government health reforms. Making some forms of care easier to access is welcome, but broad improvements alone are unlikely to close gaps in affordability and access unless they explicitly address the barriers faced by people experiencing the greatest disadvantage and poorest health outcomes. The findings reinforce the need to complement system-wide reforms with targeted support, so that people with the greatest need and fewest resources can benefit from improvements in care.

While overall patterns of access remained broadly consistent, there were small changes reported in the types of health services used by consumers. Use of urgent care and pharmacy services increased slightly, while use of hospital and specialist services declined slightly.

GP visits decreased marginally but remained the most accessed form of healthcare, with more than 82.5 per cent of respondents attending at least one appointment. The findings indicate that bulk billing was particularly important for respondents experiencing financial pressure, while continuity of care, including seeing the same GP, was most important to older respondents and people living with chronic conditions.

However, a GP visit is often only the start of a healthcare journey. People experiencing financial pressures must also consider the costs of specialist consultations, medicines, diagnostics and follow-up care. Indirect expenses, such as travel to appointments and time away from work or caring responsibilities, also influenced healthcare decisions and contributed to unmet need.

In-person consultations remained the primary way respondents accessed healthcare services. However, home visits declined, while attendance at virtual emergency departments almost doubled compared with the previous year.

Access to after-hours care improved slightly between 2024 and 2026 but remained more difficult for respondents facing financial, geographic, or language-related barriers.

Overall, respondents with chronic conditions were more likely to report poorer self-rated health and had fewer financial or system resources available to support their care.

As in previous surveys, access to mental healthcare and dental care remained two major areas of concern.

Half of all respondents reported having experienced a mental health condition or challenge at some point in their lives. However, only around one-quarter felt highly confident they could access mental health support quickly if needed.

Younger adults reported the highest levels of mental health need, with two thirds aged between 18 and 34 years reporting having experienced a mental health condition or challenge. Across all age groups, only 27 per cent were very or extremely confident they could access support quickly.

Mental healthcare pathways varied considerably by age. Older adults were more likely to consult a GP about mental health concerns, while younger adults were more likely to consider informal supports, specialist services or digital mental health support options.

However, as with physical health needs, more than half of respondents with relevant treatment experience reported stopping or delaying treatment because of cost, wait times or other barriers.

Dental care showed the clearest pattern of cost-related unmet need. Cost was the most commonly reported reason for delaying dental care, particularly among respondents without PHI. Nearly 60 per cent of respondents had delayed or avoided dental care at some point. Among respondents who delayed care, reported impacts included pain, difficulty eating, tooth loss, poorer wellbeing and worse mental health. Only around half of respondents had visited a dentist in the previous year, and 30.9 per cent reported seeking care for a specific issue.

Despite the access and equity challenges, 81 per cent of respondents who had received healthcare reported being satisfied with their care. While care was more difficult to manage when respondents needed to move between providers, particularly when they were required to repeat their medical history, small improvements were reported across most aspects of person-centred care. These included involvement in decision-making and having individual needs and preferences taken into account.

From a consumer perspective, the overall findings of the 2026 NCSS highlight several priorities:

- Improve the affordability of healthcare, including services beyond GP bulk billing.
- Expand access to mental health services by improving affordability and providing greater support to navigate the system.
- Reduce the cost of dental care, and improve access, particularly for people on lower incomes and those experiencing financial stress.
- Improve care experience and co-ordination, particularly for people with chronic or complex health needs and those facing affordability barriers.

Quotas and weighting were used to align the sample with key Australian population benchmarks, and the sampling approach was applied consistently across waves to support trend analysis. Due to methodology limitations, some populations remain slightly under-represented, including respondents who spoke a language other than English at home, respondents born overseas and people with limited digital access. This limits how fully the survey captures the diversity of experiences within these groups, but does not invalidate comparisons over time. Questions introduced in 2026, including GP costs and access to bulk billing GP appointments, provide baseline findings for future comparison in 2027.

For further information about the survey methodology, sampling and analysis, please refer to Appendix A.

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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
GP:	general practitioner
HLQ:	Health Literacy Questionnaire
IRSAD:	Index of Relative Socio-economic Advantage and Disadvantage
LGBTQIA+:	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual/Aromantic/Agender with the "+" [plus] signifying other sexual orientations, gender identities and sex characteristics not explicitly named
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

Foreword

There is plenty of public data about what our health system does: how many services are delivered, where money is spent and how programs perform. There is much less systematic evidence about how people actually experience that system. That is the gap the National Consumer Sentiment Survey fills. Funded by the Australian Government and now in its third consecutive year, the NCSS provides nationally representative, consumer-reported evidence about whether people can access care, afford it, navigate it and stay connected to it over time.

That matters because reform cannot be judged by activity alone. Government may know that more services have been funded or delivered. Consumer research helps show whether people can use them, whether they are improving people's experience of care, and who is benefiting. As the national independent peak body for health consumers, CHF adds evidence that administrative and service data cannot provide on their own: whether people can actually access, afford and sustain care. Over time, that contribution becomes even more valuable. One survey gives us a snapshot. Three years begin to show us what is shifting, what remains stubbornly fixed, and whether progress is being experienced equally.

That last question is particularly important now. Strengthening Medicare is intended to improve access to affordable, high-quality care and to reduce disparities in who can get the care they need. Our 2026 findings suggest that some things are improving. But improving the average is not the same as improving equity. Almost every respondent used a health service during the year, yet almost half still missed or delayed at least one type of care they needed. Among people experiencing financial stress, that rose to 77 per cent, compared with 34 per cent among those who were not. That tells us something important. High levels of service use can coexist with substantial unmet need.

Affordability remains the clearest divide. Nearly six in ten Australians said they had put off or avoided dental care at some point, with cost the most common reason for delay. Cost was also a major reason people missed medicines, tests, treatment and doctor visits. Bulk billing matters to most Australians, but it matters most to those with the least financial room to move. More than nine in ten respondents earning under $1,000 a week rated bulk billing as important, compared with fewer than eight in ten of those earning $4,000 or more. And while 53 per cent of respondents were confident they would receive safe, high-quality care if they became seriously ill, only 29.6 per cent were confident they could afford the care they would need. People may trust the care they would receive, while still doubting whether they could afford it.

Those barriers do not fall evenly across the population. Younger adults reported much higher levels of unmet need and financial stress than older Australians. Women were more likely than men to report unmet need, poorer mental health, delayed dental care and experiences of discrimination. Respondents who selected an LGBTQIA+ response to the sexual orientation question also reported particularly high levels of unmet need and poorer mental health. People in regional and rural communities reported greater difficulty accessing services and lower confidence navigating the health system.

There are positive signs too. More people reported usually seeing the same GP, and perceptions of access to after-hours care improved modestly. These gains matter and should be acknowledged. But the central question remains: Who is benefiting, and who is still being left behind?

That is why ongoing consumer monitoring matters. If Strengthening Medicare succeeds in making care easier to access on average, that is progress. The test is whether those gains are also narrowing the gaps experienced by people with the greatest health needs and the fewest resources. The NCSS gives governments, parliamentarians and health leaders a way to see that distinction. It complements expenditure, activity and clinical performance data with evidence about whether reforms are actually translating into care that people can access, afford and sustain. Its value will grow as the series continues. We will be able to see whether progress holds, whether stubborn gaps begin to close and whether the people who have historically missed out are finally benefiting.

Consumer experience should be part of how we judge whether reform is working. The measure of successful health reform is not only whether national averages improve, but whether progress reaches the people who need it most.

About the National Consumer Sentiment Survey

As the national peak body for health consumers, the Consumers Health Forum of Australia (CHF) plays a central role in capturing and representing consumer perspectives to inform health policy and system improvement.

This report presents findings from the 2026 National Consumer Sentiment Survey (NCSS), a nationally representative annual survey that provides a consumer perspective on Strengthening Medicare and broader health reforms.

First conducted in 2024, the NCSS enables tracking of changes in consumer attitudes and experiences over time, particularly in relation to access, affordability, quality of care and confidence in the health system.

The survey provides consumer-reported evidence and insights, complementing administrative and performance data.



Chapter 1: Consumer Insights from the National Consumer Sentiment Survey

The 2026 NCSS provides an updated picture of consumers' reported experiences, perceptions and interactions with the healthcare system. It captures how Australians experience healthcare, with a focus on access, affordability, quality of care, health needs, and confidence in the system.

While many Australians continue to report positive healthcare experiences, the 2026 NCSS findings also highlight ongoing system pressures and inequities. Rather than evaluating specific policies or programs, the survey examines how respondents experience healthcare and provides evidence to inform broader discussions about system performance and future reform priorities.

1.1 Why this is important

The NCSS provides a consumer perspective on health reform, offering evidence that complements administrative and service performance data while reflecting the lived experiences of Australians who use the healthcare system.

The survey provides insight into whether people can access and afford care, navigate the system, find the information and services they need, and experience care that is timely, coordinated, respectful and responsive. By examining experiences over time, the NCSS tracks whether consumer experiences change alongside developments in policy, funding, service delivery and models of care.

Consumers may report positive experiences in one part of the healthcare system, while encountering difficulties in another, such as moving between services or maintaining continuity of care. A consumer perspective brings these experiences together and helps identify where healthcare experiences may not align with the way services are designed, delivered or measured.

The NCSS series is built around a stable core set of questions established in 2024, which provides the baseline for tracking changes over time. This core has been supplemented with additional modules in 2026 to reflect emerging policy and health system priorities.

By providing nationally representative and consistent consumer experience data over time, the NCSS offers insights that extend beyond measures of consumer satisfaction. It identifies emerging patterns, disparities and persistent barriers, and highlights where policy objectives may not be reflected in people's experiences of care. It also helps identify where experiences are improving, where challenges remain, and which population groups are most affected.

These findings can support governments, policymakers and health system leaders to better understand consumer priorities and identify areas where further improvements may be needed.

Chapter 2: A two-speed health system

Australians experience the healthcare system differently. For many people, care is accessible and their experiences are positive. For others, particularly those experiencing financial pressure or managing greater health needs, care can be more difficult to access, navigate and sustain.

The experience of this 'two-speed' health system is associated not only with income, but also with factors such as age, health status and levels of system advantage, including higher income, socio-economic status and access to private health insurance (PHI).

2.1 Consistency across the findings

In 2026, 94.3 per cent of respondents reported using at least one healthcare service, yet almost half (49.5%) reported missing or delaying at least one type of care they needed. Accessing healthcare services does not necessarily mean people can obtain all the care they need, when they need it, or in a way that is affordable and sustainable.

The findings suggest that these differences are not explained by a single barrier, nor by a simple divide between those who can and cannot access care. Instead, three factors consistently emerge across the survey results: affordability, complexity of health need and system advantage.

Financial pressure can make it more difficult to access care or continue treatment. People with more complex health needs often interact with multiple health services and providers, creating additional challenges in accessing and coordinating care. By contrast, people with greater financial resources, private health insurance, confidence or familiarity with the health system may have more options for overcoming barriers to care.

As a result, people can experience the same health system in very different ways. Those with greater health needs and fewer resources may have limited options when care is unavailable, unaffordable or difficult to navigate. People with greater system advantage may be better positioned to overcome barriers through provider choice, private care or greater familiarity with the healthcare system.

These findings reinforce CHF's longstanding position that universal healthcare must be accessible and usable in practice, regardless of a person's financial circumstances, location or access to system resources.

2.2 Healthcare is experienced at different speeds

The term 'two-speed' is used in this report to describe a gradient of experiences, rather than suggesting that Australians fall into two distinct groups. People occupy different positions along a continuum of need and advantage, and these circumstances may change over time. Therefore, positive results at the national level do not necessarily indicate that the health system is working equally well for everyone.

Accordingly, the focus of this report is not only on whether the healthcare system is improving overall, but also on which groups are benefiting from those improvements, and which continue to face greater challenges in accessing and using care. The chapters that follow examine how affordability, complexity of health needs and system advantage influence different aspects of the healthcare experience.

A key finding of the 2026 survey is that high service use co-exists with substantial unmet need, particularly among people experiencing financial stress.

2.3 High use, persistent unmet need, and affordability pressure

High use did not eliminate unmet need

Figure 1: The coexistence of high levels of healthcare use and unmet need

94.3%
used at least one healthcare service in 2026
(*n* = 5,178)

49.5%
missed or delayed at least one type of care
(*n* = 5,178)

Financial pressure is the clearest divide: 77 per cent of respondents with financial stress had an unmet need, compared with 34.4 per cent of respondents with no financial stress. As Chapter 3 will show, cost was a common reason for missed care, especially dental care, prescriptions, and tests or treatment.

Financial stress widened the access gap

Figure 2: Respondents under financial pressure were much more likely to miss or delay care



(*n* = 1,834) **77.0%** of respondents with financial stress had an unmet need



(*n* = 3,345) **34.4%** of respondents with no financial stress had an unmet need

GP affordability was mixed

Figure 3: The new 2026 GP cost and bulk billing questions provide a baseline for consumer-reported experiences



Base: ^GP visits (n = 4,919); *Total (n = 5,178)

Chapter 3: High service use does not guarantee equitable or effective access

Access to healthcare remained uneven in 2026. Most respondents used at least one healthcare service, yet almost half reported missing or delaying care when they needed it. This key measure has remained largely unchanged over the last three years.

High levels of service use can coexist with substantial unmet need. Service use alone should not be mistaken for effective access. Effective access means being able to obtain the right care, at the right time, in a way that is affordable and sustainable.

3.1 Healthcare service use

Use of healthcare services remained high in 2026. Most respondents reported using at least one healthcare service in the past 12 months (94.3%), broadly consistent with previous survey waves (95.8% in 2025 and 95.3% in 2024). General practice remained the most commonly used point of care (82.5%), followed by pharmacies (71.8%) and dental or oral health services (49.9%).

While healthcare use remained high overall, utilisation declined slightly among some groups. Service use fell among younger adults aged between 18 and 34 years (92.6% to 89.1%), respondents with chronic conditions (98.9% to 97.1%), respondents who spoke a language other than English at home (LOTE) (96.5% to 92.4%), and respondents living in metropolitan areas (95.8% to 94.3%). Although these changes were modest, they suggest that patterns of service use were not equally stable across all population groups.

Overall, use of most health services remained broadly stable between 2024 and 2026, with GPs and pharmacies continuing to be the most commonly accessed services. However, despite high levels of service use, the key access indicator has not materially improved across the three surveys. Put simply, using healthcare services does not necessarily mean people are receiving all the care they need.

3.2 Barriers to access

Almost half of respondents (49.5%) reported missing or delaying at least one type of care in the previous 12 months, consistent with findings from 2025 (49.8%) and 2024 (50.0%).

There has been little change since 2024 in the proportion of respondents who were unable to access recommended care when needed. Dental care remained the most commonly missed or delayed service, followed by doctor visits and tests or treatment. Difficulty accessing prescriptions was less common and remained relatively stable over time.

Subgroup analyses showed that unmet need was not evenly distributed across the population. Financial stress, age, health status, and private health insurance status were the factors most strongly associated with access barriers.

Financial stress showed the strongest association with unmet need

Respondents experiencing financial stress had more than four times the odds of reporting unmet need after adjustment for other measured characteristics (OR = 4.26). In descriptive analyses, 77 per cent of financially stressed respondents reported unmet need in 2026, compared with 34 per cent of those not experiencing financial stress. This disparity changed little between 2025 and 2026.

Younger adults were more likely to experience unmet need

Older adults aged 55 years and over were significantly less likely to report unmet need than younger adults (55–74: OR = 0.47; 75+: OR = 0.25). By contrast, unmet need remained concentrated among younger and mid-life adults aged between 18 and 54 years, with little change over time (18–34: 62.2% to 61.8%; 35–54: 57.2% to 56.4%).

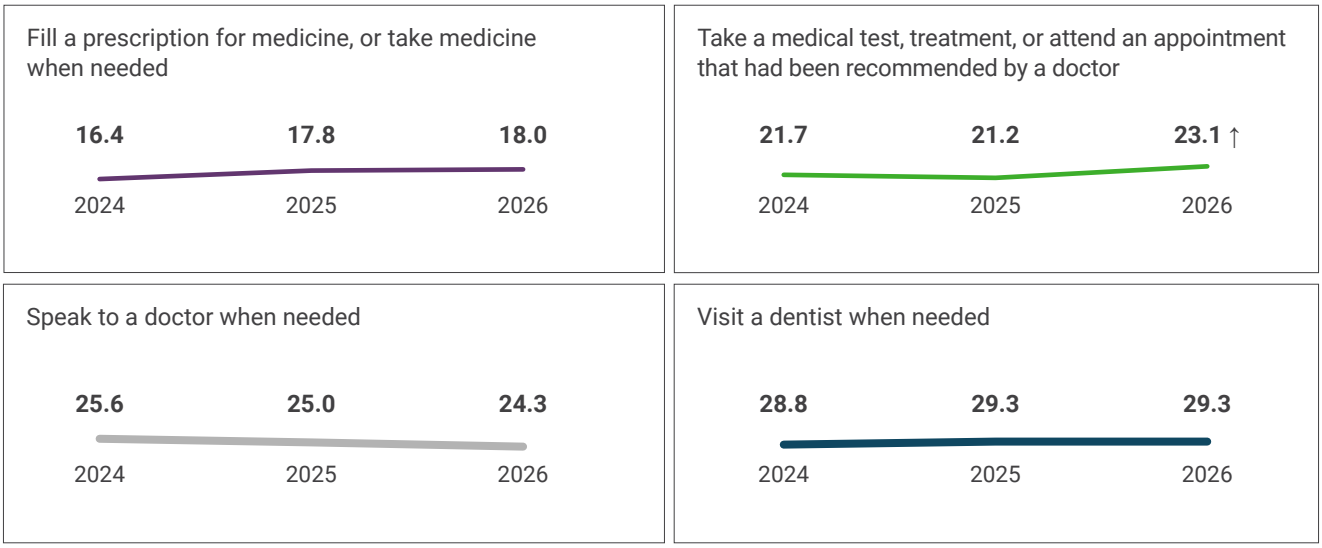
Health status was also associated with unmet need

Respondents with chronic conditions were more likely to report unmet need than those without chronic conditions (OR = 1.49), with levels remaining elevated between 2025 and 2026 (52.8% to 53.5%). Women also reported higher unmet need than men (52.8% compared with 45.6%; OR = 1.32).

Private health insurance was associated with lower unmet need[1]

Respondents with private health insurance were less likely to report unmet need after adjustment for other measured characteristics (OR = 0.61). In descriptive analyses, unmet need remained substantially higher among respondents without private health insurance (60.6% compared with 41.4% among those with PHI). Unmet need was also higher among respondents who selected an LGBTQIA+ response to the sexual orientation question (63.7% compared with 47.5% among heterosexual respondents). These patterns remained broadly stable between 2025 and 2026.

Figure 4: The proportion of respondents who reported not accessing recommended care when needed



Base: Overall (2024 *n* = 5,029, 2025 *n* = 5,160, 2026 *n* = 5,178)

3.3 Reasons for unmet healthcare needs

Cost was the most commonly reported reason for missing or delaying care across several service types. Cost was cited by just under 50 per cent of respondents who did not fill a prescription, 41 per cent of those who missed tests or treatment, 33 per cent of those who did not see a doctor when needed, and 67 per cent of those who delayed dental care[2].

Other barriers also contributed to unmet need. For respondents who missed a GP visit, appointment availability was a common issue, with 36 per cent reporting that a suitable appointment time was not available[3]. Competing priorities, particularly being 'too busy', also contributed to missed or delayed care across several service types. Psychosocial barriers, such as feeling embarrassed, unsafe, or expecting unfair treatment, were less commonly reported and changed little over time.

3.4 GP access and continuity of care

General practice remained the most commonly used entry point to the healthcare system in 2026. Respondents' preferences regarding GP access and continuity of care also remained highly stable over time.

Practical aspects of GP care, including location, availability of same-day appointments, bulk billing, and the ability to see the same GP over time, continued to be rated as important by most respondents. While the reported importance of bulk billing and continuity of care increased modestly since 2024, the overall pattern remained consistent.

1 PHI should be interpreted as a marker of relative advantage within the health system rather than a causal explanation for lower unmet need. The regression models adjust for income, socio-economic status, education and other key factors. Where PHI remains significant after adjustment, this indicates an independent association with lower unmet need, rather than evidence that PHI itself reduced levels of unmet need.

2 The 'tests or treatment' category is broad and should be interpreted with caution. It may include pathology, diagnostic imaging, procedures, specialist investigations, follow-up appointments, and other recommended healthcare services. The survey does not distinguish between these types of care. As a result, the findings should not be interpreted as evidence of access issues within any specific diagnostic, treatment or specialist service.

3 The response option 'the service was not available at a suitable time' may capture a range of access barriers. For some respondents, this may reflect difficulties fitting appointments around work, caring responsibilities, transport arrangements or other personal commitments. For others, it may indicate limited availability of care at the time when it was needed, including outside standard service hours. As the survey does not distinguish between these circumstances, and the findings should be interpreted as a broad measure of timing-related barriers rather than a specific indicator of service availability.

Income was strongly associated with the reported importance of bulk billing

The 2026 NCSS introduced new baseline measures relating to changes in GP out-of-pocket costs and access to bulk billing GP appointments. Separately, the survey continued to measure the importance respondents placed on bulk billing. The importance of bulk billing was highest among lower-income and financially constrained groups, including those unable to pay for healthcare (93.2%), those earning under $1,000 per week (91.7%), and those experiencing financial stress (91.2%). Lower importance was reported among higher-income respondents ($4,000 or more per week: 78.8%) and those with private health insurance (79.4%).

Bulk billing remained particularly important to respondents with fewer financial resources, and differences in its reported importance across population groups remained broadly stable between 2025 and 2026.

Age and chronic illness shaped the importance of continuity of care.

The importance placed on continuity of care varied substantially by age and health status. The importance of seeing the same GP rose from 75 per cent among those aged between 18 and 34 years to 89 per cent among those aged between 55 and 74 years and 93 per cent among those aged 75 years and over. Respondents with chronic conditions were also more likely to value continuity than those without chronic conditions (87.1% compared with 74.0%). This pattern reinforces the particular importance of ongoing and coordinated care for older adults and people with more complex health needs.

3.5 After-hours access[4]

Reported ease of accessing after-hours care improved modestly between 2024 and 2026. Fewer respondents described after-hours access as difficult, while slightly more reported that it was easy. These findings should be interpreted with caution. Among respondents who had used after-hours services, perceptions changed little over time.

Improvements were largely driven by respondents who had not used after-hours care, many of whom reported uncertainty about access. This suggests that overall findings may reflect perceptions of service availability as well as direct experience.

Analyses indicated that perceived ease of after-hours access was most strongly associated with affordability difficulty, age, geographic location, and language spoken at home.

3.6 Modes of access

In-person care remained the primary way respondents accessed healthcare in 2026. Patterns of telehealth use were mixed. Telephone consultations declined slightly since 2025, while video consultations, support lines, and virtual emergency departments increased modestly:

- 74.5% reported accessing care in person
- 33.9% reported telephone consultations, down from 38.2%
- 12.7% reported video consultations, up from 11.4%
- 3.5% reported using a virtual emergency department, up from 1.7%
- 5.2% reported home visits, down from 7.5%

3.7 What this means for our healthcare system

Chapter 3 shows that access is shaped by more than the availability of services. Consumers may face barriers related to cost, appointment availability, service location, work and caring responsibilities, or concerns about their experience of care. These factors often interact and affect people differently depending on their financial circumstances, health needs and personal circumstances.

Affordability was a major contributor to unmet need, particularly among respondents experiencing financial stress. However, cost alone does not explain all access challenges. The ability to access care at a suitable time and location, manage competing responsibilities, and maintain care over time also plays an important role.

