

24 October 2026

Australian Commission on Safety and Quality in Health Care

GPO Box 5480

Sydney NSW 2001

RE: National Safety and Quality Health Service Standards Third Edition Consultation

Dear Australian Commission on Safety and Quality in Health Care

Thank you for the opportunity to provide feedback on the draft third edition of the National Safety and Quality Health Service Standards.

I am writing on behalf of Women's Health NSW and our membership. Women's Health NSW (WHNSW) is the peak body for 21 non-government community-based women's health centres (WHCs) in New South Wales (NSW). We are proactive on priority issues relevant to women's health, advocating for improved health outcomes so that women and girls can reach their potential within a gender and culturally safe and healthy environment.

We are funded by a Ministerial Approved Grant called the Women's Health Program. Women's Health