For people with ongoing or complex health needs, continuity of care is an important aspect of access. The ability to see the same healthcare professional and receive coordinated care may influence both care experiences and healthcare outcomes.

The new measures relating to GP cost and bulk billing provide useful baseline information on consumer experiences and complement broader measures of access, continuity of care and healthcare affordability.

Taken together, these findings support a broader understanding of access: whether people can obtain the care they need, when they need it, at a cost they can manage and in a way that can be sustained over time. Service utilisation alone does not provide a complete picture of system performance. Understanding whether consumers are able to obtain the care they need after entering the healthcare system is equally important.

4 In this report, after-hours access refers to respondents' reported ability to obtain medical care outside usual service hours without attending an emergency department. The survey did not separately identify the type of service used, such as an after-hours clinic, medical deputising services or after-hours telehealth services. Accordingly, the findings should be interpreted as a measure of overall access to care outside usual service hours rather than access to any specific service type.

Chapter 4: Affordability shapes the whole healthcare journey

Healthcare costs added to wider household financial pressure in 2026.

Healthcare costs can accumulate across the care pathway, including costs related to consultations, medicines, tests, treatment, and follow-up care. Consumers may also face indirect costs such as travel to and from appointments, time away from work, childcare and other caring responsibilities, home modifications, and other expenses associated with managing health.

These costs are not experienced equally. For some households, healthcare expenses occur alongside broader cost-of-living pressures, influencing whether care feels affordable, manageable and timely.

Financial pressure can also influence how people engage with healthcare, including whether they seek or continue care, how they experience care, and whether they feel confident they could afford care if they became seriously ill. As a result, affordability can shape the healthcare journey and influence broader perceptions of the health system, including trust and satisfaction.

4.1 Financial stress

Financial stress remained persistent in 2026. In the previous 12 months, just over one-third of respondents (35.4%) reported at least one indicator of financial stress, virtually unchanged from the results in 2025 (35.6%). Levels of financial stress were broadly stable between 2025 and 2026, following increases observed since 2024.

While most respondents (64.6%) reported no indicators of financial stress, around one in five (21.3%) reported multiple forms of financial stress.

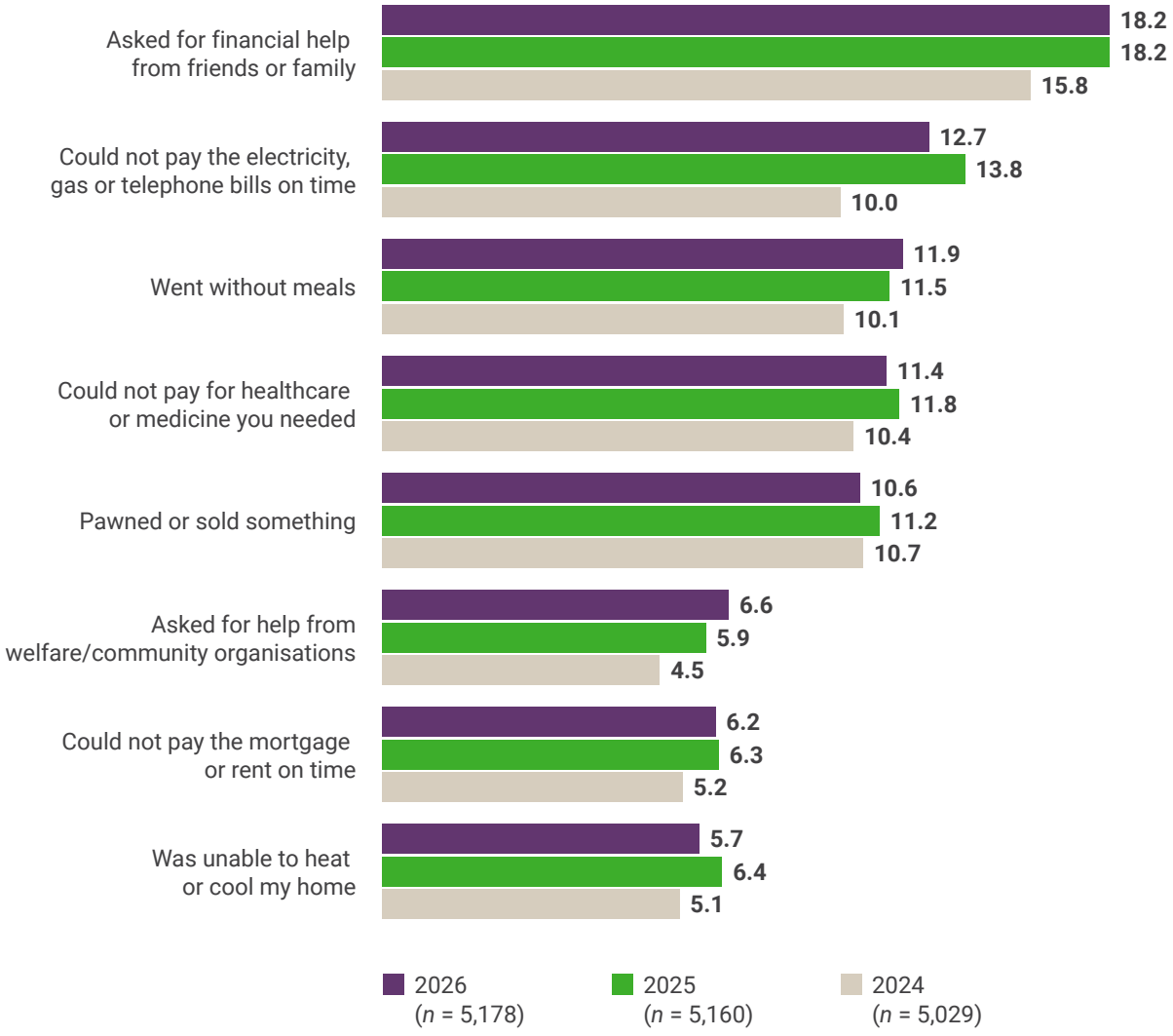
Financial stress was most common among younger adults and those experiencing greater health or financial vulnerability

Financial stress was most common among younger adults, affecting almost half of those aged between 18 and 34 years (49.7%) and more than two in five people aged between 35 and 54 years (42.7%). This compared with 20 per cent of those aged between 55 and 74 years and 9.6 per cent of those aged 75 years and over.

Financial stress was also more prevalent among lower-income respondents (47.5% of those earning less than $1,000 per week), people without private health insurance (48.6% compared with 26.0% of PHI holders), respondents with chronic conditions (40.9% compared with 26.1% among those without chronic conditions), respondents who selected an LGBTQIA+ response to the sexual orientation question (52.1% compared with 33.0% of heterosexual respondents), and people with disability (56.8% compared with 31.0% among those without disability).

There was little evidence of improvement between 2025 and 2026. Levels of financial stress remained broadly stable across most age, gender, socio-economic and geographic groups.

Figure 5: Financial stress indicators



4.2 GP costs and bulk billing

Respondents reported mixed experiences of GP costs and access to bulk billing in 2026[5]. As shown in Figure 6, 41.8 per cent of respondents reported paying less out of pocket, paying nothing, or mostly using bulk billing, while 24.6 per cent reported paying more for GP care[6]. Only 11.4 per cent said access to a bulk billing GP had become easier, compared with 25.5 per cent who said it had become harder. Among those reporting a change, worsening access to bulk billing was more common than improved access.

Younger adults were most likely to report easier access to bulk billing GP appointments

Analyses showed that respondents aged between 18 and 34 years were the most likely to report that access to bulk billing GP appointments had become easier. In 2026, 15.8 per cent of those aged between 18 and 34 years reported easier access, compared with 9.9 per cent of those aged between 35 and 54 years and 8.6 per cent of those aged between 55 and 74 years.

5 The GP out-of-pocket cost and bulk billing access questions were introduced in 2026 and should be interpreted as baseline measures. They capture respondents' perceptions of changes in GP costs and access to bulk billing GP appointments over the previous six months and are not directly comparable with earlier NCSS waves.

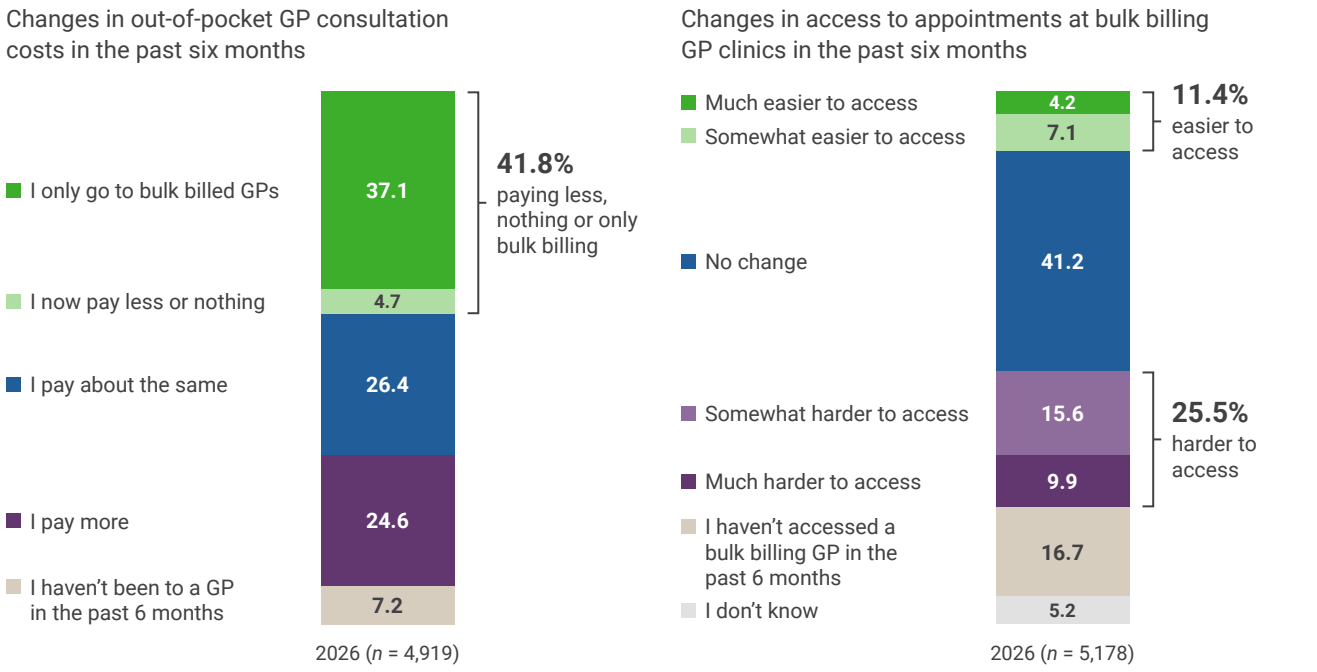
6 These response categories reflect respondents' reported experience and may overlap conceptually. For example, paying nothing out-of-pocket may reflect bulk billing, concession arrangements, third-party payment or other billing arrangements. The survey does not verify billing arrangements or identify the specific reason a respondent incurred no out-of-pocket cost.

Lower-cost GP care remained important for older adults and people facing financial constraints

The second affordability measure, paying less or nothing out of pocket for GP care, showed a broader pattern of reliance on lower-cost care. This was most common among older adults (46.8% of those aged 55–74 years and 57.4% of those aged 75 years and over), lower-income respondents (56.3% of those earning under $1,000 per week), and groups more likely to experience health or financial disadvantage. This included respondents with chronic conditions (47.0% compared with 32.5% of those without chronic conditions), those without private health insurance (54.7% compared with 32.6% of PHI holders), respondents in low socioeconomic status (SES) groups (49.8% compared with 31.5% in high SES groups), and people with disability (61.7% compared with 37.7% among those without disability).

GP affordability remained an important issue in 2026. While some respondents reported easier access to bulk billing GP appointments, more reported that access had become harder. Many respondents also continued to rely on lower-cost GP care, including paying less or nothing out- of-pocket. Together, these findings suggest that GP costs remained a significant consideration for many consumers, even though most respondents reported no change in their out-of-pocket costs.

Figure 6: Change in out of pocket GP consultation costs and changes in access to appointments at bulk billing GP Clinics



4.3 What this means for our healthcare system

The 2026 findings reinforce that, for many consumers, healthcare expenses occur alongside broader household financial pressures. Financial stress can reduce the resources available to meet healthcare costs.

Affordability is not a discrete barrier encountered at a single point in the healthcare journey. For some consumers, the challenge is not whether a particular service is affordable in isolation, but whether the combined costs of consultations, medicines, tests, treatment and follow-up care remain manageable over time.

Affordability is therefore closely linked to whether consumers can follow through with recommended care, rather than simply whether they can enter the healthcare system in the first place. It is also associated with consumer satisfaction, confidence in the health system and the ability to navigate care effectively.

Affordability can shape experiences across the healthcare journey. Universal healthcare is experienced as universal only when people can afford to access and use care when they need it. For the health system, this means affordability should be considered across the full care pathway, rather than assessed primarily through GP fees or bulk billing alone. Monitoring affordability across the healthcare journey would provide a more complete picture of whether consumers can access, continue with, and benefit from, healthcare in practice.

Chapter 5: Greater need does not equal easier access

Overall health status changed little in 2026, but chronic conditions remained common and continued to shape the level of healthcare need reported by respondents.

Healthcare need is not uniform. A substantial proportion of the population requires ongoing, coordinated and often multi-service care.[7] In Australia, chronic conditions are commonly managed through a combination of general practice, specialist, allied health and community-based services, with many consumers navigating care across multiple providers and settings over time.[8] As chronic conditions and multimorbidity become more common, coordination across the healthcare system becomes increasingly important. The distribution and complexity of health need influence how healthcare services are used and where gaps in access may have the greatest impact for consumers.[9]

5.1 Self-rated health and chronic conditions

Self-rated health remained broadly stable in 2026. The proportion reporting at least one chronic condition changed little, from 61.7 per cent in 2025 to 63.1 per cent in 2026. Similarly, 23.8 per cent reported fair or poor health in 2026, compared with 22.3 per cent in 2025, while 38.8 per cent reported excellent or very good health, compared with 38.2 per cent in 2025.

The overall pattern of chronic conditions changed little over time, although mental health conditions accounted for a slightly larger share of reported conditions in 2026.

Chronic conditions were the clearest marker of poorer self-rated health

Respondents with chronic conditions were significantly less likely to report excellent or very good health (OR = 0.34). This was reflected in the large difference in the proportion reporting excellent or very good health between respondents with at least one chronic condition (28.4%) and those without a chronic condition (56.6%).

Respondents who experienced difficulty affording care were also less likely to report excellent or very good health (OR = 0.64). Excellent or very good health was reported by 26.3 per cent of those unable to pay for healthcare when needed, compared with 43.3 per cent of those who did not report affordability barriers.

Better self-rated health was more common among respondents with greater financial resources

A strong socio-economic gradient was evident in analysis of self-rated health. Over half of respondents in high SES groups (50.3%) reported excellent or very good health, compared with 32.1 per cent of those in low SES groups. High SES was also independently associated with better self-rated health (OR = 1.89). Respondents earning $4,000 or more per week were more likely to report excellent or very good health (OR = 1.52) than those earning under $1,000 per week (53.5% compared with 31.8%).

Private health insurance (PHI) was also associated with better self-rated health (OR = 1.33). In 2026, 44.9 per cent of PHI holders reported excellent or very good health, compared with 30.3 per cent of respondents without PHI[10].

7 Srinivasan et al., "Depression and Comorbid Chronic Physical Health Diseases in the Australian Population: A Scoping Review."

8 Wang et al., "Chronic Illness, Subjective Wellbeing, and Health Services Availability: A Study of Older Adults in Australia"; Walker, "Multiple Chronic Diseases and Quality of Life: Patterns Emerging from a Large National Sample, Australia."

9 Baker et al., "Experiences, Perceptions and Expectations of Health Services amongst Marginalized Populations in Urban Australia: A Meta-ethnographic Review of the Literature"; Khatri and Assefa, "Drivers of the Australian Health System towards Health Care for All: A Scoping Review and Qualitative Synthesis"; Mengistu et al., "Successes and Challenges of Primary Health Care in Australia: A Scoping Review and Comparative Analysis."

10 Private health insurance should be interpreted as a marker of relative advantage within the health system, rather than a causal explanation for outcomes. While PHI is associated with factors such as income, SES, education and capacity to absorb out-of-pocket costs, the regression analyses adjust for these characteristics. Where PHI remains statistically significant after adjustment, it indicates an independent association with the outcome, rather than evidence that PHI itself causes the outcome.

5.2 What this means for our healthcare system

Chapter 5 shows that health need was not evenly distributed across the population. Chronic conditions and poorer self-rated health were more common among respondents with chronic conditions, lower socio-economic status, lower incomes, affordability barriers, no private health insurance, and respondents who selected an LGBTQIA+ response to the sexual orientation question.

People living with chronic conditions are more likely to require ongoing care and to have repeated interactions with the health system. This pattern has been evident across the NCSS series. However, greater use of healthcare services does not necessarily mean that care is easier to access, navigate or more responsive to their needs. In some cases, frequent contact with the health system may increase the demands placed on consumers as they manage appointments, referrals, follow-up care and information across multiple providers and settings.

This has important implications for how access is understood. High levels of service use among people with chronic illness should not be interpreted as evidence that their healthcare needs are being met effectively. Contact with the health system is not the same as successful access. A person may attend multiple appointments and still experience delays, unmet need, uncertainty about next steps or difficulty maintaining continuity of care. For consumers with more complex needs, the cumulative effort required to access and coordinate care can itself become a barrier.

Coordinated care should not depend on a consumer's ability to manage complexity within the healthcare system. Where care spans multiple providers or services, the system has a responsibility to make care pathways clear, connected and manageable. This is particularly important for people with ongoing healthcare needs.



5.3 Mental health need was high, but support was hard to sustain

Mental health need was widespread, but access and continuity of care remained uneven. In 2026, half of respondents reported having experienced a mental health condition or challenge, yet only around one-quarter were very or extremely confident they could access support quickly. GPs were the most commonly reported first point of contact for mental healthcare. However, ongoing treatment was often difficult to maintain, with more than half of respondents who had received treatment reporting that they had stopped or delayed treatment because of barriers to care.

Need was widespread

Figure 7: Mental health need was common across the survey population, with younger adults reporting the highest current and lifetime need

50.3%
had ever experienced a mental health condition or challenge
(*n* = 5,178)

27.3%
reported currently living with a mental health condition
(*n* = 5,178)

Confidence was low

Figure 8: Confidence in accessing support was low relative to the level of reported need



27.0%
were very or extremely confident they could access mental health support quickly.
(n = 5,178)

GPs were the main entry point

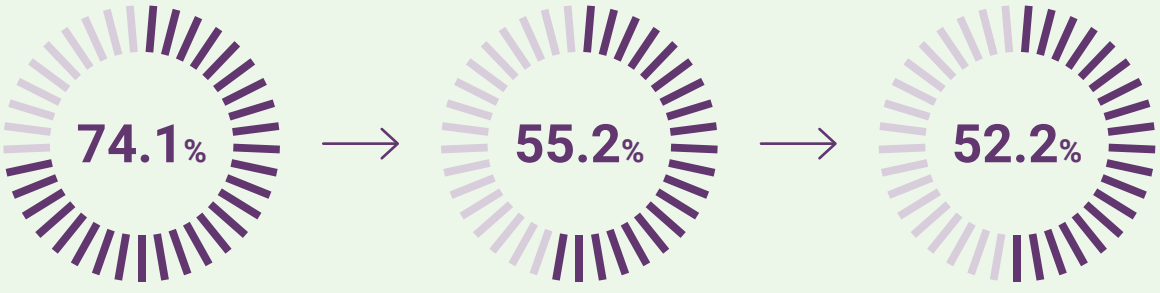
Figure 9: GPs remained the main first point of contact, but preferred pathways varied by age, need and type of support



65.3%
would go first to a GP for mental health support.
(*n* = 5,178)

Ongoing treatment was harder to sustain

Figure 10: The challenge was not only making first contact with care, but sustaining treatment when barriers arose



Respondents with a diagnosed mental health condition had a treatment plan
(n = 1,619)

Said ongoing treatment was easy to access
(*n* = 1,619)

With treatment experience: had stopped or delayed treatment because of barriers to care
(*n* = 1,619)

"Could not initiate contact (make the appointment) due to anxiety."

Female, 35-44 years old

Chapter 6: Mental Health: Getting into care is not enough

Mental health need was widespread in 2026, but many respondents were not confident they could access support quickly or maintain treatment when needed.

New data collected in the 2026 NCSS showed that only 27 per cent of respondents were very or extremely confident that they could access mental health support quickly if needed.

While access to an initial point of contact may be improving, maintaining ongoing mental health treatment remained challenging, with many respondents reporting delays or interruptions to care.

More than half of respondents with experience of mental health treatment reported having stopped or delayed treatment at some point, most commonly due to cost.

6.1 Mental health status

Mental health need remained widespread in 2026. As demonstrated in the data, around half of respondents (50.3%) reported having experienced a mental health condition or challenge at some point, while 27.3 per cent reported currently living with a mental health condition, up from 24.8 per cent in 2025. Self-rated mental health also indicated substantial need. Almost one-third of respondents (31.7%) rated their mental health as fair or poor, while 39.7 per cent rated it as very good or excellent.

Analyses showed that reporting excellent or very good mental health was most strongly associated with age, chronic condition status, affordability barriers, income, gender, and sexual orientation.

Younger adults reported the highest current mental health need

Age was one of the strongest predictors of self-rated mental health. Compared with younger adults, older adults were significantly more likely to report excellent or very good mental health, particularly those aged between 55 and 74 years (OR = 2.55) and those aged 75 years and over (OR = 4.39).

Younger adults also reported the highest prevalence of mental health conditions and challenges. Among respondents aged between 18 and 34 years, 62.3 per cent reported having experienced a mental health condition or challenge at some point in their lives, and 37.5 per cent reported currently living with a mental health condition. The prevalence of current mental health conditions among younger adults also increased from 31.4 per cent in 2025 to 37.5 per cent in 2026.

Mental health was poorer among respondents with chronic conditions and affordability pressures

Respondents with chronic conditions were less likely to report excellent or very good mental health (OR = 0.48). Just one in three (33.3%) reported excellent or very good mental health compared with 50.5 per cent of those without chronic conditions. They were also more likely to report having experienced a mental health condition or challenge (59.9% compared with 33.9%) at some point in their lives.

Affordability pressures were also associated with poorer self-rated mental health. Respondents who had difficulty affording healthcare were less likely to report excellent or very good mental health (OR = 0.51), as were respondents experiencing financial stress (OR = 0.64). Only 20.1 per cent of respondents unable to afford healthcare reported excellent or very good mental health, compared with 46.5 per cent of those who did not report affordability barriers.

Self-rated mental health also differed by income, gender and sexual orientation

Higher income was associated with better self-rated mental health. Respondents earning $2,000–$3,999 (OR = 1.49) and $4,000 or more per week (OR = 1.66) were more likely to report excellent or very good mental health than those earning less than $2,000 per week.

Women were less likely than men to report excellent or very good mental health (OR = 0.79), with positive mental health reported by 35.8 per cent and 43.8 per cent respectively.

Respondents who selected an LGBTQIA+ response to the sexual orientation question were also less likely to report excellent or very good mental health (OR = 0.64). Just over one-fifth (22.9%) reported excellent or very good mental health compared with just over two-fifths (42.1%) of heterosexual respondents.

Current mental health conditions were particularly common among respondents who identified as LGBTQIA+ (54.3%) and respondents with disability (54.5%). Lifetime experience of a mental health condition or challenge was also high in these groups, reported by 78.5 per cent of LGBTQIA+ respondents and 73.4 per cent of respondents with disability.

6.2 Access and confidence

Confidence in accessing mental health support was low relative to the level of self-reported need. In 2026, only 27 per cent of respondents reported being very or extremely confident that they could access support quickly if needed. A further 29.3 per cent reported low confidence and 35.4 per cent reported moderate confidence. Confidence in accessing support was moderate overall but was lower among respondents reporting a current mental health condition or challenge than among those without current or past mental health need.

Analyses showed that confidence in accessing mental health support was most strongly associated with affordability, private health insurance, gender, age, and income.

6.3 Care pathways

Respondents most often said they would first seek support from a GP for a mental health concern (65.3%). Other commonly nominated sources of support included friends or family (26.3%), specialist mental health services (19.4%), chat or phone support services (17.5%), online support services (16.2%), and government mental health information sources (8.5%). General practice remained the main entry point regardless of current mental health status. Many respondents also identified informal, specialist and digital support options as their preferred first point of contact.

Patterns identified across population groups suggest that preferred pathways to mental health support varied by age and level of need, reflecting differences in how people access and navigate care.

Younger adults were more likely to consider informal, specialist and digital supports

Preferred pathways differed markedly by age. Older adults were increasingly likely to nominate a GP as their preferred source of support, with the proportion rising from 45.1 per cent among those aged between 18 and 34 years to 78.9 per cent among those aged between 55 and 74 years and 86.7 per cent among those aged 75 years and over.

Younger adults were more likely to prefer a broader range of support options, including friends or family (39.7%), specialist mental health support (28.3%), chat or phone services (20.6%), online support services (21.8%), and government information sources (11.5%).

Respondents with higher reported need were more likely to nominate formal or specialist supports

Respondents with chronic conditions were more likely to nominate a GP as their first point of contact (69.4% compared with 58.3% among those without chronic conditions). They were also more likely to nominate specialist mental health support (21.3% compared with 16.2%).

A similar pattern was observed among respondents with disability, who were also more likely to nominate specialist mental health support (26.9% compared with 17.9% among those without disability).

Respondents who selected an LGBTQIA+ response to the sexual orientation question were more likely than heterosexual respondents to nominate specialist mental health support (31.3% compared with 18.0%) and less likely to nominate a GP (60.4% compared with 66.4% for heterosexual respondents).

6.4 Treatment access and barriers

Accessing ongoing mental health treatment appeared more difficult than making initial contact with care. Among respondents with a diagnosed mental health condition, 74.1 per cent reported having had a mental health treatment plan, and 66.7 per cent reported that these plans were easy to access. However, only 55.2 per cent reported that ongoing treatment was easy to access. This figure fell to 47.4 per cent among respondents without a treatment plan. As illustrated in Figure 10, delays and interruptions to care remained common, although the pattern differed depending on whether respondents had a treatment plan.

Wait times were a key barrier affecting continuity of care[11]. Only 15.4 per cent of respondents accessed care within one week, while 36 per cent waited up to four weeks and 28.8 per cent waited more than one month. Over half of respondents with relevant treatment experience (52.2%) reported having stopped or delayed treatment at some point because of barriers to care. This proportion was higher among respondents who had a mental health treatment plan (60.7%).

Subgroup analyses indicated that treatment disruption was concentrated among respondents with higher levels of need and financial stress, mirroring patterns observed for self-rated mental health and access to services.

11 The survey asked respondents whether they had ever stopped or delayed mental health treatment because of barriers to care. These findings should not be interpreted as meaning that all treatment ended before recovery or clinical completion. Mental health treatment may appropriately conclude when treatment goals have been achieved, symptoms have improved, or care is no longer required. The results reported here relate specifically to respondent-reported treatment interruptions or delays associated with barriers to accessing care.

Affordability barriers were closely linked to stopping or delaying treatment

Respondents experiencing financial stress were much more likely to report having stopped or delayed treatment because of barriers to care (71.4% compared with 33.9% of those not experiencing financial stress). They were also less likely to report that treatment was easy to access (50.1% compared with 60%) or that treatment provided through a mental health treatment plan was easy to access (61.6% compared with 72.5%).

A similar pattern was evident among respondents who reported being unable to afford healthcare. This group was more likely to report stopping or delaying treatment (73.4% compared with 37.6%), and less likely to report that treatment was easy to access (45.9% compared with 61.6%) or that treatment-plan access was easy (58.9% compared with 72.8%).

6.5 What this means for our healthcare system

The 2026 NCSS findings reinforce a central message about mental health care: getting into care is not enough if people cannot access support when they need it or sustain treatment over time.

The gap between reported mental health need and confidence in accessing timely support was substantial. Despite widespread experience of mental health conditions and challenges, only around one-quarter of respondents reported being very or extremely confident they could access support quickly if needed.

The findings reinforce the central role of primary care in Australia's mental health system. In 2026, GPs were the most commonly nominated first point of contact for mental health support (63%), underscoring their importance as a gateway to care.

However, ongoing treatment was often more difficult to sustain than initial access. More than half of respondents with treatment experience reported having stopped or delayed treatment at some point because of barriers to care. Treatment disruption was most common among younger adults, women, respondents experiencing financial stress, those unable to afford healthcare, and respondents with higher levels of need.

These findings should not be interpreted as evidence that treatment ended before clinical completion. Rather, they indicate that barriers to access were associated with interruptions or delays in the treatment journey. The findings suggest that entering care alone is not a sufficient measure of success if people are unable to continue treatment when needed.

As CHF has consistently highlighted, affordability appears to be an important part of this picture. Respondents experiencing financial stress were substantially more likely to report stopping or delaying treatment because of barriers to care, while those unable to afford healthcare reported both greater treatment disruption and greater difficulty accessing care.

Improving access to an initial point of contact remains important, but it may not be sufficient if consumers continue to face cost, availability, waiting time, or navigation barriers later in their care journey. Performance measures focused primarily on whether someone has entered care may overlook whether that care remains accessible and sustainable over time. The 2026 findings therefore highlight the importance of considering continuity of care and treatment sustainability alongside access when assessing whether mental health reforms are translating into meaningful consumer access.

Chapter 7: Dental care: the clearest affordability gap

Dental care showed the clearest pattern of association between affordability barriers, delayed care and reported impacts.

In Australia, dental care forms part of the broader healthcare system, but access and funding arrangements differ from many Medicare-subsidised services. Public dental services are available for eligible consumers, while many access dental care through private providers and face substantial out-of-pocket costs.[12] As a result, consumers may be more likely to delay or avoid dental care because of cost, contributing to unmet need and reported impacts on health and wellbeing.[13]

These findings highlight a tension within the system. While a large majority of respondents (89.1%) considered dental care to be part of healthcare, access remained closely associated with affordability and private payment arrangements.[14]

This pattern has remained consistent across the three years of NCSS reporting.

7.1 Access and use

Dental service use remained stable in 2026. Almost half (49.9%) of respondents reported visiting a dentist in the previous 12 months, compared with 48.2 per cent in 2025. Many visits were for routine care; however, 30.9 per cent of respondents sought care for a specific issue rather than for preventative care. This suggests that a substantial proportion of respondents accessed dental care in response to an immediate need rather than as part of ongoing prevention.

Analyses showed that dental service use was associated with private health insurance, age, affordability, gender, education, chronic condition status, and socio-economic status.

Private health insurance was strongly associated with dental use

Respondents with private health insurance were much more likely to have visited a dentist (OR = 2.45). In 2026, 61.4 per cent of PHI holders reported a dental visit, compared with 34.5 per cent of those without PHI.

This was one of the strongest associations between PHI and service use observed in the report. Consistent with the approach adopted throughout this report, PHI should be interpreted as a marker of relative advantage within the health system and access to additional care options, rather than a causal explanation for service use.

Older adults were more likely to use dental services

Dental service use increased with age. Compared with those aged between 18 and 34 years, older adults had higher odds of visiting a dentist (35–54: OR = 1.31; 55–74: OR = 2.33; 75+: OR = 2.44). This pattern was reflected in service attendance, which increased from 39.9 per cent among respondents aged between 18 and 34 years to 61.4 per cent among those aged between 55 and 74 years and 62.4 per cent among those aged 75 years and over.

Affordability barriers were associated with lower dental use

People who had difficulty affording healthcare were less likely to visit a dentist (OR = 0.59). Dental attendance was 34.8 per cent among those unable to afford healthcare, compared with 55.3 per cent among those without affordability barriers.

A similar pattern was observed for financial stress. Only 37.5 per cent of respondents experiencing financial stress reported a dental visit compared with 56.7 per cent of those not experiencing financial stress.

Other differences were present, but less pronounced

Women, people with post-school education, those in high socio-economic status (SES) groups, and those with chronic conditions were also more likely to report dental service use. For example, attendance was higher among women than men (52.4% compared with 47.4%), and higher among people in high SES groups than those in low SES groups (57.7% compared with 43.9%).

12 Proaño et al., “Oral Health Care Out-of-Pocket Costs and Financial Hardship: A Scoping Review.”

13 Crocombe et al., “Access to Dental Care Barriers and Poor Clinical Oral Health in Australian Regional Populations”; Sloan et al., “Primary Care Dentistry: An Australian Perspective.”

14 Jayasekara Liyana Patabendige et al., “Exploring Strategies for Enhancing Access to Oral Healthcare for Adults in Australia: A Scoping Review.”

Overall, dental service use remained stable, but utilisation was strongly associated with affordability and the resources available to meet out-of-pocket costs. People with private insurance and greater financial resources were more likely to access dental services, while those experiencing financial stress or difficulty affording healthcare were less likely to have visited a dentist.

7.2 Impacts of delaying or avoiding dental care

Delayed or avoided dental care was widespread in 2026, with almost six in ten respondents (59.5%) reporting that they had put off or avoided dental treatment at some point. Delayed care was commonly associated with pain, poorer wellbeing and impacts on daily function.

Nearly half of those who delayed care reported ongoing pain or discomfort (45.4%). Around one-quarter reported difficulty eating (23.4%) or tooth loss (23.2%) associated with delaying treatment.

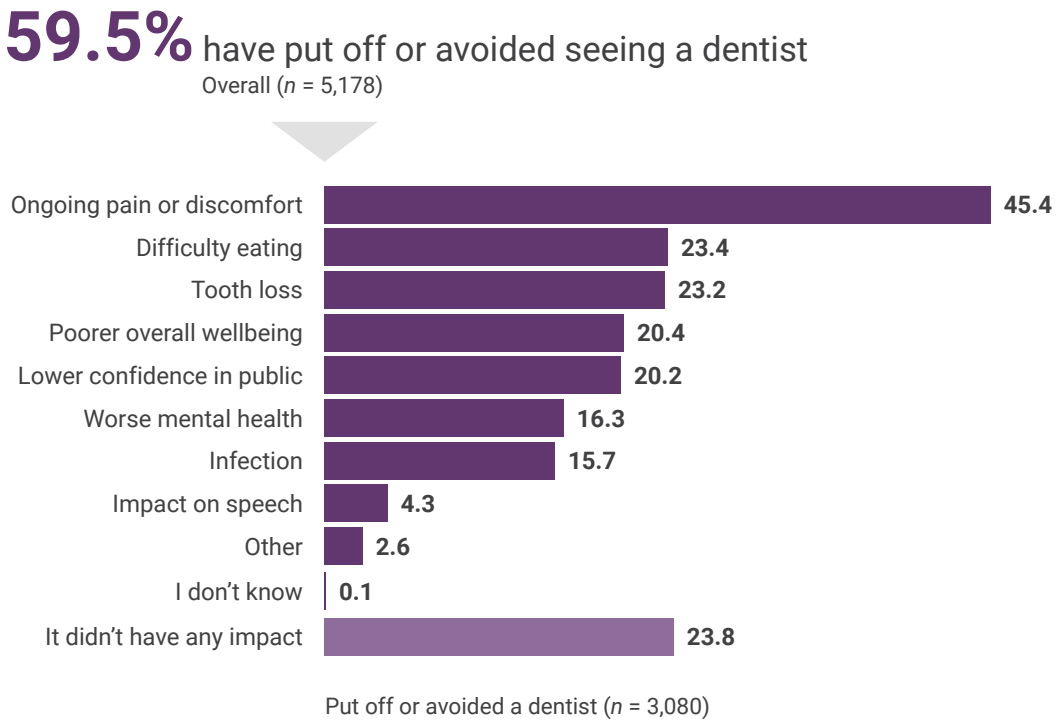
These findings suggest that delayed dental care was linked to significant impacts on everyday health, functioning and wellbeing.

Cost was the most common reason respondents delayed dental care

Respondents who were unable to afford healthcare were particularly likely to report delaying dental care (93.6% compared with 47.4% among those without affordability barriers). Similarly, those experiencing financial stress were much more likely to report delaying dental care (80.0% compared with 48.2% among those not experiencing financial stress).

These groups were also more likely to report broader impacts associated with delayed dental care. Among respondents experiencing financial stress, 28.4 per cent reported poorer overall wellbeing, compared with 13.2 per cent of those not experiencing financial stress. Worse mental health was also reported more frequently by those experiencing financial stress (26.6%) than by those who were not experiencing financial stress (6.9%).

Figure 11: Avoiding or delaying dental care was common and frequently associated with negative health, wellbeing, and functional impacts



Absence of private health insurance and lower SES were associated with greater delay in dental care

Respondents without private health insurance were more likely to report delaying dental care than those with PHI (74.5% compared with 48.8%). Similarly, respondents in low socioeconomic status groups (SES) were more likely than those in high SES groups to report putting off dental care (65.2% compared with 51.1%).

Groups experiencing greater health or social disadvantage reported more impacts

Respondents with chronic conditions were more likely to report delaying dental care (64.2% compared with 51.3% among those without chronic conditions). They were also more likely to report impacts on wellbeing (23.1% compared with 14.9%) and mental health (20.0% compared with 8.4%).

Mid-life adults and women were also more likely to delay dental care

Delayed care was most commonly reported among respondents aged between 35 and 54 years (71.0%). Women were also more likely than men to report having delayed or avoided dental care (65.3% compared with 53.0%).

7.3 High levels of support for dental care as part of healthcare

Support for dental care being considered part of the healthcare system was very high in 2026. Overall, 89.1 per cent of respondents agreed that dental care should be considered part of the healthcare system, including 66.1 per cent who strongly agreed.

Agreement was high across almost all population groups, although it was somewhat stronger among those most exposed to dental costs and unmet need.

7.4 What this means for our healthcare system

The high level of consumer support for dental care being considered part of the healthcare system is noteworthy. It reflects a widespread view that oral health is an integral part of overall health and that barriers to obtaining necessary dental care should not be considered separately from broader questions of equitable access to healthcare. Support was widespread across survey respondents and strongest among those most affected by dental costs and unmet need.

The persistent dental affordability gap identified across three waves of the NCSS is increasingly evident in its reported consequences for consumers. Delayed dental care was associated with substantial impacts on health and wellbeing. Cost was the most common reason respondents reported delaying care, and those who did so frequently reported pain, difficulty eating, poorer wellbeing, and worse mental health.

Dental care provides one of the clearest examples in the NCSS of how affordability influences access to healthcare in practice. The issue is not simply whether a person recognises a need for care, but whether they are able to act on that need when cost presents a barrier. Unlike many other areas of healthcare, dental care remains heavily reliant on private payment, private health insurance, and variable public provision. This creates a distinct access environment in which the ability to pay may influence whether care is received, delayed or avoided.

The 2026 findings add an important dimension to the picture established across previous NCSS waves. Dental care has consistently emerged as an area of unmet need, but this year's results provide greater insight into the reported consequences of delayed care. The focus therefore shifts from dental attendance as a measure of service use to whether people can access dental care when they need it. The key question is not simply whether people visit a dentist, but whether they can obtain care early enough to prevent problems from worsening and avoid negative impacts on health and wellbeing.

Dental affordability is a mainstream healthcare access issue. Taken together, these findings strengthen the case for systemic reform aimed at improving equitable access to dental care, consistent with the policy position advocated by CHF.

7.5 Care was rated well, but experience was uneven

In 2026, most respondents were satisfied with the healthcare they received and reported respectful treatment. Measures of person-centred care remained broadly positive, with incremental improvements since 2024. However, some groups reported less positive experiences. Satisfaction was lower among respondents experiencing affordability barriers while issues such as cost, service availability, feeling rushed and discrimination continued to affect how care was experienced.

Person-centred care

Figure 12: Person-centred care indicators



Base: 2024 (*n* = 5,029); 2026 (*n* = 5,178)

Chapter 8: Good care, fragmented journeys

Most respondents rated their care positively, but experiences were less positive for those facing barriers to affordability, access or navigation.

Experiences of healthcare quality are shaped not only by clinical care itself, but also by the conditions in which care is accessed and delivered. Factors such as time pressures, cost constraints, service capacity and continuity influence whether people feel listened to, involved in decisions, and supported to receive appropriate care.[15] While many interactions with healthcare providers were positive, experiences varied according to service type, complexity of care, and whether care was affordable, timely and accessible.[16]

Overall satisfaction with healthcare remained high and stable in 2026. In total, 81 per cent of respondents reported being satisfied with the healthcare they had received, similar to 81.6% in 2025. This indicates that most respondents who accessed care rated their overall experience positively.

Analyses showed that overall satisfaction was most strongly associated with affordability barriers, age, private health insurance, language spoken at home and internet engagement.

8.1 Overall experience

Affordability barriers were most clearly associated with lower satisfaction

Respondents who had difficulty affording care were less likely to report satisfaction (OR = 0.57) with healthcare. Satisfaction was lower among respondents who reported being unable to afford healthcare, with 71.1 per cent reporting satisfaction compared with 84.5 per cent of those who did not report affordability barriers. This suggests that affordability was associated not only with access to care, but also with people's experiences once care was accessed.

Similarly, satisfaction was lower among respondents experiencing financial stress. Overall, 72 per cent of respondents experiencing financial stress reported satisfaction, compared with 86 per cent of those who were not experiencing financial stress.

Older respondents and PHI holders reported higher satisfaction

Satisfaction tended to increase with age. Among respondents aged between 18 and 34 years, 73.6 per cent reported being satisfied with their healthcare, compared with 89.8 per cent of those aged 75 years and over. This pattern was also evident in the adjusted analysis, which showed higher odds of satisfaction among older respondents.

Respondents with private health insurance were also more likely to report satisfaction with their healthcare (OR = 1.47). Overall, 84.9 per cent of PHI holders reported satisfaction, compared with 75.9 per cent of respondents without private health insurance.

Language differences were also evident

Respondents who spoke a language other than English (LOTE) at home were less likely to report satisfaction (OR = 0.68) with their healthcare. Overall, 72.9 per cent reported satisfaction, compared with 82.4 per cent of those who spoke English only at home.

8.2 Experience Measures

Person-centred care remained a strength of the healthcare system in 2026, with some signs of improvement over time. Since 2024, the proportion of respondents reporting positive experiences has increased across several indicators, including providers making sure they received the best care possible (72.9% to 75.9%), involving them in decisions (69.6% to 72.9%) and taking their needs, priorities and preferences into account (66.2% to 69.9%).

The clearest improvement between 2025 and 2026 was in respondents feeling that their opinions about their own health and treatment were valued, increasing from 60.8 per cent to 63.5 per cent. Together, these findings suggest modest improvements in communication, involvement in decision-making and recognition of consumers' views.

15 Kwame and Petrucka, "A Literature-Based Study of Patient-Centered Care and Communication in Nurse-Patient Interactions: Barriers, Facilitators, and the Way Forward"; Parkinson et al., "Putting the Consumer First: Creating a Consumer-Centred Health System for a 21st Century Australia. A Health Policy Report."

16 Hobden et al., "Experiences of Patient-Centered Care Among Older Community-Dwelling Australians."; Rahja et al., "What Is Important to Older People When Accessing Urgent Health Care: Key Considerations and Recommendations From Consumer Consultations."; Snoswell et al., "How Do Consumers Prefer Their Care Delivered: In-Person, Telephone or Videoconference?"

Financial stress was associated with less positive care

Respondents experiencing financial stress were less likely to report positive experiences across most measures. For example, 65.5 per cent reported that providers made sure they received the best care possible, compared with 81.6 per cent among those not experiencing financial stress. Similarly, fewer felt their needs were considered (59.7% compared with 75.5%) or that their opinions were valued (55.1% compared with 68.1%).

They were also more likely to report feeling rushed during appointments (33.7% compared with 18.1%) and to identify cost as a serious barrier to care (50.6% compared with 15.1%).

Younger adults reported less positive care experiences

Younger adults were less likely than older age groups to report positive care experiences.

Among respondents aged between 18 and 34 years, 62.9 per cent felt they received the best care possible, 60 per cent said their needs were considered, 59.4 per cent felt their opinions were valued and 54.8 per cent reported being able to access care at a time and place that suited them. They were also more likely to report feeling rushed during appointments (36.6%) and to identify cost as a serious barrier (41.2%).

Other groups also reported poorer experiences

Respondents with disability, those who selected an LGBTQIA+ response to the sexual orientation question, and those without private health insurance also reported fewer positive experiences across several experience measures, particularly in relation to access, cost and feeling valued in care decisions.

In contrast, respondents with private health insurance generally reported more positive experiences across most indicators.

8.3 Perceived quality of care by provider type

Perceived quality of care remained high across most service types in 2026. Positive ratings (very good and good) were highest for dental services (89.8%) and pharmacies (89.0%). Ratings were lower for hospitals (74.5%), psychology services (74.4%), urgent care services (72.6%), Aboriginal Community Controlled Health Services (64.9%) and pain clinics (63.2%).

Differences in ratings may reflect variation in service context, urgency, complexity of care and consumer expectations. Services used during urgent, complex or ongoing episodes of care may be experienced differently from routine or familiar care settings. For this reason, differences between service types should not be interpreted as direct comparisons of provider quality alone.

Affordability pressures were associated with lower quality ratings

Respondents experiencing financial stress were less likely to rate dental and GP services positively.

For dental services, 78.7 per cent of respondents experiencing financial stress reported positive quality ratings, compared with 93.9 per cent of those not experiencing financial stress. Positive ratings were also lower among respondents who were unable to afford healthcare (77.2%) than among those without affordability barriers (92.6%).

A similar, though smaller, pattern was evident for GP care. Positive GP ratings were reported by 80.3 per cent of respondents experiencing financial stress, compared with 90.7 per cent of those not experiencing financial stress. Among respondents unable to afford healthcare, GP quality was rated positively by 81.6%, compared with 89.1% among those without affordability barriers.

PHI holders and older respondents rated quality more positively

Respondents with private health insurance (PHI) were more likely to rate both dental and GP care positively than those without PHI. For dental care, 93.6% of PHI holders reported a positive rating, compared with 80.4% of respondents without PHI. For GP care, the equivalent figures were 89.5 per cent and 83.5 per cent respectively.

Positive ratings also increased with age, particularly for GP care. Ratings rose from 76.7 per cent among respondents aged between 18 and 34 years to 97.4 per cent among those aged 75 years and over.



8.4 What this means for our healthcare system

The 2026 findings are broadly consistent with previous survey waves. When consumers interact with healthcare professionals, their experiences of care are generally positive. Overall satisfaction, person-centred care and perceived quality remained strengths across many provider types.

Person-centred care indicators remained broadly stable between 2025 and 2026. The clearest improvement was in respectful treatment, with the proportion of respondents who said they were treated with respect often or always increasing from 86.5 per cent to 88.9 per cent.

However, these positive experiences were not shared equally. Respondents who reported experiencing affordability or access barriers, people with disability, respondents who spoke a language other than English at home and respondents who selected an LGBTQIA+ response to the sexual orientation question were less likely to report positive experiences on some measures.

The findings highlight an important distinction between the experience of individual healthcare encounters and the experience of navigating the healthcare system as a whole. While many consumers reported positive interactions with healthcare professionals, affordability, access, and navigation barriers continued to shape the broader care journey.

Maintaining the strengths of person-centred care while addressing these broader system barriers will be important for improving healthcare experiences across the full consumer journey. These broader system challenges are explored further in the following chapter.

Chapter 9: Challenges in navigation, communication and coordination

Navigating care became more challenging when respondents needed to move between providers and services.

As people move across different parts of the healthcare system, effective care depends on coordination between providers and consumers' ability to navigate services over time.[17] While many interactions with healthcare providers are positive, consumer experiences can vary depending on how well services work together. Communication between providers, care planning, discharge processes, service availability and waiting times can all affect how easy care is to access and navigate.[18]

Experiences also varied according to access and timeliness, with barriers such as cost, waiting times and service availability shaping experiences across population groups and care settings.[19]

9.1 Health literacy and navigation

The NCSS measured healthcare navigation using Domain 7 of the *Health Literacy Questionnaire* (HLQ)[20] which assesses how easily people can find, access and engage with healthcare services. In 2026, the average HLQ Domain 7 score was 3.51, slightly higher than 3.48 in 2025. This placed the overall score just above the level at which navigation tasks are generally considered manageable rather than difficult.

Navigation scores were most strongly associated with affordability barriers, geography, age, private health insurance and socioeconomic status.

Affordability barriers were associated with lower navigation scores

Respondents who reported difficulty affording care found the healthcare system harder to navigate than those without affordability barriers. Average navigation scores were 3.15 among those experiencing affordability barriers, compared with 3.64 among those without. This difference remained evident in the adjusted analysis, where affordability barriers were the strongest independent predictor of lower navigation scores ($\beta = -0.32$).

Respondents experiencing financial stress also reported greater difficulty navigating the healthcare system (average score 3.25 compared with 3.66 among those not experiencing financial stress). This association remained significant in the adjusted model ($\beta = -0.13$).

Together, these findings suggest that affordability was associated not only with access to care, but also with how easy the healthcare system felt to navigate.

Navigation scores were lower outside metropolitan areas

Respondents living in metropolitan areas reported higher navigation scores (3.57) than those living in regional (3.42) and rural or remote areas (3.39).

These differences remained evident in the adjusted analysis. Living in a regional or rural area was independently associated with lower navigation scores ($\beta = -0.13$ and $\beta = -0.16$, respectively). This suggests that place of residence was associated with how easy the healthcare system felt to navigate.

Older respondents reported greater ease navigating the system

Navigation scores tended to increase with age. Average scores rose from 3.42 among respondents aged between 18 and 34 years to 3.78 among those aged 75 years and over. This pattern was also evident in the adjusted analysis, where respondents aged between 55 and 74 years and 75 years and over had significantly higher navigation scores ($\beta = +0.18$ and $\beta = +0.30$, respectively).

Although the survey cannot determine the reasons for this age pattern, one possible explanation is that older adults had more experience navigating the healthcare system.

17 Hartati et al., "Care Navigation and Coordination Program on Reducing Hospital Use for Adults with Complex Health and Psychosocial Needs in Southwest Sydney, Australia"; van der Gaag et al., "The Importance of Health Literacy for Self-Management: A Scoping Review of Reviews."

18 Harrison et al., "Patients' Experiences in Australian Hospitals: A Systematic Review of Evidence."; Rapport et al., "What Do Patients Really Want? An in-Depth Examination of Patient Experience in Four Australian Hospitals."

19 Butler et al., "Does Use of GP and Specialist Services Vary across Areas and According to Individual Socioeconomic Position? A Multilevel Analysis Using Linked Data in Australia."; Demant, "Access Denied: Financial, Structural, and Personal Barriers to Health Service Use in a Universal Health System."

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

Private health insurance and higher SES were associated with stronger navigation scores

Respondents with private health insurance reported higher navigation scores than those without PHI (3.60 compared with 3.39). This difference remained significant in the adjusted analysis (β = +0.07).

Respondents in high socio-economic status (SES) groups also reported higher navigation scores than those in low SES groups (3.61 compared with 3.42). High SES remained independently associated with stronger navigation scores in the adjusted analysis (β = +0.09).

9.2 Navigation confidence

Most respondents felt confident in accessing and engaging with healthcare services. In 2026, 73.7 per cent agreed that they knew how to access the healthcare they needed, 6.8 per cent disagreed, 18.7 per cent neither agreed nor disagreed and 0.8 per cent selected 'I don't know' as their response.

Most respondents also reported being able to work with health professionals to make decisions about their care (86.5%) and to understand the information they received (77.4%).

Affordability barriers were associated with lower navigation confidence

Respondents without affordability barriers were more likely to feel confident navigating care. Almost four in five (78.8%) reported knowing how to access the care they needed, compared with 59.1 per cent of respondents who reported being unable to afford healthcare. They were also more likely to report being able to work with health professionals to make decisions about their care (88.6% compared with 80.3%).

A similar pattern was evident among respondents experiencing financial stress. Those who were not experiencing financial stress were more likely to report that they knew how to access care (79.4% compared with 63.3%) and more likely to report that providers made sure they understood information about their health and treatment (81.1% compared with 70.7%).

These findings suggest that affordability was associated not only with access to care, but also with how prepared and supported people felt when engaging with the healthcare system.

Some groups reported lower confidence navigating care and understanding health information

Younger adults were less likely than older respondents to agree that they knew how to access the care they needed, consistent with the broader health literacy findings reported in Section 9.1.

Respondents who selected an LGBTQIA+ response to the sexual orientation question also reported lower confidence in knowing how to access care (68.0% compared with 74.8% among heterosexual respondents). They were also less satisfied with how information about their health and treatment was communicated (65.9% compared with 76.1%).

9.3 Multiple providers

Many respondents received care from multiple healthcare providers in 2026, making coordination an important part of their overall care experience.

Respondents reported substantial use of GPs, pharmacists, nurses, specialists and allied health providers, and many saw more than one provider within the same category. For example, 36.4 per cent reported seeing two or more GPs. This occurred despite continuity of GP care remaining important to many respondents and care involving multiple providers was common, particularly for GPs and pharmacists.

Higher levels of service use were more common among respondents with chronic conditions and disability, reflecting the greater care demands associated with ongoing health needs.

9.4 Coordination experience

Reported experiences of care coordination were mixed in 2026. Many respondents reported positive experiences, but challenges remained in information sharing and continuity.

Additionally, 66.9 per cent of respondents reported that providers had access to up-to-date information, 57.4 per cent reported effective communication between providers, and 57 per cent felt their care was well coordinated.

However, only half of respondents (50.8%) reported that they did not need to repeat their medical history. This suggests that information did not always flow smoothly between providers.

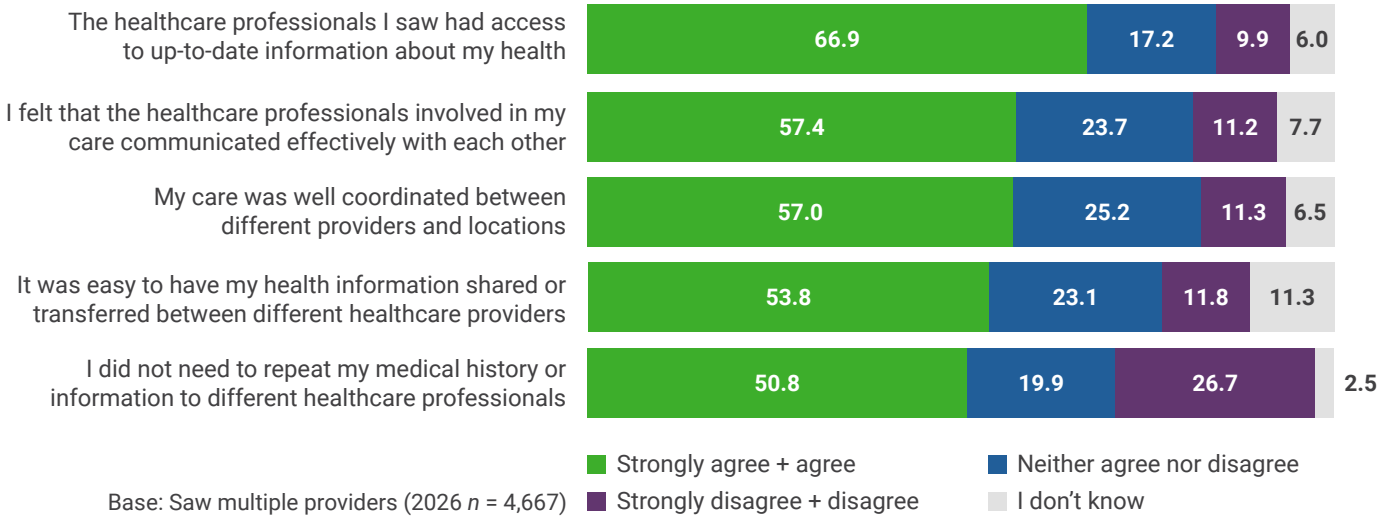
Subgroup analyses indicated that experiences of coordination were associated with financial stress, access conditions and complexity of need, with coordination challenges becoming more evident among respondents with higher or more complex care needs.

Financial pressure was associated with less positive coordination experiences

Respondents experiencing financial stress reported less positive experiences of care coordination. They were less likely to report that providers had access to up-to-date information (60.9% compared with 70.1% among those not experiencing financial stress), that providers communicated effectively with each other (52.9% compared with 59.8%), or that they did not need to repeat their medical history (41.3% compared with 56.0%).

This pattern was consistent with the findings presented in Section 9.1, where financial stress and affordability barriers were associated with greater difficulty navigating the healthcare system. Together, these findings suggest that navigation and coordination challenges may be amplified when consumers face financial barriers or have more complex care needs.

Figure 13: While most respondents reported some level of care coordination, challenges remained, particularly in information sharing and avoiding repetition



Older respondents reported more positive coordination experiences

Coordination experiences generally became more positive with age. The proportion of respondents who reported that their healthcare providers had access to up-to-date information increased from 65 per cent among young adults aged between 18 and 34 years to 77.6 per cent among those aged 75 years and over.

Similarly, the proportion reporting that they did not need to repeat their medical history increased from 47.3 per cent among younger adults to 66.6 per cent among those aged 75 years and over.

Coordination experiences were less positive for respondents with complex needs

Respondents with chronic conditions were less likely to report that they did not need to repeat their medical history (47.1% compared with 57.9% among those without chronic conditions). A similar pattern was evident among people with disability, with 37.9 per cent reporting that they did not need to repeat their medical history, compared with 53.6 per cent of those without disability.

Respondents who selected an LGBTQIA+ response to the sexual orientation question also reported less positive coordination experiences of care coordination. They were less likely to agree that they did not need to repeat information between healthcare providers (43.3% compared with 52.1% among heterosexual respondents) and less likely to report effective communication between providers (53.2% compared with 58.4%).

9.5 What this means for the healthcare system

These findings reinforce that most consumers feel able to access, navigate and engage with healthcare. However, experiences become more challenging when care involves multiple providers, services or organisations. While confidence in navigating care was generally high, it was lower among respondents experiencing affordability barriers.

Care involving multiple providers was common, particularly among people with chronic conditions, disability and other ongoing health needs. In these circumstances, effective coordination becomes an essential component of safe, continuous and person-centred care.

One of the clearest indicators of fragmentation was that only around half of respondents reported not needing to repeat their medical history or other information when receiving care from multiple providers. Respondents experiencing financial stress, those with chronic conditions or disability, and those who selected an LGBTQIA+ response to the sexual orientation question were more likely to report repeating information or experiencing weaker communication between providers.

When consumers are required to carry, repeat or coordinate information that should already be available within the healthcare system, they are effectively bridging gaps between providers themselves. This creates an additional and unnecessary burden and may affect continuity of care, efficiency, safety and the overall consumer experience.

The findings highlight an important distinction between how services are connected within the healthcare system and how connected care is experienced by consumers. Referral pathways, information systems and formal relationships between providers are important, but they only translate into connected care when information is available to the right professionals at the right time and communication occurs effectively.

Consumers should not have to act as the messenger, checker or coordinator between providers. Responsibility for maintaining continuity of information and managing the risks associated with communication gaps should sit with the healthcare system.

As in previous chapters, these experiences were not distributed evenly across the population. Respondents experiencing financial stress and those with chronic conditions or disability reported less positive experiences of care coordination. These findings should not be interpreted as evidence that financial stress or more complex health needs cause poorer coordination. Rather, they highlight where gaps in coordination may place greater demands on consumers, particularly where care already involves multiple providers.

Taken together, the findings suggest that connected care should be assessed from the consumer's perspective, not only through the structures and relationships that exist between providers. A connected healthcare system is one in which information moves with the consumer, providers communicate effectively and care is experienced as continuous across service and organisational boundaries.



Chapter 10: What consumers can see and use

Awareness increased for some health programs, but visibility did not always translate into use or registration.

Consumer awareness of national health programs depends on more than a program's existence. It also depends on whether people recognise the program, understand its purpose and see it as relevant to their own care.[21] Awareness does not arise from availability alone. Differences between awareness, self-reported registration and reported use provide insight into how visible programs are to consumers, and whether people understand how these programs fit into their healthcare experiences.[22]

10.1 Medicare & MyMedicare[23]

Medicare coverage remained almost universal in 2026, with 97.5 per cent of respondents reporting that they had a Medicare card. This remained consistently high across major population groups, reflecting Medicare's role as the foundation of access to healthcare in Australia.

Consumer-reported awareness of MyMedicare increased substantially, rising from 32.8 per cent in 2025 to 46.3 per cent in 2026. However, this increase in awareness was not matched by the same increase in self-reported registration.

These findings should be interpreted with caution because the 2026 survey introduced MyMedicare using simpler and more direct wording, which may have improved recognition of the program name.

Awareness was higher among younger and more healthcare-engaged respondents

Analyses showed that awareness of MyMedicare was not evenly distributed across the population. More than half of respondents aged between 18 and 34 years (52.1%) reported being aware of MyMedicare. In the adjusted analysis, older respondents had lower odds of reporting awareness (35–54: OR = 0.68; 55–74: OR = 0.74).

Awareness was also higher among respondents with chronic conditions (47.8%; OR = 1.30), respondents with private health insurance (47.7%; OR = 1.21) and respondents experiencing financial stress (51.0%; OR = 1.33).

Respondents who used the internet less frequently were less likely to recognise the program. Those with low internet use had lower odds of awareness than respondents who used the internet three or more times a day (OR = 0.69).

These findings suggest that awareness of the program may be higher among people who have greater contact with, or interest in, the healthcare system, although the survey cannot determine the reason for these differences.

Self-reported registration lagged behind awareness

Among respondents who were aware of MyMedicare, just over half (54.1%) reported being registered. However, uncertainty about registration remained common. These findings should be interpreted as a measure of consumer understanding and recall rather than administrative registration status.

Overall, self-reported registration changed little. The clearest increase was among respondents with post-secondary education, rising from 49.5 per cent in 2025 to 55.9 per cent in 2026.

Although MyMedicare became more visible to respondents in 2026, awareness increased more rapidly than self-reported registration. Some of the increase in reported registration may reflect clearer survey wording. The findings may also suggest that awareness of MyMedicare has grown more quickly than consumers' understanding of registration and whether they are registered.

10.2 My Health Record

Consumer-reported awareness and use of My Health Record both increased in 2026.

Awareness rose from 70.2 per cent in 2025 to 82.6 per cent in 2026, while reported use increased from 38.2 per cent to 53.7 per cent. My Health Record was the clearest example in this chapter where increased awareness was accompanied by increased use.

21 Lin et al., "Uptake of Patient Enrolment in Primary Care and Associated Factors: A Systematic Review and Meta-Analysis"; Holt et al., "Knowledge of Australia's My Health Record and Factors Associated with Opting out: Results from a National Survey of the Australian General Population and Communities Affected by HIV and Sexually Transmissible Infections."

22 Krahe et al., "Factors That Influence Digital Health Implementation in Rural, Regional, and Remote Australia: An Overview of Reviews and Recommended Strategies."; Baker et al., "Experiences, Perceptions and Expectations of Health Services amongst Marginalized Populations in Urban Australia: A Meta-ethnographic Review of the Literature"; Buckley et al., "Community Awareness of the Availability of Health Services and Information-Seeking Practices across a Large Health Service District in Rural Australia."

23 MyMedicare findings should be interpreted as consumer-reported awareness and self-reported registration, not administrative registration data. The 2026 survey used simpler and more direct wording than in previous years, which may have improved recognition of the program. Differences between survey findings and administrative registration data may reflect consumer recall, awareness of the program or its name and understanding of what registration involves.

As with MyMedicare, these findings should be interpreted with some caution because the 2026 survey used simpler and more direct wording when introducing the program, which may have improved recognition.

Awareness was higher among older respondents, women and people with chronic conditions

Awareness of My Health Record varied across population groups and was most strongly associated with age, gender, education, income and chronic condition status.

Older respondents were more likely to report awareness than younger adults. Awareness was highest among respondents aged between 55 and 74 years (90.8%), compared with those aged between 18 and 34 years (70.7%). This pattern remained evident in the adjusted analysis, with older age groups having higher odds of awareness (35-54 years: OR = 2.45; 55–74 years: OR = 3.70; 75 years and over: OR = 1.90).

Women were also more likely than men to report awareness of My Health Record. Overall, 86.1 per cent of women reported being aware of the program, compared with 78.9 per cent of men. This difference remained significant in the adjusted analysis (OR = 1.83).

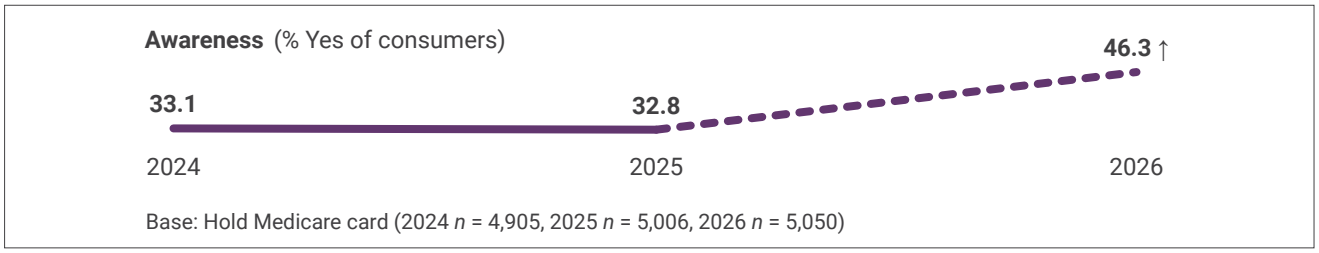
Awareness was also higher among respondents with post-secondary education (OR = 1.44) and among respondents with chronic conditions. Overall, 85.2% of respondents with chronic conditions reported awareness, compared with 78.3 per cent of those without chronic conditions (OR = 1.47).

Higher-income respondents were also more likely to report awareness, particularly those earning $2,000–$3,999 (OR = 1.69) or those earning $4,000 or more per week (OR = 1.64).

Figure 14: Self-reported registration with MyMedicare remained stable, while consumer-reported awareness increased in 2026

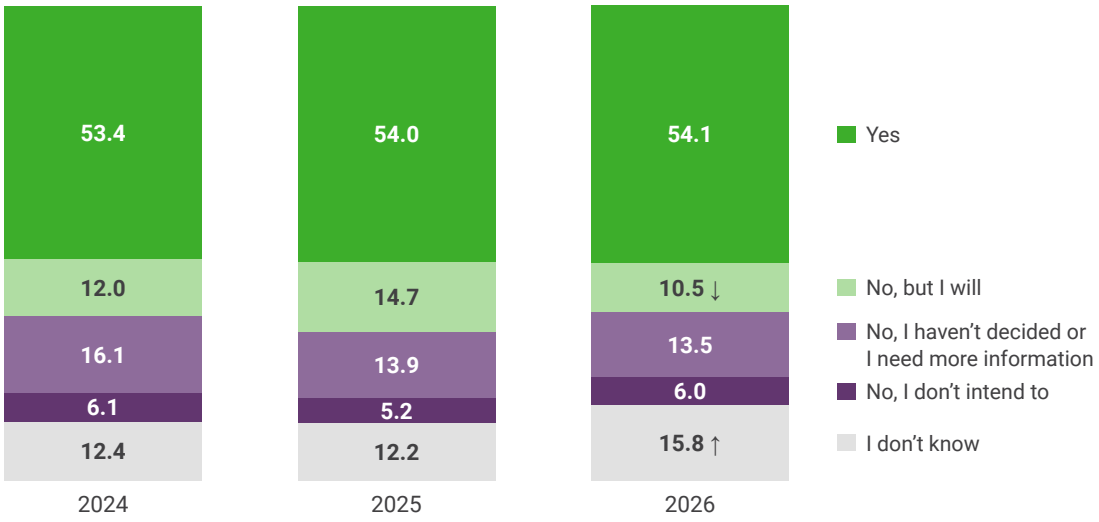
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2024 and 2025	2026
MyMedicare is a voluntary patient registration model. It formalises the relationship between patients, their general practice, general practitioner (GP) and primary care teams. This formalised relationship aims to deliver better health outcomes for patients in line with international evidence.	MyMedicare is a voluntary registration system that links a patient with their usual general practice, their general practitioner (GP), and their primary care teams to help deliver and coordinate care better health outcomes for patients.



Base: Hold Medicare card (2024 *n* = 4,905, 2025 *n* = 5,006, 2026 *n* = 5,050)

Registration for MyMedicare (%)



Base: Aware of MyMedicare (2024 *n* = 1,624, 2025 *n* = 1,693, 2026 *n* = 2,422)

Use also increased across most groups

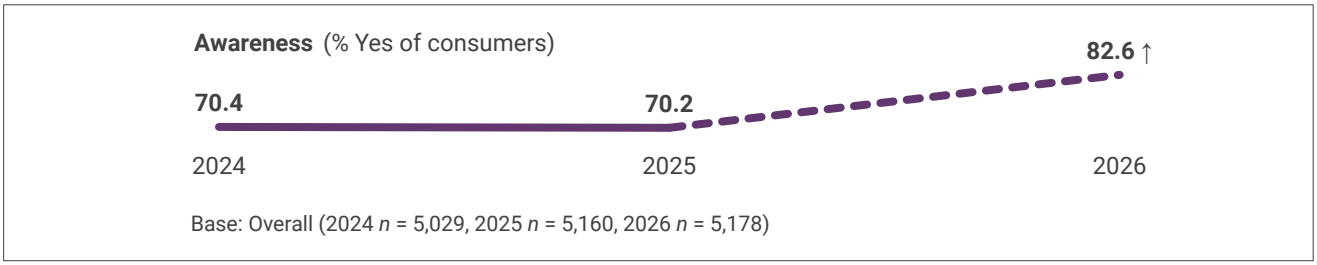
The increase in My Health Record use was widespread rather than concentrated within a single population sub-group. Both awareness and reported use increased across most major groups, including younger adults, women, higher-income respondents and respondents with chronic conditions.

Overall, My Health Record appeared to be both more visible and more widely used in 2026. Unlike MyMedicare, where self-reported registration increased more slowly than awareness, My Health Record showed a substantial increase in both consumer-reported awareness and use.

Figure 15: Awareness and use of My Health Record

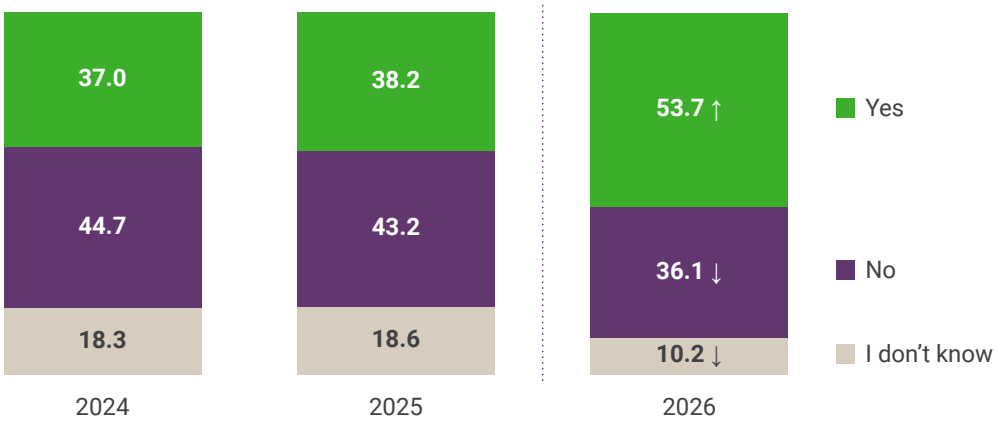
Statement shown

2024 and 2025	2026
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.	My Health Record is a secure, national system that gives you and your healthcare providers access to key health information. It can be available to you and your healthcare providers at any time, including in an emergency.



Base: Overall (2024 *n* = 5,029, 2025 *n* = 5,160, 2026 *n* = 5,178)

Ever used My Health Record (%)



Base: Aware of My Health Record (2024 n = 3,539, 2025 n = 3,623, 2026 n = 4,278)

10.3 1800MEDICARE

Consumer-reported awareness of 1800MEDICARE was relatively low in 2026, with 23.5 per cent of respondents reporting that they had heard of the service. Awareness was substantially lower than for MyMedicare and My Health Record, suggesting that 1800MEDICARE was not yet widely recognised by consumers at the time of the survey[24].

24 The 1800MEDICARE findings should be interpreted as an early baseline measure of consumer awareness. Fieldwork was conducted between 23 February and 23 March 2026, shortly after the service was introduced and before broader consumer awareness activities had occurred. The survey measured whether respondents had heard of 1800MEDICARE, not whether they understood the full scope of the service, had used it, or knew how it fits within broader healthcare pathways.

Awareness was higher among younger adults and PHI holders

Awareness of 1800MEDICARE varied across population groups, with younger adults most likely to report being aware of the service. In the adjusted analysis, respondents aged between 35 and 54 years and between 55 and 74 years had lower odds of awareness than those aged between 18 and 34 years (OR = 0.60 and OR = 0.73, respectively).

Respondents with private health insurance were also more likely to report awareness of 1800MEDICARE (OR = 1.30).

10.4 What this means for our health system

How visible health programs are to consumers is an important part of how health reforms are experienced in practice.

The findings show that awareness does not necessarily translate into engagement. The different patterns observed across programs illustrate this clearly. Awareness of MyMedicare increased substantially, but self-reported registration grew more slowly. In contrast, My Health Record showed increases in both consumer-reported awareness and reported use.

These findings suggest that making programs available, or increasing consumer awareness of them, may not be sufficient to drive participation. Consumers also need to understand what a program does, why it is relevant and how it fits within their healthcare.

The findings also highlight the importance of clear, consumer-focused communication. Simpler program descriptions may have helped respondents recognise MyMedicare and My Health Record. However, the survey cannot determine the extent to which the observed changes reflect survey wording, broader communication efforts, or genuine increases in consumer awareness.

However, if consumers do not understand what a program offers or whether they are participating in it, the intended benefits of that program may be difficult to achieve. Future survey waves will help determine whether increased visibility is sustained and whether it translates into greater engagement and use over time.

The relatively low awareness of 1800MEDICARE also highlights the importance of considering where a program is in its implementation journey. As a newly introduced service at the time of fieldwork, these findings should be interpreted as an early consumer baseline rather than evidence of program success or failure.

Future survey waves will provide a clearer picture of whether awareness grows and whether consumers increasingly understand and use the service as part of their healthcare options.



Chapter 11: Trust and confidence in the health system

Respondents trusted healthcare providers more than government, and confidence was lowest in relation to healthcare affordability.

Confidence in the healthcare system is shaped by both people's experiences of care and their perceptions of how the system is funded, governed, communicated and accessed. Trust influences whether people feel confident relying on the health system,[25] particularly when facing serious illness or complex healthcare needs.[26]

Differences in trust and confidence across institutions provide insight into how consumers perceive the health system. They can help identify where the system is seen to be working well, and where concerns about affordability, fairness and accountability are more common.[27]

11.1 Confidence in the system

Confidence in the healthcare system remained mixed in 2026 and was lowest among among respondents experiencing affordability pressures.

The proportion of respondents reporting reduced confidence in the healthcare system fell slightly from 28.7 per cent in 2025 to 25.9 per cent in 2026. However, respondents facing affordability barriers remained more likely to report declining confidence. This suggests that confidence may have stabilised somewhat, although there was little evidence of a substantial improvement.

Analyses indicated that reduced confidence was most strongly associated with difficulty affording care (OR = 1.72) and financial stress (OR = 1.56), followed by gender and age.

Affordability pressures were most clearly associated with lower confidence

Respondents who reported difficulty affording healthcare were considerably more likely to report reduced confidence in the healthcare system. Overall, 38.9 per cent reported declining confidence, compared with 21.3 per cent of respondents who did not report affordability barriers.

A similar pattern was evident among respondents experiencing financial stress. More than one-third (34.3%) reported declining confidence in the healthcare system, compared with one-fifth of respondents (21.3%) who were not experiencing financial stress.

Confidence varied across age and gender

Women were more likely than men to report reduced confidence in the healthcare system. Reduced confidence was also more common among respondents aged between 35 and 54 years (OR = 1.36) and between 55 and 74 years (OR = 1.48) than among those aged between 18 and 34 years.

Some groups reported modest improvements between 2025 and 2026. For example, the proportion of respondents aged 75 years and over reporting reduced confidence fell from 26.2 per cent in 2025 to 18.8 per cent in 2026. This suggests that recent stabilisation in confidence was not experienced equally across all groups.

11.2 Trust in government and healthcare providers

This was the first NCSS wave to include measures of trust in government and healthcare providers.

Respondents reported substantially higher levels of trust in healthcare providers than in government. As shown, 60.3 per cent agreed that healthcare providers communicated changes to care clearly, compared with 30 per cent who said the same about government entities. Similarly, 71.5 per cent trusted healthcare providers to prioritise patient wellbeing, compared with 36.6 per cent who trusted government to act in the public's best interests.

25 Ward et al., "A Qualitative Study of Patient (Dis)Trust in Public and Private Hospitals: The Importance of Choice and Pragmatic Acceptance for Trust Considerations in South Australia."

26 Australian Commission on Safety and Quality in Health Care, OECD Patient-Reported Indicator Surveys (PaRIS): Australian National Report 2025.

27 Tran et al., Speaking Up for Health: Findings from the 2025 National Consumer Sentiment Survey.; Hayes and Smith, Speaking Up for Health: Findings from the 2024 National Consumer Sentiment Survey.; Australian Academy of Health and Medical Sciences, Understanding Trust in Health and Medical Sciences: Policy Explainer.

The gap between trust in healthcare providers and trust in government was widest among respondents experiencing affordability barriers

Respondents who were unable to afford healthcare reported lower levels of trust in government than those not experiencing affordability barriers. Only 20.9 per cent trusted government to communicate changes to care clearly, compared with 33.2 per cent of those without affordability barriers. Similarly, 23.6 per cent trusted government to act in the public's best interests, compared with 41.2 per cent among those who did not report affordability barriers.

Trust in healthcare providers remained substantially higher. Even among respondents who could not afford healthcare, 61.2 per cent trusted providers to prioritise consumer wellbeing, compared with 75.1 per cent of those not experiencing affordability barriers.

Other differences in trust were smaller

Trust tended to be somewhat lower among respondents who selected an LGBTQIA+ response to the sexual orientation question and among groups experiencing disadvantage. Trust was generally higher among older respondents, men, PHI holders and respondents in higher SES groups.

However, these differences were smaller than the overall disparity between trust in healthcare providers and trust in government.

11.3 Confidence in care if seriously ill

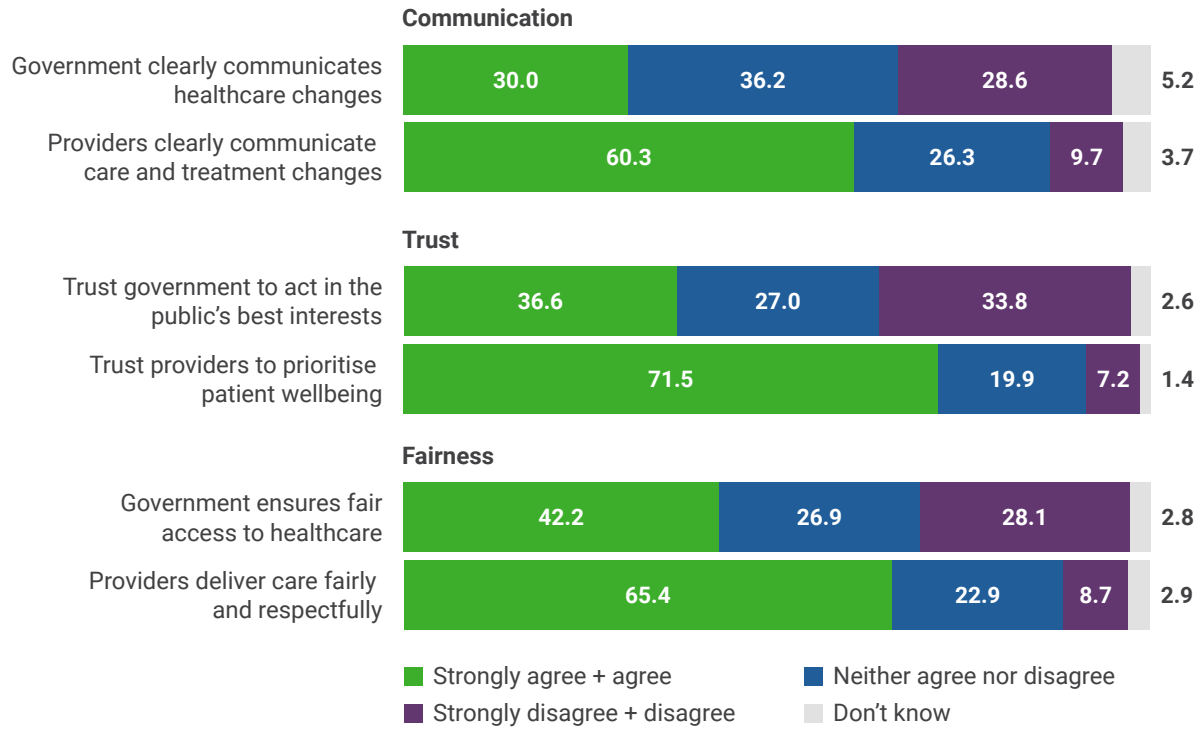
Confidence remained stronger for receiving clinical care than for being able to afford it.

The data indicates 53 per cent of respondents were confident they could receive safe and high-quality medical care if they became seriously ill. Almost half (47.0%) were confident they could access the most effective medication, while 45 per cent were confident they could access the best available medical technology.

In contrast, only 29.6 per cent were confident they could afford the care they would need if they became seriously ill, down from 32.3 per cent in 2025.

Confidence that people would receive the same quality of care regardless of their background was higher, with 57.6 per cent expressing confidence in 2026. This measure was included in the NCSS for the first time in 2026.

Figure 16: Respondents distinguished between the people delivering care and the institutions responsible for organising, funding and communicating system changes. Trust in healthcare providers was substantially higher than trust in government



Base: Overall (2026 *n* = 5,178)

Affordability remains the weakest area of healthcare system confidence

More than half of respondents who were not experiencing financial stress were confident they would receive safe and high-quality care if critically ill (59.4%), compared with just over two-fifths (41.4%) of those experiencing financial stress. Confidence in receiving effective medication was higher among respondents not experiencing financial stress (53.7%) than among those experiencing financial stress (34.7%).

Similar patterns were evident across other confidence measures, with respondents who could afford care consistently reporting higher confidence in the healthcare system.

This pattern was not limited to a single aspect of care. It reflected a broader divide between respondents who could absorb healthcare costs and those experiencing household financial pressure.

Age and system advantage were also associated with higher confidence.

Confidence in receiving care, medication and healthcare technologies generally increased with age. Older respondents, particularly those aged 75 years and over, reported the highest levels of confidence in the healthcare system's capability.

Confidence in receiving safe, high-quality care increased among respondents aged 75 years and over (56.1% to 67.3%), women (45.1% to 48.7%), respondents with chronic conditions (49.2% to 52.6%), PHI holders (54.8% to 60.1%) and respondents without disability (52.0% to 55.3%).

While confidence in clinical care remained relatively stable, confidence in affordability declined

Confidence in being able to afford healthcare weakened between 2025 and 2026 across several groups. Declines were observed among respondents aged between 35 and 54 years (28.5% to 21.7%), those earning $2,000–$3,999 per week (37.2% to 32.3%), respondents with post-secondary education (34.2% to 31.3%), respondents with chronic conditions (30.4% to 26.2%), metropolitan respondents (34.2% to 31.0%), those without private health insurance (22.1% to 18.5%) and those experiencing financial stress (18.3% to 14.4%).

These findings suggest that while confidence in clinical care remained relatively stable or improved over time, confidence in affordability declined.

11.4 System priorities

Respondents' views about government healthcare spending remained stable in 2026. More than half of respondents (56.7%) believed spending on health was too low, a finding largely unchanged from 2025 (57.1%).

Concern about healthcare underfunding was highest among those facing affordability barriers

Respondents who could not afford healthcare were substantially more likely to say spending on health was too low (69.9% compared with 52.1% among those without affordability barriers). A similar pattern was also observed among respondents experiencing financial stress (63.0% compared with 53.3%).

Views also differed by health need and vulnerability

Higher levels of concern about underfunding were also reported by respondents with chronic conditions (62.9%), people with disability (69.1%) and respondents who selected an LGBTQIA+ response to the sexual orientation question (68.7%).

These findings suggest that views about healthcare funding may be influenced by respondents' own experiences of health need, access to care and affordability.

11.5 What this means for our healthcare system

This chapter highlights two distinct dimensions of confidence in the healthcare system**:** confidence in the quality of care provided and confidence in being able to access and afford that care when needed.

While consumers generally remain confident in the quality of healthcare they would receive if needed, they are less certain about whether they could access and afford that care. This gap remains a significant challenge for overall system confidence.

Overall confidence in the healthcare system appears to have stabilised, but there is little evidence of a broader recovery. Looking across the NCSS series, confidence in the healthcare system has remained relatively stable, while confidence in being able to afford needed care has weakened over the three-year period.

Findings on trust in healthcare providers and government, collected for the first time in 2026, further reinforce this distinction. Consumers reported substantially higher levels of trust in healthcare providers than in government across measures relating to communication, wellbeing, and acting in the public interest. As a baseline measure, these findings do not indicate a trend over time. However, they highlight that confidence in the healthcare system extends beyond individual care experiences to include how healthcare is governed, funded and made accessible.

Taken together, the findings suggest that maintaining confidence in the healthcare system requires attention to both quality of care and the conditions under which that care can be accessed. While many consumers remain confident in the care they would receive if needed, they are less certain about whether it would be affordable. Affordability, fairness and reliable access therefore appear to be as important to system confidence as confidence in the quality of clinical care itself.

Chapter 12: Who is benefiting from improvement in healthcare and who continues to face barriers?

Healthcare experiences were shaped by a small number of common factors.

The findings in this report show that people did not experience the healthcare system in the same way. Similar patterns emerged across access, affordability, health status, care experience, navigation and confidence.

Three factors were consistently linked to people's experiences of healthcare: their ability to afford care, the complexity of their health needs, and financial and social resources available to them. Together, these factors influenced whether healthcare was experienced as accessible, manageable and reliable.

12.1 Affordability and financial stress

People's ability to afford care was the factor most consistently linked to their experiences of the healthcare system. Respondents experiencing financial stress or difficulty affording care were more likely to miss or delay care, report poorer mental health, postpone dental treatment and report lower satisfaction with their care. They also reported greater difficulty navigating the healthcare system and lower confidence in the system overall.

Importantly, affordability was linked not only to whether people could access care in the first place. It also influenced whether they could continue treatment, manage their healthcare needs over time, feel confident engaging with providers and trust the healthcare system.

Across multiple areas of the survey, respondents experiencing financial stress consistently reported having to invest more time, effort and resources to access and manage their care. Improvements seen in some areas, such as after-hours access, aspects of care experience and system confidence, were also less likely to be reported by those facing the greatest financial pressure.

These findings suggest that people experiencing financial stress were less likely to benefit from broader system improvements, even when overall results showed stability or improvement.

12.2 How healthcare experiences differed by age

Age was closely linked to how people experienced the healthcare system, although the pattern differed across age groups.

Younger adults were more likely to report unmet need, poorer mental health, disruptions to treatment, lower use of dental care and greater impacts when dental care was delayed. They were also less likely to report positive care experiences, confidence navigating the healthcare system, or well-coordinated care.

Older adults, by contrast, were more likely to report higher satisfaction, better navigation and greater confidence in the healthcare system, despite being more likely to live with chronic health conditions. This may reflect greater familiarity with the healthcare system among older respondents, although the survey cannot determine the reasons for this age-related pattern.

Overall, younger adults were more likely to report difficulties accessing and using healthcare, while older adults generally reported greater confidence in navigating the system.

12.3 Chronic conditions, disability and ongoing healthcare needs

People living with chronic conditions interacted with the healthcare system more often than other respondents, but they also faced more challenges in accessing, managing and coordinating their care.

Respondents with chronic conditions reported higher use of services, but also higher unmet need, poorer self-rated health, greater mental health burden and more difficulty maintaining treatment. More frequent contact with healthcare services did not necessarily make care easier to access or manage.

They were also more likely to experience challenges coordinating care, including needing to repeat information and manage care across multiple providers. For many people with ongoing health needs, managing care required additional effort to organise appointments, share information and coordinate services.

People with disability showed a similar but more pronounced pattern. This likely reflects the strong overlap between disability and chronic illness. In 2026, 95.1 per cent of respondents with disability reported at least one chronic health issue, compared with 56.6 per cent of respondents without disability.

People with disability faced both high healthcare needs and greater barriers to accessing and managing care. Across the survey, respondents with disability were more likely to report poorer health, more barriers to care, lower confidence in the healthcare system and weaker care coordination. These findings suggest that high health complexity and access challenges often occurred together.

12.4 The role of financial and social advantage

Across the survey, people with greater financial resources and social advantage generally reported better experiences of the healthcare system. This included respondents with private health insurance (PHI), higher incomes and higher socio-economic status.

People with greater financial and social advantage were more likely to report positive outcomes across several access, experience, navigation and confidence measures. However, awareness and use of national health programs did not consistently follow the same socio-economic pattern.

These people appeared to benefit from a combination of factors that made accessing and navigating care easier. These included greater financial protection, more provider choice, stronger familiarity with the healthcare system and greater confidence managing healthcare decisions.

The advantages associated with financial and social resources were most apparent in areas that required out-of-pocket expenses, proactive consumer engagement or coordination across multiple providers.

12.5 Gender and healthcare experiences

Women were more likely than men to report difficulties accessing and navigating healthcare, despite remaining highly engaged with healthcare services.

Across multiple areas of the survey, women were more likely to report unmet need, poorer mental health, delays in dental care and experiences of discrimination. They were also more likely to report lower confidence in the healthcare system.

These findings suggest that women were not less connected to healthcare services, but more likely to encounter situations where care was difficult to access, delayed or did not meet their needs.

12.6 Equity and inclusion: sexual orientations, language, and geography

Some groups consistently reported poorer experiences of the healthcare system than others. This included respondents who selected an LGBTQIA+ response to the sexual orientation question, those who spoke a language other than English at home (LOTE) and those living in regional and rural areas.

Respondents who selected an LGBTQIA+ response were more likely to report poorer mental health, higher rates of delayed care, particularly dental care, and less positive experiences across several aspects of care.[28]

Respondents who spoke a language other than English at home were more likely to report challenges relating to affordability and access, including after-hours care, communication and navigation.[29]

Respondents living in regional and rural areas were more likely to report difficulties accessing services and lower confidence in navigating the healthcare system.

These findings suggest that healthcare experiences are shaped not only by financial resources and health needs, but also by whether services are accessible, culturally appropriate and available where people live.

12.7 What this means for our health system

The findings in this report demonstrate that healthcare experiences were shaped by a small number of overlapping factors.

The report identifies modest improvements or stability in several areas, including person-centred care, after-hours access, overall confidence, and the visibility and use of some digital health programs. From an equity perspective, an important question is whether these improvements are being experienced by people who face the greatest barriers to healthcare.

Across the survey, financial pressure was the most consistent factor influencing whether people benefited from broader healthcare system improvements.

Three factors were particularly important in shaping people's experiences of healthcare:

- People's ability to afford care influenced whether they could access and continue to use it.
- The complexity of their health needs influenced the amount of care required and how difficult that care was to coordinate.
- Financial and social advantage influenced how easily people could navigate the healthcare system and obtain the care they needed.

28 These findings relate only to the sexual orientation measure included in the survey and should not be interpreted as representing the full diversity of LGBTQIA+ identities or experiences.

29 Similarly, these findings should be interpreted with caution because LOTE is only one indicator of cultural and linguistic diversity and does not capture preferred language, interpreter need, cultural safety, migration experience or digital access.



These factors often compounded one another. People experiencing financial pressure, ongoing health needs or fewer resources were more likely to face multiple barriers at the same time. In contrast, people with greater financial security and familiarity with the health system were more likely to describe their care as accessible, coordinated and reliable.

The findings also highlight differences between age groups and between people with different levels of health need. Younger adults reported greater instability, unmet need and difficulty navigating the healthcare system. Older adults, despite living with higher levels of chronic illness, generally reported greater satisfaction with and confidence in the healthcare system.

Similarly, people with chronic conditions or disability often needed to interact with the healthcare system more frequently, but this did not necessarily make care easier to access, maintain or coordinate. These findings suggest that healthcare experiences depend not only on how much care a person needs, but also on how easily they can access, organise and coordinate that care. For people with ongoing health needs, managing healthcare may involve multiple providers, appointments, treatments and decisions, which can place additional demands on time, knowledge and personal resources.

These findings are important for how progress is measured. National averages can show whether the healthcare system is changing, but they cannot show whether those changes are being experienced equally. Equity monitoring therefore needs to consider who is benefiting from change and who is not, particularly where financial pressure, greater health needs or limited system resources make improvement harder to achieve.

Overall, these findings suggest that the success of healthcare reform should not be judged solely by whether services improve, but by who experiences those improvements. A more equitable healthcare system is one in which the benefits of change are shared across the community, including by people facing financial pressure, ongoing health needs or other barriers to care. As CHF has consistently argued, access to healthcare should not depend on a person's bank balance, postcode or ability to navigate a complex system.

Chapter 13: Implications for Strengthening Medicare

Strengthening Medicare is a long-term reform program aimed at making healthcare easier to access, more affordable, better coordinated and more responsive to people's needs, while strengthening the healthcare workforce and reducing pressure on hospitals. Its success ultimately depends on whether people can get the care they need, afford it, stay in care when necessary, move easily between services and feel confident that the healthcare system will support them when they need it.

13.1 What progress are consumers seeing?

Three years of NCSS findings provide insight into how consumers are experiencing healthcare reform.

Overall, the findings paint a mixed picture. Australians continue to report positive experiences of care and confidence in the quality of care provided, and there are signs of improvement in some areas. However, many people still face barriers to accessing, affording, coordinating and staying connected to the care they need.

There have also been modest gains in some aspects of person-centred care, alongside improvements or stability in some access measures and greater visibility and use of digital health reforms.

However, some important barriers remain. Unmet need has remained high, financial pressure has remained elevated and many people continue to experience difficulty accessing care, particularly when they face affordability or other barriers. For people with ongoing or complex healthcare needs, managing and coordinating care still requires significant personal effort.

Ultimately, the success of Strengthening Medicare will be measured by whether people can access, afford and stay connected to the care they need to move smoothly between services, and feel supported by the healthcare system.

13.2 Progress is being made, but not everyone is benefiting equally

Across the three NCSS waves, many respondents continued to report positive experiences of healthcare. Some aspects of person-centred care have improved, and measures of access and after-hours care either improved or remained stable. Respondents also continued to report high confidence in the quality of care provided, although confidence in being able to afford care remained substantially lower.

Consumers are also becoming more aware of some digital health reforms. For example, awareness of My Health Record and MyMedicare increased in 2026. These findings suggest that reforms are more likely to resonate with consumers when people know about them, understand how they work and can see how they relate to their own healthcare.

While progress is evident in some areas, improvements have not yet made the healthcare journey consistently easier for everyone. This has important implications for future phases of Strengthening Medicare.

13.3 Four persistent gaps in the consumer experience

Four recurring issues emerge from the findings and have important implications for the reform agenda.

1. Access is about getting the care people need, when they need it

Unmet need remains a significant challenge. Despite high levels of engagement with the healthcare system, many people continue to miss or delay care, particularly dental care, GP visits and tests or treatment. This pattern has changed little over the past three years.

The findings show that access is about more than whether services are available or being used. It is about whether people can get the right care, at the right time, and at the right stage of their healthcare journey. After-hours care illustrates this challenge. While access has improved in some areas, barriers remain for people facing financial pressure, language barriers, or difficulties accessing services where they live.

To understand whether access is improving, it is important to look across the whole healthcare journey, not just individual services or levels of service use.

2. Affordability affects every stage of the healthcare journey

Affordability continues to shape whether people can get the care they need and continue receiving it over time. Financial pressure can affect decisions about seeking care, attending appointments, filling prescriptions, accessing specialist or dental care and continuing treatment.

The findings also show a clear gap between confidence in the quality of care and confidence in being able to afford it. For many consumers, healthcare costs do not come from a single service. They accumulate across consultations, medicines, tests, specialist appointments, dental treatment and continuing care.

Affordability is therefore about more than the cost of a single visit or whether a service is bulk billed. The key question is whether people can afford the care they need throughout their healthcare journey and continue that care for as long as necessary.

3. Poorly coordinated care can leave consumers doing the work

The 2026 NCSS findings highlight gaps in coordination and information sharing between healthcare providers. Respondents reported needing to repeat their health history, difficulty having information shared or transferred, and less effective communication between providers.

These experiences point to an aspect of healthcare that is often invisible in service statistics: the work consumers sometimes need to do themselves to keep their care moving.

For people with chronic or complex health needs and those with lower health literacy, good coordination and reliable information sharing are essential. Consumers should not have to act as the link between providers, be expected to keep track of important information or take responsibility for coordinating their own care.

4. Mental health and dental care highlight where barriers remain

The findings for mental health and dental care show how multiple barriers can combine to create ongoing unmet need.

For people experiencing mental health challenges, getting into care is often only the first step. Many people face difficulties continuing treatment when costs, service availability or other barriers arise. The challenge is not only about accessing care, but staying connected to care over time.

Dental care presents a similar challenge. It remains the most commonly missed or delayed form of care. The 2026 findings show the impact of going without needed dental care, including pain, difficulty eating and reduced wellbeing.

13.4 People experience reform differently

The three-year findings show that the benefits and challenges of the healthcare system are not experienced equally. People's experiences of healthcare are shaped by their health needs, financial circumstances, their ability to navigate the healthcare system and the support available to them.

People with ongoing or complex health needs often have more frequent and more complicated interactions with the healthcare system. Financial resources and other advantages can make these interactions easier to manage. For example, people with higher incomes, private health insurance, strong health literacy, confidence navigating services or familiarity with digital tools may be better able to overcome barriers.

By contrast, people with fewer resources have less capacity to overcome gaps in affordability, service availability, care coordination or information.

These challenges can also build on one another. As a result, the same healthcare system may be experienced very differently depending on a person's circumstances, needs, available support and their capacity to navigate the system.

This means that improvements seen at the national level may not be experienced equally across the community or within population sub-groups.

13.5 What should government continue to monitor?

The NCSS highlights a range of consumer outcomes that should be monitored alongside service, activity and administrative measures when assessing the progress of Strengthening Medicare. Together, these measures help show how reform is being experienced by consumers and provide a broader picture than service use, expenditure and clinical performance alone.

These measures include the following areas for monitoring:

- **Unmet and delayed need**
  Are fewer people missing or delaying care, and is improvement reaching people who currently face the greatest barriers?
- **Affordability across the healthcare pathway**
  Can people afford the care they need, including consultations, medicines, tests, specialist care, dental care and follow-up treatment?
- **Staying connected to care**
  Once people enter care, can they continue treatment for as long as they need it?

- **Coordination and information continuity**
  Does information move reliably between providers, and are people being supported rather than burdened by the need to coordinate their own care?
- **Awareness and use of reforms**
  Do people know about new programs, understand their purpose and use them as intended?
- **Confidence in affordability**
  Do people believe they will be able to access and afford care if they become seriously ill?
- **Who is benefiting from improvement?**
  Are improvements being experienced across the population, including by people with greater health needs, financial pressure or other barriers?

13.6 What this means for the next phase of Strengthening Medicare

The three-year NCSS findings suggest that Australia has a healthcare system with many strengths. People continue to report positive care experiences, confidence in the quality of care remains relatively strong and there are areas where consumers are seeing improvement.

At the same time, too many people continue to face barriers to getting the care they need. These findings show that success is not only about delivering services. It is also about whether people can access those services, afford them, and continue using them when they need to.

The next phase of Strengthening Medicare should place greater emphasis on the consumer experience, alongside the continued development of services and programs. Consumer insights can help identify where reform is working, where barriers remain and where improvements are not being experienced equally.

Ultimately, the success of Strengthening Medicare will be measured by whether reform makes healthcare more accessible, affordable and coordinated for the people who need it most.

Tracking consumer outcomes alongside activity, expenditure and service delivery performance measures will be important for understanding whether reforms are translating into meaningful improvements in people's experiences of healthcare and whether those improvements are being experienced equally across the community.



Chapter 14: Why Consumer Monitoring Matters

14.1 Understanding reform through people's experiences

The purpose of health reform is to improve people's experience of the healthcare system. To understand whether reform is working, it is important to measure not only what the healthcare system delivers, but also how people experience it.

The NCSS series provides insight into the consumer experience of healthcare. It captures whether people can obtain the care they need, afford it, navigate the healthcare system, and receive care that is coordinated, respectful and responsive to their needs.

This perspective complements administrative data, which measures aspects of the healthcare system such as service use, waiting times, hospital admissions, costs and clinical outcomes. Together, these sources of information provide a more complete picture of how the healthcare system is performing.

Considering both perspectives on performance also shines a light on important gaps. For example, services may appear available according to administrative data, while consumers continue to report difficulties accessing care. Similarly, clinical outcomes may be strong while consumers report challenges with affordability, coordination or continuity of care.

Consumer monitoring is therefore an essential mechanism for assessing whether healthcare reforms are translating into meaningful improvements in people's experiences of care.

14.2 Why tracking experiences over time matters

Understanding change requires more than consideration of a single snapshot in time.

A one-off survey can describe people's experiences at a particular point in time. Repeated surveys using consistent measures and methodology make it possible to identify trends over time, including what is improving, what is staying the same, what is deteriorating, and which groups are benefiting from the change.

The NCSS now provides three years of consumer evidence. The 2024 survey established a baseline, while the 2025 and 2026 surveys make it possible to identify areas of improvement, ongoing challenges and emerging issues.

As the series grows, its value increases. Each new survey wave helps place current findings into context and provides a clearer picture of how people's experiences change over time.

This information helps policymakers and the health sector answer important questions. Are reforms making a lasting difference? Are improvements reaching the people who face the greatest barriers to healthcare? Are some problems proving harder to address than others?

Maintaining a long-term consumer monitoring program requires a balance between consistency and flexibility. Measures need to be stable enough to identify genuine change while also adapting to new priorities and reforms.

14.3 Monitoring that can adapt as reform evolves

An effective monitoring program combines a stable set of core measures with the flexibility to explore new issues as they emerge.

Core measures allow trends to be tracked over time and provide a consistent basis for assessing change. At the same time, new questions can be added to explore emerging reforms, policy priorities or areas where earlier findings suggest a need for deeper investigation.

This approach allows each survey to build on previous waves rather than operating as a series of disconnected studies.

Over time, the series can show several types of change: when conditions are improving, where challenges persist, and where different groups are experiencing reform differently. Each of these findings can help inform future policy and reform efforts.



14.4 Turning consumer evidence into policy insight

Consumer monitoring is most valuable when it helps identify issues that require further investigation.

This is particularly important when considering equity. National averages may improve while people experiencing financial pressure, complex health needs or other barriers experience little or no improvement. Assessing differences across population groups helps show whether reform is benefiting the people who need it most.

The same principle applies to confidence in the healthcare system. Consumers may feel confident in the quality of care provided by healthcare professionals while remaining uncertain about whether they will be able to access care or afford that care when they need it.

These are different aspects of confidence, and each provides useful information about how people experience the healthcare system and where improvement may be needed.

14.5 A source of national policy insight

The NCSS is more than a measure of consumer satisfaction. It provides a source of national insight into how people experience the healthcare system and how those experiences are changing over time.

Its value grows as the survey series continues. Repeated measurement can reveal trends, persistent challenges and differences between population groups that might otherwise remain hidden.

Consumer monitoring is not intended to provide all the answers. Its role is also to identify where consumer experiences raise questions that warrant further investigation through administrative data, research or targeted evaluation.

Ultimately, ongoing consumer monitoring helps answer a simple but important question: **are healthcare reforms improving people's experiences of care, and are those improvements being shared across the community?**

By tracking consumer experiences alongside service activity, expenditure and clinical outcomes, policymakers can better understand not only what the healthcare system is delivering but also how those changes are being experienced by the people it is intended to serve.

Appendix A. Methodology

A1. Data collection and weighting

Data collection for the 2026 National Consumer Sentiment Survey (NCSS) was undertaken online between 23 February and 23 March 2026. A total of 5,249 responses were collected. Following data-cleaning procedures, 71 responses were removed due to quality concerns, resulting in a final sample of 5,178 respondents.

Due to additional questionnaire content in 2026, the average survey completion time was approximately 18.8 minutes, compared with approximately 15 minutes in 2025. This increase reflected the larger 2026 questionnaire, which included 66 questions, compared to 56 questions in 2025.

Ethics approval for the study was obtained from the Bellberry Human Research Ethics Committee (reference: HREC2024-07-939-A-5).

A1.1 Survey development

The 2026 NCSS builds on previous waves conducted in 2024 and 2025, and incorporated updates reflecting evolving policy priorities and emerging areas of interest.

The 2026 questionnaire was refined through a structured, multi-phase review process involving CHF and the Department of Health, Disability and Ageing (the Department). An internal review of the 2024 and 2025 survey instruments informed the proposed modifications and question improvements while maintaining comparability across survey waves.

Consumer validation was undertaken through qualitative testing, including a structured workshop (n = 9) conducted in September 2025, followed by cognitive interviews (n = 5). These activities assessed question comprehension, interpretation, and response processes. These activities identified opportunities to simplify questions, reduce duplication and improve conceptual clarity.

Findings from both phases informed the final revisions to the survey, including the removal of low-value or duplicated items and the refinement or addition of questions relating to healthcare access, mental health, care coordination, and financial barriers. The final questionnaire was reviewed and approved by CHF and the Department prior to pilot testing and fieldwork.

Key changes in the 2026 questionnaire included questions about:

- mental health and access to support
- dental health, dental care use and delayed care
- GP out-of-pocket costs and access to bulk billing GP services
- awareness of 1800MEDICARE
- barriers to accessing quality healthcare
- cultural background, disability and health conditions.

The following areas were removed or revised in the 2026 survey:

- reasons for holding or not holding private health insurance
- some MyMedicare and My Health Record experience items
- detailed telehealth experience comparisons
- suggested improvements to the healthcare system
- current employment status.

Core areas were retained to ensure comparability across survey waves, including:

- access to healthcare services, including GP and after-hours care
- barriers to healthcare access
- perceptions of the healthcare system
- awareness and use of MyMedicare and My Health Record.

The final questionnaire comprised 66 questions, including a mix of closed-ended and open-ended items. The survey was programmed for completion on smartphones, tablets and personal computers.

A1.2 Soft launch

A soft launch was conducted between 19 and 23 February 2026 with 78 respondents to test the updated questionnaire and its functionality.

No technical issues were identified. Feedback suggested minor improvements to response options, such as adding a 'not applicable' option. No substantive changes were made before full fieldwork commenced.

A1.3 Sampling and recruitment

The survey targeted adults aged 18 years or older living in Australia. Respondents were eligible to participate only if they provided their age, gender and location of residence.

Respondents who participated in the 2025 wave were excluded to avoid consecutive participation. Respondents from the 2024 wave were eligible to participate in 2026.

Respondents were invited via email and SMS and were incentivised through redeemable points.

Sampling was conducted using online research panels:

- Roy Morgan Single Source panel as the primary panel
- Pureprofile panel as a supplementary panel.

A1.4 Quotas

To support a broadly representative sample of the Australian adult population, interlocking quotas were applied across multiple characteristics simultaneously:

- **Gender:** Male or female for quota management. Respondents who selected non-binary or 'I use a different term' were randomly allocated to one of the two quota categories for sampling and weighting purposes only, to align with ABS benchmark categories. Original gender responses were retained in the dataset for reporting where sample size and reliability thresholds allowed.
- **Age groups:** 18-24, 25-34, 35-44, 45-54, 55-64 and 65 years and over.
- **Geographic location:** 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 the Northern Territory, Hobart and rest of Tasmania.

These quotas were based on the most recent available ABS population benchmarks at the time of fieldwork.[30]

Supplementary panels were used to support representation of harder-to-reach groups such as younger respondents living in regional areas.

A1.5 Data handling

All survey responses underwent quality assurance checks. Responses were excluded if they:

- were completed in under five minutes, indicating possible 'speeding'
- were identified as duplicates
- selected the same response option across all items in a multi-item question without variation, known as 'straight-lining'.

Duplicates were identified using:

- email address
- telephone number
- IP address
- basic demographics, including age, gender and postcode.

Respondents were required to complete all questions sequentially, which minimised missing data. 'Don't know' and 'Prefer not to say' responses were retained and reported where relevant. Personally identifiable information was removed, and open-ended responses were reviewed to minimise disclosure risk.

A1.6 Response rates

A total of 70,931 survey invitations were sent to the Roy Morgan panel, resulting in a response rate of 4.1 per cent, similar to the 2024 and 2025 waves. The completion rate was 66.7 per cent, substantially higher than in 2025, indicating fewer incomplete survey responses.

30 Australian Bureau of Statistics, "Labour Force, Australia."

A1.7 Data weighting

Data were weighted so that the achieved sample aligned with key characteristics of the Australian adult population. The same weighting approach used in 2024 and 2025 survey waves was applied in 2026 and included five dimensions:

- **Gender:** Male, Female
- **Age groups:** 18-24, 25-34, 35-44, 45-54, 55-64 and 65 years and over
- **Geographic location**
- **Education (highest level attained):** Postgraduate degree / graduate diploma, bachelor's degree, diploma, Certificate III & IV, secondary education and below
- **Internet usage frequency:** 3 or more times daily, twice daily, once daily or less.

A core weighting matrix was constructed based on gender, age and geography, with additional rim-weighting applied for education and internet use.

Population benchmarks were sourced from:

- ABS Labour Force Survey (December 2025 release)
- Roy Morgan Single Source data (for internet usage)

To minimise extreme weights, categories were collapsed where necessary and outlier weights were capped. The weighting efficiency (WEFF) was calculated at 1.8. This means that weighting reduced the effective sample size relative to the achieved sample size, which is common in weighted survey analysis. The reported confidence intervals and subgroup thresholds account for this design effect.

A1.8 Analytical considerations

Statistical significance and confidence interval

- Statistical significance was assessed using conventional thresholds, including $p < 0.05$, alongside effect sizes and 95% confidence intervals. Point estimates are reported with 95% confidence intervals where relevant to reflect precision and uncertainty. Differences were considered meaningful when they were both statistically significant and substantively important.

Minimum subgroup size, reliability and interpretation

- To ensure reliable and stable estimates, minimum subgroup size thresholds were applied. Small subgroups were combined or excluded from regression models where necessary. Very small cell counts, fewer than 10 observations per category, can produce unstable estimates, wide confidence intervals, and low statistical power.

Results are interpreted using the following thresholds:

- **n < 50**: not reported separately (insufficient reliability)
- **n = 50-199**: low reliability (reported selectively with caution)
- **n = 200-499**: moderate reliability (reported with caveats)
- **n ≥ 500:** high reliability (reported and interpreted)

Where subgroup differences are described in the Results section, they reflect:

- statistically meaningful differences, and
- differences of practical or meaningful relevance

Subgroup differences highlighted in the Results section reflect findings that exceed expected sampling variation and are substantively meaningful. The precision of estimates varies according to subgroup size and outcome prevalence. Approximate 95% confidence intervals presented below account for a design effect of 1.8 and provide a guide to the precision of subgroup estimates. Confidence intervals are widest for estimates near 50% and narrower for estimates close to 0% or 100%. Estimates for very small subgroups or rare outcomes should be interpreted with additional caution.

Approximate 95% confidence intervals (percentage points):

Sample size (n)	1% or 99%	25% or 75%	50%
50	±3.7 pp	±16.1 pp	±18.6 pp
100	±2.6 pp	±11.4 pp	±13.1 pp
200	±1.9 pp	±8.1 pp	±9.3 pp
500	±1.2 pp	±5.1 pp	±5.9 pp
1,000	±0.8 pp	±3.6 pp	±4.2 pp

(pp = percentage points)

Estimates for smaller subgroups (n < 200) may vary by ~±6-14 points. Differences are highlighted only where they exceed this range. Larger subgroups (n ≥ 500) support comparisons that are more precise.

1.9 Limitations of methodology

Sample representativeness and data quality

Online-only and English-language survey:

Conducting the survey online and in English may have under-represented people with limited digital access, lower digital literacy or limited English proficiency. This may include some older adults, people living in remote areas, recent migrants and populations experiencing socio-economic disadvantage. As a result, some barriers experienced by these groups may not be fully reflected in the survey results.

Culturally and linguistically diverse communities were under-represented in the achieved sample. Respondents who spoke a language other than English at home and respondents born outside Australia were represented at lower levels than ABS benchmarks. As a result, findings for LOTE respondents and multicultural consumers should be interpreted with caution and should not be generalised to all culturally and linguistically diverse communities.

Panel-based recruitment:

Recruitment via online research panels may introduce selection bias because panel members may differ from the broader population in terms of survey experience, digital access, healthcare engagement or willingness to participate in research. Their experiences, attitudes and healthcare engagement levels may not fully reflect those of the broader Australian adult population.

Even with weighting, online panel methods may over-represent people who are more motivated, digitally connected or health-engaged, while under-representing people are harder to reach.

Non-response bias:

Individuals who chose not to participate may differ systematically from respondents in ways not captured by weighting. This may affect the representativeness of findings, particularly if non-respondents have different healthcare experiences or levels of engagement with the healthcare system.

Recall and social desirability bias*:*

Findings rely on self-reported data and is therefore subject to recall and social desirability bias. While self-administered online surveys may reduce social desirability bias compared with interviewer-led,[31] surveys, respondents' reports of healthcare use, costs or program participation may differ from administrative records because of recall error, uncertainty or different interpretations of survey questions.

Potential sample overlap:

The NCSS used a rotating sampling design that allowed participation in non-consecutive survey waves, such as 2024 and 2026. Although weighting supported representativeness on key benchmark variables, some respondents may have participated in more than one survey wave This introduces a degree of non-independence between survey waves. Because the design effect does not explicitly account for this possibility across non-consecutive waves, standard errors may be slightly underestimated and statistical significance may be slightly overstated.

31 Crutzen and Göritz, "Social Desirability and Self-Reported Health Risk Behaviors in Web-Based Research: Three Longitudinal Studies."

Broad "tests or treatment" category:

Some survey categories combine several types of care. In particular, the category 'tests or treatment recommended by a doctor' is broad and may include pathology, diagnostic imaging, procedures, specialist investigations, follow-up appointments or other recommended treatments.

The survey does not separately identify pathology, diagnostic imaging or other diagnostic services. Findings for this category should therefore be interpreted as representing a broad range of recommended tests and treatments rather than evidence about any specific diagnostic sector or service type.

Analytical and interpretive limitations

Multivariable regression controlled for key measured characteristics, but findings identify associations rather than causality. Results may also be influenced by unmeasured variables, such as local service availability, healthcare system changes, media coverage or policy developments.

Observed changes between survey waves should therefore be interpreted as changes within the NCSS series, rather than evidence of long-term trends.

Consumer-reported experience and administrative data

The NCSS is designed to measure consumer experiences, sentiment, perceptions and self-reported behaviour. It does not verify individual responses against administrative datasets, clinical records, program registration records or service-use data. This is consistent with the purpose of the survey, which is to understand how consumers perceive, recall and experience the healthcare system.

Differences between survey findings and administrative data should not necessarily be interpreted as survey error. They may reflect differences between how programs operate and how consumers understand, recognise or recall those programs. This is particularly relevant for newer or more complex programs, where respondents may not recognise program names, know whether they are registered, or distinguish between related services.

A2. Respondent classifications

A2.1. Chronic conditions

To support consistency with sector reporting, the questionnaire included a chronic conditions question adapted from the Patient Experience Survey.[32] Respondents were presented with a list of seven conditions, with the option to report any other condition that had lasted, or was expected to last, six months or more.

For analysis and reporting, respondents who reported at least one chronic condition were compared to respondents who did not report any chronic conditions.

A2.2. Disability

Respondents were asked whether they identified as someone living with a disability, with response options of "Yes", "No" and "Prefer not to say". Responses were used to classify respondents by disability status.

A2.3. Disability groupings

Disability groupings were based on respondents' reported health conditions and/or impairments. Respondents could be classified into more than one disability grouping.

Respondents were asked to identify which categories best described their condition and could select multiple options, including sensory, intellectual, physical, psychosocial, head injury/stroke/acquired brain injury, or other.

A2.4. Education status

For reporting purposes, respondents were allocated to two groups according to the highest level of education that they had completed.

Respondents whose highest level of education was secondary school or below were allocated to the 'High school or below' group. Respondents with certificate, diploma, undergraduate or postgraduate qualifications were allocated to the 'Post-secondary' group.

A2.5. Financial stress and difficulties in affording care

Financial stress was assessed using questions adapted from the Menzies-Nous Australian Health Survey (2008).[33] Respondents were shown eight statements and were asked whether any had occurred in the previous 12 months because of a shortage of money.

32 Australian Bureau of Statistics, "Patient Experiences."

33 Menzies Centre for Health Policy, The Menzies-Nous Australian Health Survey 2008.

For analysis and reporting, financial stress was coded as 'Yes' if at least one of the eight statements was selected.

Respondents were also asked if their healthcare needs were not met for four types of care in the past 12 months: not visiting a dentist, not speaking to or seeing a doctor, not attending recommended tests, treatment or appointments, and not filling a prescription or taking medication. In a follow-up question, respondents indicated whether affordability was a reason care was delayed or not accessed. For analysis, respondents were coded as having difficulties affording care if they selected affordability as a reason for unmet need in at least one of the four healthcare categories.

A2.6. Gender and sexual orientation

The 2026 NCSS collected gender and sexual orientation as separate questions, closely aligned with the ABS 2020 Standard wording for these variables. Gender was asked using the question "How do you describe your gender?", with response options of man or male, woman or female, non-binary and "I use a different term".

Sexual orientation was asked using the question "How do you describe your sexual orientation?", with response options of straight or heterosexual, gay or lesbian, bisexual, "I use a different term", "I don't know" and "Prefer not to say". Sexual orientation was grouped into three categories for analysis: heterosexual; LGBTQIA+ sexual orientation response, including gay or lesbian, bisexual or "I use a different term"; and unknown orientation, including "I don't know" and "Prefer not to say".

The survey did not separately collect sex recorded at birth or variations of sex characteristics. Findings based on sexual orientation should therefore not be interpreted as representing all dimensions of LGBTQIA+ identity or experience, including trans experience or variations of sex characteristics. Where the report refers to respondents who selected an LGBTQIA+ response, this refers to the sexual orientation item unless otherwise stated.

A2.7. Income groupings

Household income was categorised into five groups based on reported weekly household income: less than $1,000 per week; $1,000 to $1,999; $2,000 to $3,999; $4,000 or more; and "Prefer not to say".

A2.8. Internet usage

Internet use frequency was categorised into three groups to support weighting and analysis of digital access: three or more times daily, twice daily, and once daily or less. The once daily or less category included respondents who reported using the internet once daily, a few times a week, or less often.

A2.9. Language other than English spoken at home (LOTE) and other cultural background indicators

Like the 2024 and 2025 NCSS, the 2026 NCSS collected information about respondents' language and cultural backgrounds. The primary measure used for subgroup analysis was '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 English only. Respondents were also asked "Were you born in Australia?" and "When did you first arrive in Australia to live?". Information about Aboriginal and/or Torres Strait Islander status was also collected and used in sample profiling and interpretation.

In 2026, an additional question captured respondents' self-identified cultural background. This complemented LOTE and migration measures by providing information about cultural identity, including English-speaking, Australian-born and culturally diverse groups. LOTE should not be interpreted as a complete measure of cultural and linguistic diversity. It does not capture preferred language, interpreter need, English proficiency, cultural safety, migration pathway, racism, or use of community and bicultural support.

A2.10. Metropolitan areas, regional and large rural centres, small and medium rural centres and remote areas classification

Area of residence was classified using the Modified Monash Model (MMM), [34]grouped into metropolitan areas, regional and large rural centres, and small and medium rural centres and remote areas. The MMM categorises areas based on remoteness and population size and is used in Australian Government health workforce programs. NCSS respondents were grouped into three categories:

- Metropolitan areas: MM 1, including capital cities except Darwin and Hobart
- Regional and large rural centres: MM 2 and MM 3, including areas within or less than 15 km from a town with a population of at least 15,000, including Darwin and Hobart
- Small and medium rural centres and remote areas: MM 4 to MM 7, including areas more than 15 km from the closest town with a population of at least 15,000

A2.11. Navigating the healthcare system

Respondents' reported ability to navigate the healthcare system was assessed using Scale 7 of the Health Literacy Questionnaire (HLQ), "Navigating the healthcare system".[35] 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.

34 Australian Government Department of Health and Aged Care, "Modified Monash Model (MMM)."

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

The scale comprised six 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 reported ease navigating the healthcare system. Scores above 3.5 indicate that navigation tasks are generally manageable rather than difficult.

A2.12. Private health insurance

Respondents were asked whether they had private health insurance, with response options of "Yes", "No" and "I don't know". Responses were used to classify respondents by PHI status.

A2.13. Dental cover as part of PHI

Respondents with private health insurance were asked whether their policy included dental cover, with response options of "Yes", "No" and "I don't know". Responses were used to classify respondents by dental cover status.

A2.14. Self-rated health

Self-rated health is a common measure of health status used to predict various health outcomes.[36] In the NCSS, respondents provided a self-rated assessment 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".

A2.15. Self-rated mental health

The NCSS used a single-item measure of self-rated mental health, consistent with approaches widely used in health research and population surveys.[37]. Respondents were asked to rate their overall mental health using the question 'Overall, how would you rate your mental health in the past four weeks?'. Response options included:

- Excellent
- Very good
- Good
- Fair
- Poor

Respondents could also select 'I don't know' or 'Prefer not to say'.

For analysis, these five categories were collapsed into three groups: Excellent/Very good, Good, and Fair/Poor for self-rated health and mental health.

A2.16. Socio-economic status

This survey used the Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA), specifically the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD).

The IRSAD summarises relative advantage and disadvantage based on the economic and social characteristics of people and households within an area. Respondents living in areas with IRSAD deciles 1 to 4 were classified as low SES, those in deciles 5 to 8 as mid SES, and those in deciles 9 and 10 as high SES.[38]

SES is therefore an area-level measure and should not be interpreted as a direct measure of an individual's income, education or household resources.

A3. Statistics used in this report

Counts: This report presents weighted counts and percentages unless otherwise stated. See A1.7 (Data weights) for further information.

Base size: The base size refers to the number of respondents included in a question, chart, table or filtered result. It is reported in brackets as *(n = …)*, unless it represents the full sample. "Prefer not to say" and "Don't know" responses were generally excluded from charts and tables where they represented a small proportion of responses.

Percentage: Percentages are calculated as the number of responses divided by the relevant base size. Percentages are generally reported to one decimal place in text and may be rounded in charts.

Mean: Mean scores for the HLQ were calculated by averaging valid responses and were reported to two decimal places. "Don't know" and "Prefer not to say" responses were excluded.

Rounding: Percentages are rounded, so totals may not always sum to 100%.

Net figures: In some cases, response categories were combined to produce summary, or net, measures.

36 Crossley and Kennedy, "The Reliability of Self-Assessed Health Status."

37 Ahmad et al., "Single Item Measures of Self-Rated Mental Health: A Scoping Review."

38 Januszewski et al., "Online Tool for Cross-Sectional and Longitudinal Comparison of Socio-Economic Status Indices Based on Postcodes in Australia."

Statistical analyses

Statistical tests were used to assess whether observed differences were unlikely to be due to sampling variation alone.

Differences between groups were reported only when they were statistically significant ($p < 0.05$) and substantively meaningful.

Chi-square test: Chi-square tests were used to assess whether categorical distributions differed between groups or waves beyond what would be expected from sampling variation.

Independent samples t-test: These tests were used to assess whether differences in average scores between two groups, such as mean HLQ score in 2025 compared with 2026, were statistically significant.

Regression: Regression models were used to investigate whether respondent characteristics were independently associated with outcomes of interest after adjusting for other measured characteristics.

Non-significant variables ($p > 0.05$) were retained in multivariable models for consistency across analyses and because previous research has identified them as relevant to the outcomes being examined.

Sensitivity analyses were performed by excluding non-significant predictors. Their removal did not materially change the significance or direction of retained predictors, indicating that the findings were robust. We used:

- Binomial logistic regression: This method was used for binary outcomes, such as “Yes” or “No”, to assess whether respondent characteristics were independently associated with the likelihood of a specific outcome.
- Linear regression: This method was used for continuous outcomes, such as the HLQ Scale 7 score, to assess whether respondent characteristics were independently associated with higher or lower scores.

Weighted regression analyses were conducted using the survey package in R (version 4.6.0), which accounted for population weights and survey design features. In 2026, responses coded as ‘Don’t know’, ‘Prefer not to say’ or equivalent non-substantive categories were treated as missing values and excluded from regression analyses. This is standard practice in regression modelling because these responses do not reflect a substantive position on the underlying concept being measured and cannot be directly compared with substantive response categories.

These responses represented a small proportion of the sample, reducing the likelihood that their exclusion materially affected the results.

Appendix B: Logistic and linear regression results

B1. Unmet healthcare need (yes)

A binomial logistic regression was used to identify factors associated with unmet healthcare need (not access care when needed compared with accessed needed care). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.346$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.02 to 1.09, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,210; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.507
- Model deviance: 4,697.00
- Akaike Information Criterion (AIC): 4,767.32
- Mean predicted probability: 0.490
- Predicted probability range: 0.086-0.967

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-0.462	0.205	-2.26	0.024	0.63	*
Age, 35-54 vs 18-34	-0.180	0.120	-1.49	0.136	0.84	NS
Age, 55-74 vs 18-34	-0.765	0.135	-5.65	<0.001	0.47	***
Age, 75+ vs 18-34	-1.370	0.231	-5.93	<0.001	0.25	***
Gender, Female vs Male	0.276	0.094	2.94	0.003	1.32	**
Gender, Other/Non-binary vs Male	1.347	0.699	1.93	0.054	3.85	NS
Income, $1,000-$1,999 vs < $1,000	0.212	0.137	1.55	0.120	1.24	NS
Income, $2,000-$3,999 vs < $1,000	0.182	0.140	1.30	0.192	1.20	NS
Income, > $4,000 vs < $1,000	0.231	0.164	1.41	0.159	1.26	NS
Education, Post-secondary vs High school	0.034	0.109	0.31	0.756	1.03	NS
Chronic conditions, Yes vs No	0.397	0.102	3.89	<0.001	1.49	***
Regional vs Metropolitan	0.230	0.134	1.72	0.085	1.26	NS
Rural/Remote vs Metropolitan	0.012	0.157	0.07	0.940	1.01	NS
PHI, Yes vs No	-0.499	0.104	-4.79	<0.001	0.61	***
LOTE spoken at home vs English only	0.103	0.146	0.70	0.481	1.11	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	0.186	0.157	1.19	0.236	1.20	NS
High SES vs Low SES	-0.073	0.135	-0.54	0.591	0.93	NS
Mid SES vs Low SES	0.164	0.119	1.38	0.169	1.18	NS
Internet use, once daily or less vs 3 or more times daily	0.044	0.236	0.19	0.853	1.04	NS
Internet use, twice daily vs 3 or more times daily	-0.120	0.165	-0.73	0.467	0.89	NS
Financial stress, Yes vs No	1.450	0.106	13.70	<0.001	4.26	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B2. Ease of accessing after-hours care (very easy/somewhat easy)

A binomial logistic regression was used to identify factors associated with reporting after-hours care as very or somewhat easy to access, compared with all other substantive responses. The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.231$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.20, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.338
- Model deviance: 4,439.00
- Akaike Information Criterion (AIC): 4,508.58
- Mean predicted probability: 0.262
- Predicted probability range: 0.047-0.595

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-0.729	0.213	-3.42	<0.001	0.48	***
Age, 35-54 vs 18-34	-0.130	0.116	-1.12	0.264	0.88	NS
Age, 55-74 vs 18-34	-0.510	0.143	-3.58	<0.001	0.60	***
Age, 75+ vs 18-34	-0.856	0.223	-3.83	<0.001	0.42	***
Gender, Female vs Male	-0.086	0.095	-0.90	0.367	0.92	NS
Gender, Other/Non-binary vs Male	-0.509	0.617	-0.82	0.409	0.60	NS
Income, $1,000-$1,999 vs < $1,000	-0.147	0.141	-1.05	0.295	0.86	NS
Income, $2,000-$3,999 vs < $1,000	-0.017	0.148	-0.12	0.908	0.98	NS
Income, > $4,000 vs < $1,000	0.190	0.172	1.10	0.269	1.21	NS
Education, Post-secondary vs High school	0.062	0.111	0.56	0.575	1.06	NS
Chronic conditions, Yes vs No	-0.019	0.103	-0.18	0.856	0.98	NS
Regional vs Metropolitan	-0.143	0.139	-1.03	0.304	0.87	NS
Rural/Remote vs Metropolitan	-0.535	0.178	-3.01	0.003	0.59	**
PHI, Yes vs No	0.151	0.110	1.37	0.170	1.16	NS
LOTE spoken at home vs English only	-0.433	0.146	-2.97	0.003	0.65	**
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.323	0.171	-1.89	0.059	0.72	NS
High SES vs Low SES	0.071	0.141	0.50	0.616	1.07	NS
Mid SES vs Low SES	0.098	0.129	0.76	0.450	1.10	NS
Internet use, once daily or less vs 3 or more times daily	0.088	0.215	0.41	0.682	1.09	NS
Internet use, twice daily vs 3 or more times daily	0.465	0.171	2.73	0.006	1.59	**
Financial stress, Yes vs No	0.150	0.117	1.28	0.202	1.16	NS
Difficulties affording care, Yes vs No	-0.541	0.133	-4.07	<0.001	0.58	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B3. Ease of accessing a bulk billing GP (much easier/somewhat easier)

A binomial logistic regression was used to identify factors associated with the perceived ease of accessing a bulk billing GP (much easier or somewhat easier compared with not easy). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.228$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.05 to 1.22, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.294
- Model deviance: 2,827.66
- Akaike Information Criterion (AIC): 2,891.93
- Mean predicted probability: 0.122
- Predicted probability range: 0.030-0.443

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-1.946	0.302	-6.44	<0.001	0.14	***
Age, 35-54 vs 18-34	-0.438	0.148	-2.96	0.003	0.65	**
Age, 55-74 vs 18-34	-0.415	0.187	-2.22	0.026	0.66	*
Age, 75+ vs 18-34	-0.103	0.283	-0.36	0.717	0.90	NS
Gender, Female vs Male	-0.182	0.125	-1.46	0.145	0.83	NS
Gender, Other/Non-binary vs Male	-0.934	1.095	-0.85	0.394	0.39	NS
Income, $1,000-$1,999 vs < $1,000	-0.250	0.178	-1.41	0.160	0.78	NS
Income, $2,000-$3,999 vs < $1,000	-0.006	0.180	-0.03	0.975	0.99	NS
Income, > $4,000 vs < $1,000	0.424	0.208	2.04	0.042	1.53	*
Education, Post-secondary vs High school	0.191	0.145	1.31	0.190	1.21	NS
Chronic conditions, Yes vs No	-0.027	0.128	-0.21	0.833	0.97	NS
Regional vs Metropolitan	-0.084	0.177	-0.48	0.634	0.92	NS
Rural/Remote vs Metropolitan	-0.004	0.202	-0.02	0.984	1.00	NS
PHI, Yes vs No	0.125	0.135	0.93	0.355	1.13	NS
LOTE spoken at home vs English only	0.442	0.173	2.55	0.011	1.56	*
Sexual orientation, LGBTQIA+ vs Heterosexual	0.162	0.197	0.82	0.410	1.18	NS
High SES vs Low SES	-0.314	0.181	-1.74	0.083	0.73	NS
Mid SES vs Low SES	-0.128	0.161	-0.80	0.426	0.88	NS
Internet use, once daily or less vs 3 or more times daily	-0.110	0.250	-0.44	0.659	0.90	NS
Internet use, twice daily vs 3 or more times daily	0.178	0.241	0.74	0.459	1.20	NS
Financial stress, Yes vs No	0.533	0.145	3.69	<0.001	1.70	***
Difficulties affording care, Yes vs No	-0.147	0.162	-0.91	0.364	0.86	NS

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B4. Self-rated health (excellent/very good)

A binomial logistic regression was used to identify factors associated with reporting excellent or very good health (compared with reporting good, fair or poor health). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.292$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.24, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.439
- Model deviance: 4,894.97
- Akaike Information Criterion (AIC): 4,969.33
- Mean predicted probability: 0.415
- Predicted probability range: 0.082-0.841

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	0.045	0.201	0.23	0.821	1.05	NS
Age, 35-54 vs 18-34	-0.568	0.113	-5.01	<0.001	0.57	***
Age, 55-74 vs 18-34	-0.331	0.135	-2.44	0.015	0.72	*
Age, 75+ vs 18-34	-0.172	0.192	-0.89	0.371	0.84	NS
Gender, Female vs Male	0.018	0.091	0.19	0.847	1.02	NS
Gender, Other/Non-binary vs Male	0.763	0.926	0.82	0.410	2.14	NS
Income, $1,000-$1,999 vs < $1,000	0.046	0.126	0.36	0.717	1.05	NS
Income, $2,000-$3,999 vs < $1,000	0.207	0.132	1.57	0.117	1.23	NS
Income, > $4,000 vs < $1,000	0.418	0.165	2.54	0.011	1.52	*
Education, Post-secondary vs High school	0.041	0.103	0.40	0.688	1.04	NS
Chronic conditions, Yes vs No	-1.070	0.096	-11.11	<0.001	0.34	***
Regional vs Metropolitan	0.247	0.134	1.84	0.066	1.28	NS
Rural/Remote vs Metropolitan	0.327	0.148	2.21	0.027	1.39	*
PHI, Yes vs No	0.282	0.102	2.76	0.006	1.33	**
LOTE spoken at home vs English only	-0.117	0.133	-0.88	0.378	0.89	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.331	0.165	-2.01	0.044	0.72	*
High SES vs Low SES	0.635	0.134	4.73	<0.001	1.89	***
Mid SES vs Low SES	0.262	0.120	2.19	0.028	1.30	*
Internet use, once daily or less vs 3 or more times daily	-0.186	0.203	-0.91	0.361	0.83	NS
Internet use, twice daily vs 3 or more times daily	-0.306	0.180	-1.70	0.089	0.74	NS
Financial stress, Yes vs No	-0.126	0.114	-1.10	0.269	0.88	NS
Difficulties affording care, Yes vs No	-0.454	0.124	-3.66	<0.001	0.64	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B5. Mental health (excellent/very good)

A binomial logistic regression was used to identify factors associated with reporting excellent or very good mental health (compared to good, fair or poor health). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.315$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.19, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.467
- Model deviance: 4,761.19
- Akaike Information Criterion (AIC): 4,833.02
- Mean predicted probability: 0.424
- Predicted probability range: 0.052-0.898

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-0.405	0.202	-2.01	0.045	0.67	*
Age, 35-54 vs 18-34	0.078	0.117	0.66	0.509	1.08	NS
Age, 55-74 vs 18-34	0.936	0.135	6.93	<0.001	2.55	***
Age, 75+ vs 18-34	1.479	0.195	7.58	<0.001	4.39	***
Gender, Female vs Male	-0.237	0.092	-2.59	0.010	0.79	**
Gender, Other/Non-binary vs Male	1.383	0.742	1.86	0.062	3.99	NS
Income, $1,000-$1,999 vs < $1,000	0.138	0.133	1.03	0.301	1.15	NS
Income, $2,000-$3,999 vs < $1,000	0.397	0.138	2.88	0.004	1.49	**
Income, > $4,000 vs < $1,000	0.504	0.168	3.01	0.003	1.66	**
Education, Post-secondary vs High school	0.116	0.104	1.11	0.268	1.12	NS
Chronic conditions, Yes vs No	-0.730	0.099	-7.37	<0.001	0.48	***
Regional vs Metropolitan	-0.025	0.137	-0.19	0.853	0.97	NS
Rural/Remote vs Metropolitan	0.187	0.151	1.24	0.216	1.21	NS
PHI, Yes vs No	0.185	0.105	1.76	0.079	1.20	.
LOTE spoken at home vs English only	-0.217	0.140	-1.54	0.123	0.81	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.446	0.162	-2.75	0.006	0.64	**
High SES vs Low SES	0.271	0.141	1.92	0.055	1.31	NS
Mid SES vs Low SES	-0.052	0.121	-0.43	0.666	0.95	NS
Internet use, once daily or less vs 3 or more times daily	0.072	0.201	0.36	0.721	1.07	NS
Internet use, twice daily vs 3 or more times daily	0.048	0.176	0.27	0.786	1.05	NS
Financial stress, Yes vs No	-0.444	0.115	-3.88	<0.001	0.64	***
Difficulties affording care, Yes vs No	-0.682	0.129	-5.30	<0.001	0.51	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B6. Confidence in accessing mental health support quickly (very confident/ extremely confident)

A binomial logistic regression was used to identify factors associated with confidence in accessing mental health support (confident compared to not confident). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.247$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.20, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.364
- Model deviance: 4,543.97
- Akaike Information Criterion (AIC): 4,613.58
- Mean predicted probability: 0.284
- Predicted probability range: 0.056-0.605

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-0.647	0.211	-3.07	0.002	0.52	**
Age, 35-54 vs 18-34	-0.353	0.116	-3.03	0.002	0.70	**
Age, 55-74 vs 18-34	-0.258	0.139	-1.86	0.063	0.77	NS
Age, 75+ vs 18-34	-0.019	0.195	-0.10	0.924	0.98	NS
Gender, Female vs Male	-0.315	0.095	-3.33	<0.001	0.73	***
Gender, Other/Non-binary vs Male	-0.279	0.658	-0.42	0.671	0.76	NS
Income, $1,000-$1,999 vs < $1,000	-0.304	0.136	-2.23	0.025	0.74	*
Income, $2,000-$3,999 vs < $1,000	0.018	0.138	0.13	0.897	1.02	NS
Income, > $4,000 vs < $1,000	0.243	0.167	1.45	0.147	1.27	NS
Education, Post-secondary vs High school	-0.067	0.108	-0.62	0.532	0.93	NS
Chronic conditions, Yes vs No	0.072	0.104	0.69	0.489	1.07	NS
Regional vs Metropolitan	0.049	0.141	0.35	0.730	1.05	NS
Rural/Remote vs Metropolitan	-0.191	0.158	-1.21	0.226	0.83	NS
PHI, Yes vs No	0.420	0.109	3.83	<0.001	1.52	***
LOTE spoken at home vs English only	0.223	0.139	1.60	0.109	1.25	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	0.051	0.163	0.32	0.752	1.05	NS
High SES vs Low SES	0.093	0.144	0.65	0.519	1.10	NS
Mid SES vs Low SES	-0.190	0.125	-1.52	0.129	0.83	NS
Internet use, once daily or less vs 3 or more times daily	-0.361	0.217	-1.66	0.096	0.70	NS
Internet use, twice daily vs 3 or more times daily	0.195	0.164	1.19	0.234	1.22	NS
Financial stress, Yes vs No	-0.034	0.118	-0.29	0.774	0.97	NS
Difficulties affording care, Yes vs No	-0.605	0.136	-4.43	<0.001	0.55	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B7. Dental service use (yes)

A binomial logistic regression was used to identify factors associated with reporting use of dental services (yes compared to no). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.292$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.02 to 1.16, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.443
- Model deviance: 5,085.25
- Akaike Information Criterion (AIC): 5,158.04
- Mean predicted probability: 0.542
- Predicted probability range: 0.089-0.857

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-1.283	0.210	-6.10	<0.001	0.28	***
Age, 35-54 vs 18-34	0.271	0.111	2.44	0.015	1.31	*
Age, 55-74 vs 18-34	0.844	0.132	6.38	<0.001	2.33	***
Age, 75+ vs 18-34	0.890	0.198	4.50	<0.001	2.44	***
Gender, Female vs Male	0.391	0.089	4.37	<0.001	1.48	***
Gender, Other/Non-binary vs Male	0.620	0.730	0.85	0.396	1.86	NS
Income, $1,000-$1,999 vs < $1,000	0.052	0.125	0.41	0.680	1.05	NS
Income, $2,000-$3,999 vs < $1,000	0.064	0.129	0.50	0.619	1.07	NS
Income, > $4,000 vs < $1,000	0.201	0.166	1.22	0.224	1.22	NS
Education, Post-secondary vs High school	0.205	0.100	2.04	0.041	1.23	*
Chronic conditions, Yes vs No	0.218	0.096	2.27	0.023	1.24	*
Regional vs Metropolitan	-0.040	0.130	-0.31	0.757	0.96	NS
Rural/Remote vs Metropolitan	-0.081	0.142	-0.57	0.569	0.92	NS
PHI, Yes vs No	0.896	0.099	9.07	<0.001	2.45	***
LOTE spoken at home vs English only	0.124	0.137	0.91	0.365	1.13	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	0.083	0.146	0.57	0.570	1.09	NS
High SES vs Low SES	0.275	0.128	2.14	0.033	1.32	*
Mid SES vs Low SES	0.136	0.113	1.21	0.227	1.15	NS
Internet use, once daily or less vs 3 or more times daily	-0.210	0.201	-1.04	0.298	0.81	NS
Internet use, twice daily vs 3 or more times daily	-0.546	0.158	-3.45	<0.001	0.58	***
Financial stress, Yes vs No	-0.176	0.106	-1.66	0.098	0.84	NS
Difficulties affording care, Yes vs No	-0.526	0.114	-4.60	<0.001	0.59	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B8. Satisfaction with healthcare (very satisfied/somewhat satisfied)

A binomial logistic regression was used to identify factors associated with overall satisfaction with healthcare (satisfied compared to not satisfied). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.297$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.19, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,092; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.399
- Model deviance: 3,404.78
- Akaike Information Criterion (AIC): 3,473.91
- Mean predicted probability: 0.829
- Predicted probability range: 0.421-0.958

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	1.219	0.234	5.20	<0.001	3.38	***
Age, 35-54 vs 18-34	0.579	0.129	4.49	<0.001	1.78	***
Age, 55-74 vs 18-34	0.694	0.170	4.09	<0.001	2.00	***
Age, 75+ vs 18-34	0.999	0.280	3.57	<0.001	2.72	***
Gender, Female vs Male	-0.003	0.114	-0.03	0.980	1.00	NS
Gender, Other/Non-binary vs Male	0.594	0.687	0.86	0.388	1.81	NS
Income, $1,000-$1,999 vs < $1,000	0.213	0.147	1.45	0.148	1.24	NS
Income, $2,000-$3,999 vs < $1,000	0.194	0.163	1.19	0.234	1.21	NS
Income, > $4,000 vs < $1,000	0.322	0.208	1.55	0.121	1.38	NS
Education, Post-secondary vs High school	-0.162	0.127	-1.28	0.201	0.85	NS
Chronic conditions, Yes vs No	0.040	0.128	0.31	0.757	1.04	NS
Regional vs Metropolitan	-0.019	0.156	-0.12	0.903	0.98	NS
Rural/Remote vs Metropolitan	0.115	0.177	0.65	0.514	1.12	NS
PHI, Yes vs No	0.382	0.120	3.18	0.002	1.47	**
LOTE spoken at home vs English only	-0.383	0.151	-2.54	0.011	0.68	*
Sexual orientation, LGBTQIA+ vs Heterosexual	0.104	0.188	0.55	0.581	1.11	NS
High SES vs Low SES	0.168	0.170	0.98	0.325	1.18	NS
Mid SES vs Low SES	-0.048	0.140	-0.34	0.733	0.95	NS
Internet use, once daily or less vs 3 or more times daily	-0.280	0.229	-1.22	0.222	0.76	NS
Internet use, twice daily vs 3 or more times daily	-0.489	0.222	-2.21	0.027	0.61	*
Financial stress, Yes vs No	-0.378	0.129	-2.92	0.004	0.69	**
Difficulties affording care, Yes vs No	-0.565	0.131	-4.33	<0.001	0.57	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B9. Experience of discrimination in healthcare (yes)

A binomial logistic regression was used to identify factors associated with experiencing discrimination in healthcare (yes compared to no). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.324$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.06 to 1.30, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,092; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.380
- Model deviance: 1,763.20
- Akaike Information Criterion (AIC): 1,828.83
- Mean predicted probability: 0.070
- Predicted probability range: 0.005-0.467

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-3.571	0.396	-9.03	<0.001	0.03	***
Age, 35-54 vs 18-34	-0.320	0.193	-1.66	0.098	0.73	NS
Age, 55-74 vs 18-34	-0.948	0.261	-3.63	<0.001	0.39	***
Age, 75+ vs 18-34	-0.720	0.382	-1.89	0.059	0.49	NS
Gender, Female vs Male	0.452	0.170	2.67	0.008	1.57	**
Gender, Other/Non-binary vs Male	0.195	0.836	0.23	0.815	1.22	NS
Income, $1,000-$1,999 vs < $1,000	0.024	0.202	0.12	0.905	1.02	NS
Income, $2,000-$3,999 vs < $1,000	-0.519	0.243	-2.14	0.033	0.60	*
Income, > $4,000 vs < $1,000	-0.038	0.280	-0.14	0.892	0.96	NS
Education, Post-secondary vs High school	0.387	0.195	1.99	0.047	1.47	*
Chronic conditions, Yes vs No	0.515	0.194	2.66	0.008	1.67	**
Regional vs Metropolitan	-0.053	0.236	-0.23	0.822	0.95	NS
Rural/Remote vs Metropolitan	-0.132	0.266	-0.49	0.620	0.88	NS
PHI, Yes vs No	-0.072	0.168	-0.42	0.671	0.93	NS
LOTE spoken at home vs English only	0.155	0.209	0.74	0.458	1.17	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	0.083	0.239	0.35	0.729	1.09	NS
High SES vs Low SES	-0.218	0.228	-0.95	0.339	0.80	NS
Mid SES vs Low SES	-0.201	0.203	-0.99	0.323	0.82	NS
Internet use, once daily or less vs 3 or more times daily	0.129	0.348	0.37	0.711	1.14	NS
Internet use, twice daily vs 3 or more times daily	0.813	0.336	2.42	0.016	2.26	*
Financial stress, Yes vs No	1.013	0.196	5.17	<0.001	2.76	***
Difficulties affording care, Yes vs No	0.462	0.198	2.33	0.020	1.59	*

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B10. Health literacy (HLQ score)

A linear regression model was used to identify factors associated with health literacy (HLQ score, continuous outcome). The overall model was statistically significant ($p < 0.001$) and showed a moderate proportion of variance ($R^2 = 0.151$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from NA to NA, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,239; full sample N = 5,178)

- R^2: 0.151
- Akaike Information Criterion (AIC): 8,223.43
- Mean predicted value: 3.524
- Predicted value range: 2.766-4.174

Coefficients

Predictor	β	SE	t	p	Sig
(Intercept)	3.631	0.061	59.69	<0.001	***
Age, 35-54 vs 18-34	0.066	0.035	1.88	0.061	NS
Age, 55-74 vs 18-34	0.182	0.043	4.27	<0.001	***
Age, 75+ vs 18-34	0.300	0.060	4.96	<0.001	***
Gender, Female vs Male	-0.054	0.028	-1.91	0.056	NS
Gender, Other/Non-binary vs Male	-0.065	0.197	-0.33	0.742	NS
Income, $1,000-$1,999 vs < $1,000	0.006	0.039	0.17	0.869	NS
Income, $2,000-$3,999 vs < $1,000	0.022	0.041	0.55	0.584	NS
Income, > $4,000 vs < $1,000	0.094	0.052	1.81	0.070	NS
Education, Post-secondary vs High school	-0.096	0.031	-3.11	0.002	**
Chronic conditions, Yes vs No	-0.049	0.029	-1.71	0.087	NS
Regional vs Metropolitan	-0.133	0.044	-3.01	0.003	**
Rural/Remote vs Metropolitan	-0.162	0.044	-3.66	<0.001	***
PHI, Yes vs No	0.072	0.031	2.34	0.019	*
LOTE spoken at home vs English only	-0.076	0.041	-1.86	0.063	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.042	0.046	-0.90	0.368	NS
High SES vs Low SES	0.088	0.040	2.19	0.029	*
Mid SES vs Low SES	0.012	0.036	0.34	0.733	NS
Internet use, once daily or less vs 3 or more times daily	-0.006	0.056	-0.11	0.914	NS
Internet use, twice daily vs 3 or more times daily	0.110	0.047	2.34	0.019	*
Financial stress, Yes vs No	-0.131	0.037	-3.55	<0.001	***
Difficulties affording care, Yes vs No	-0.318	0.040	-8.03	<0.001	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B11. MyMedicare awareness (yes)

A binomial logistic regression was used to identify factors associated with awareness of MyMedicare (yes compared to no). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.226$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.20, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,101; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.354
- Model deviance: 5,400.40
- Akaike Information Criterion (AIC): 5,472.22
- Mean predicted probability: 0.481
- Predicted probability range: 0.250-0.777

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-0.253	0.189	-1.34	0.182	0.78	NS
Age, 35-54 vs 18-34	-0.391	0.106	-3.67	<0.001	0.68	***
Age, 55-74 vs 18-34	-0.302	0.123	-2.45	0.014	0.74	*
Age, 75+ vs 18-34	-0.277	0.184	-1.51	0.132	0.76	NS
Gender, Female vs Male	0.137	0.086	1.60	0.110	1.15	NS
Gender, Other/Non-binary vs Male	1.112	0.650	1.71	0.087	3.04	NS
Income, $1,000-$1,999 vs < $1,000	0.102	0.118	0.86	0.391	1.11	NS
Income, $2,000-$3,999 vs < $1,000	-0.022	0.125	-0.17	0.863	0.98	NS
Income, > $4,000 vs < $1,000	0.299	0.157	1.91	0.056	1.35	NS
Education, Post-secondary vs High school	-0.002	0.096	-0.02	0.987	1.00	NS
Chronic conditions, Yes vs No	0.259	0.094	2.75	0.006	1.30	**
Regional vs Metropolitan	-0.022	0.121	-0.18	0.856	0.98	NS
Rural/Remote vs Metropolitan	0.019	0.134	0.14	0.889	1.02	NS
PHI, Yes vs No	0.191	0.096	2.00	0.046	1.21	*
LOTE spoken at home vs English only	0.225	0.134	1.69	0.092	1.25	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.081	0.144	-0.56	0.575	0.92	NS
High SES vs Low SES	-0.134	0.128	-1.05	0.295	0.87	NS
Mid SES vs Low SES	-0.075	0.108	-0.69	0.491	0.93	NS
Internet use, once daily or less vs 3 or more times daily	-0.366	0.184	-1.99	0.047	0.69	*
Internet use, twice daily vs 3 or more times daily	0.216	0.158	1.37	0.172	1.24	NS
Financial stress, Yes vs No	0.284	0.105	2.70	0.007	1.33	**
Difficulties affording care, Yes vs No	-0.127	0.114	-1.12	0.264	0.88	NS

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B12. My Health Record awareness (yes)

A binomial logistic regression was used to identify factors associated with awareness of My Health Record (heard of My Health Record compared to had not heard). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.312$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.04 to 1.18, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.415
- Model deviance: 3,292.11
- Akaike Information Criterion (AIC): 3,367.06
- Mean predicted probability: 0.858
- Predicted probability range: 0.444-0.978

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	0.112	0.244	0.46	0.647	1.12	NS
Age, 35-54 vs 18-34	0.896	0.145	6.19	<0.001	2.45	***
Age, 55-74 vs 18-34	1.309	0.178	7.33	<0.001	3.70	***
Age, 75+ vs 18-34	0.641	0.247	2.60	0.009	1.90	**
Gender, Female vs Male	0.605	0.124	4.87	<0.001	1.83	***
Gender, Other/Non-binary vs Male	0.827	0.974	0.85	0.396	2.29	NS
Income, $1,000-$1,999 vs < $1,000	0.201	0.160	1.26	0.208	1.22	NS
Income, $2,000-$3,999 vs < $1,000	0.522	0.170	3.07	0.002	1.69	**
Income, > $4,000 vs < $1,000	0.497	0.205	2.43	0.015	1.64	*
Education, Post-secondary vs High school	0.366	0.127	2.88	0.004	1.44	**
Chronic conditions, Yes vs No	0.383	0.127	3.03	0.002	1.47	**
Regional vs Metropolitan	-0.105	0.180	-0.58	0.559	0.90	NS
Rural/Remote vs Metropolitan	0.093	0.207	0.45	0.654	1.10	NS
PHI, Yes vs No	0.232	0.130	1.79	0.073	1.26	NS
LOTE spoken at home vs English only	-0.221	0.157	-1.41	0.158	0.80	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.056	0.203	-0.27	0.784	0.95	NS
High SES vs Low SES	-0.230	0.179	-1.28	0.199	0.79	NS
Mid SES vs Low SES	-0.060	0.164	-0.37	0.712	0.94	NS
Internet use, once daily or less vs 3 or more times daily	-0.368	0.228	-1.61	0.107	0.69	NS
Internet use, twice daily vs 3 or more times daily	-0.015	0.234	-0.06	0.950	0.99	NS
Financial stress, Yes vs No	-0.107	0.138	-0.77	0.439	0.90	NS
Difficulties affording care, Yes vs No	0.162	0.153	1.06	0.288	1.18	NS

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B13. Awareness of 1800MEDICARE

A binomial logistic regression was used to identify factors associated with having heard of 1800MEDICARE before the survey (yes compared to no). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.215$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.04 to 1.26, indicating little multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.315
- Model deviance: 4,428.27
- Akaike Information Criterion (AIC): 4,498.12
- Mean predicted probability: 0.252
- Predicted probability range: 0.073-0.457

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-0.994	0.219	-4.54	<0.001	0.37	***
Age, 35-54 vs 18-34	-0.515	0.120	-4.30	<0.001	0.60	***
Age, 55-74 vs 18-34	-0.319	0.136	-2.34	0.019	0.73	*
Age, 75+ vs 18-34	-0.324	0.208	-1.56	0.118	0.72	NS
Gender, Female vs Male	-0.055	0.098	-0.56	0.574	0.95	NS
Gender, Other/Non-binary vs Male	-0.770	0.612	-1.26	0.208	0.46	NS
Income, $1,000-$1,999 vs < $1,000	-0.209	0.137	-1.53	0.126	0.81	NS
Income, $2,000-$3,999 vs < $1,000	-0.162	0.142	-1.15	0.252	0.85	NS
Income, > $4,000 vs < $1,000	-0.050	0.174	-0.29	0.773	0.95	NS
Education, Post-secondary vs High school	0.102	0.110	0.92	0.356	1.11	NS
Chronic conditions, Yes vs No	0.096	0.107	0.90	0.368	1.10	NS
Regional vs Metropolitan	-0.088	0.141	-0.62	0.532	0.92	NS
Rural/Remote vs Metropolitan	-0.222	0.163	-1.36	0.174	0.80	NS
PHI, Yes vs No	0.266	0.110	2.42	0.015	1.30	*
LOTE spoken at home vs English only	0.059	0.138	0.42	0.672	1.06	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.045	0.164	-0.28	0.783	0.96	NS
High SES vs Low SES	0.108	0.146	0.74	0.458	1.11	NS
Mid SES vs Low SES	0.007	0.128	0.05	0.958	1.01	NS
Internet use, once daily or less vs 3 or more times daily	-0.317	0.207	-1.53	0.125	0.73	NS
Internet use, twice daily vs 3 or more times daily	0.139	0.189	0.73	0.464	1.15	NS
Financial stress, Yes vs No	0.154	0.123	1.25	0.210	1.17	NS
Difficulties affording care, Yes vs No	-0.101	0.131	-0.77	0.442	0.90	NS

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

B14. Decreased confidence in the health system

A binomial logistic regression was used to identify factors associated with reporting decreased confidence in the health system over the past 12 months (decreased compared to stayed the same, increased or don't know). The overall model was statistically significant ($p < 0.001$) and showed moderate explanatory power (McFadden's $R^2 = 0.265$). Adjusted Generalised Variance Inflation Factor (GVIF) values ranged from 1.03 to 1.23, indicating little evidence of multicollinearity among predictor variables.

Model fit statistics (N ≈ 4,209; full sample N = 5,178)

- Nagelkerke pseudo R^2: 0.384
- Model deviance: 4,354.45
- Akaike Information Criterion (AIC): 4,426.69
- Mean predicted probability: 0.256
- Predicted probability range: 0.066-0.616

Coefficients and odds ratios

Predictor	β	SE	z	p	OR	Sig
(Intercept)	-2.075	0.222	-9.36	<0.001	0.13	***
Age, 35-54 vs 18-34	0.305	0.124	2.46	0.014	1.36	*
Age, 55-74 vs 18-34	0.392	0.145	2.71	0.007	1.48	**
Age, 75+ vs 18-34	-0.033	0.225	-0.15	0.884	0.97	NS
Gender, Female vs Male	0.530	0.099	5.35	<0.001	1.70	***
Gender, Other/Non-binary vs Male	0.384	0.692	0.55	0.579	1.47	NS
Income, $1,000-$1,999 vs < $1,000	0.036	0.133	0.27	0.786	1.04	NS
Income, $2,000-$3,999 vs < $1,000	0.096	0.137	0.70	0.486	1.10	NS
Income, > $4,000 vs < $1,000	-0.142	0.176	-0.81	0.420	0.87	NS
Education, Post-secondary vs High school	0.160	0.111	1.45	0.148	1.17	NS
Chronic conditions, Yes vs No	0.178	0.109	1.63	0.103	1.19	NS
Regional vs Metropolitan	0.152	0.140	1.08	0.279	1.16	NS
Rural/Remote vs Metropolitan	0.172	0.149	1.16	0.248	1.19	NS
PHI, Yes vs No	-0.086	0.108	-0.80	0.426	0.92	NS
LOTE spoken at home vs English only	0.073	0.138	0.53	0.598	1.08	NS
Sexual orientation, LGBTQIA+ vs Heterosexual	-0.260	0.176	-1.48	0.140	0.77	NS
High SES vs Low SES	-0.245	0.145	-1.69	0.091	0.78	NS
Mid SES vs Low SES	0.008	0.122	0.07	0.948	1.01	NS
Internet use, once daily or less vs 3 or more times daily	0.146	0.230	0.63	0.527	1.16	NS
Internet use, twice daily vs 3 or more times daily	-0.033	0.190	-0.17	0.862	0.97	NS
Financial stress, Yes vs No	0.443	0.116	3.83	<0.001	1.56	***
Difficulties affording care, Yes vs No	0.540	0.123	4.39	<0.001	1.72	***

Significance levels: *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Non-significant results have $p > 0.05$

Appendix C: Supplementary tables

Table S1. Topics covered in the 2024-25 NCSS and the 2026 NCSS

	2024 and 2025 surveys	2026 survey
Health status and conditions		
General health rating	✔	✔
Presence of long-term health conditions	✔	✔
Reasons for having/not having private health insurance	✔	✘
Financial barriers to healthcare		
Impact of money shortages on accessing healthcare, housing, utilities, and food	✔	✔
Out-of-pocket costs and bulk billing access	✘	✔
Healthcare Access and Experiences		
Use of health services (GPs, hospitals, specialists, allied health, etc.)	✔	✔
Satisfaction/Experience with services and providers	Satisfaction	Quality
Continuity of care and coordination between providers	✘	✔
After-hours care access and usage	✔	✔
Mental health		
Mental health status	✘	✔
Access to mental health support and treatment plans	✘	✔
Confidence in accessing mental health care	✘	✔
Impacts of delayed or avoided dental/mental health care	✘	✔
Dental health		
Dental visits and types of services accessed	✘	✔
Barriers to dental care and consequences of avoidance	✘	✔
Views on public funding for dental care	✘	✔
Awareness and use of government health programs		
MyMedicare	✔	✔
My Health Record	✔	✔
1800MEDICARE helpline	✘	✔
Experience of using MyMedicare and My Health Record	✔	✘
Use of telehealth and support services		
Modes of accessing care (in-person, phone, video, online)	✔	✔
Use of specific helplines and support services (e.g. Lifeline, Healthdirect)	✔	✔

continued over

	2024 and 2025 surveys	2026 survey
Healthcare navigation and experience		
Confidence in navigating the system	✔	✔
Understanding health information	✔	✔
Inclusion in decision-making and other consumer-centred actions	✔	✔
Trust and confidence in the system		
Trust in and communication from government and healthcare providers	✘	✔
Confidence in receiving quality care if seriously ill	✔	✔
Changes in confidence over the past year	✔	✔
Demographics		
Age, gender, education, income	✔	✔
Cultural background	Limited	Expanded
Disability status and type	Status only	Status and type
Carer responsibilities	✔	✔
Language spoken at home and country of birth	✔	✔
Internet usage	✔	✔

Table S2. Full sample profile

Subgroup	2026		2025		2024	
	Weighted n	Weighted per cent	Weighted n	Weighted per cent	Weighted n	Weighted per cent
Gender						
Male	2,522	48.7	2,511	48.7	2,435	48.4
Female	2,635	50.9	2,619	50.8	2,564	51.0
Persons who identify as non-binary	18	0.3	27	0.5	19	0.4
Unknown	3	0.1	3	0.1	11	0.2
Age Group						
18-34 years	1,556	30.0	1,563	30.3	1,539	30.6
35-54 years	1,722	33.2	1,723	33.4	1,672	33.2
55-74 years	1,374	26.5	1,295	25.1	1,332	26.5
75 years and over	527	10.2	579	11.2	485	9.7
State/Territory						
New South Wales	1,597	30.8	1,614	31.3	1,556	30.9
Victoria	1,339	25.9	1,328	25.7	1,298	25.8
Queensland	1,064	20.5	1,053	20.4	1,028	20.4
South Australia	364	7.0	364	7.0	356	7.1
Western Australia	576	11.1	558	10.8	551	11.0
Tasmania	105	2.0	109	2.1	108	2.1
Northern Territory	47	0.9	46	0.9	47	0.9
Australian Capital Territory	87	1.7	89	1.7	85	1.7
Area of residence						
Metropolitan areas	3,456	66.7	3,474	67.3	3,371	67.0
Regional and large rural centres	867	16.7	842	16.3	895	17.8
Small and medium rural centres and remote areas	828	16.0	825	16.0	739	14.7
Unknown	28	0.5	19	0.4	24	0.5
Aboriginal and/or Torres Strait Islander origin						
No	4,814	93.0	4,890	94.8	4,764	94.7
Yes, Aboriginal	192	3.7	142	2.7	156	3.1
Yes, Torres Strait Islander	21	0.4	16	0.3	10	0.2
Yes, both Aboriginal and Torres Strait Islander	32	0.6	20	0.4	8	0.2
Unknown	120	2.3	92	1.8	91	1.8

continued over

Subgroup	2026		2025		2024	
	Weighted n	Weighted per cent	Weighted n	Weighted per cent	Weighted n	Weighted per cent
Household income per week						
Negative income	14	0.3	13	0.3	19	0.4
Nil income	93	1.8	75	1.5	69	1.4
$1-$299 per week	118	2.3	86	1.7	105	2.1
$300-$999 per week	1,093	21.1	1,126	21.8	1,082	21.5
$1,000-$1,999 per week	1,327	25.6	1,281	24.8	1,322	26.3
$2,000-$2,999 per week	740	14.3	817	15.8	778	15.5
$3,000-$3,999 per week	454	8.8	423	8.2	400	7.9
$4,000-$4,999 per week	193	3.7	200	3.9	232	4.6
$5,000-$5,999 per week	105	2.0	119	2.3	119	2.4
$6,000-$7,999 per week	84	1.6	124	2.4	85	1.7
$8,000 or more per week	102	2.0	94	1.8	100	2
Unknown	856	16.5	800	15.5	719	14.3
Highest level of education						
Up to the end of high school	2,186	42.2	2,138	41.4	2,108	41.9
Qualifications after secondary school	2,792	53.9	2,847	55.2	2,787	55.4
Other or prefer not to say	202	3.9	174	3.4	134	2.7
Language other than English spoken at home						
Yes	545	10.5	644	12.5	596	11.8
No	4,591	88.6	4,451	86.3	4,381	87.1
Unknown	43	0.8	64	1.2	53	1.0
Born in Australia						
Yes	4,181	80.7	4,187	81.1	4,093	81.4
No	962	18.6	937	18.2	890	17.7
Unknown	36	0.7	36	0.7	46	0.9

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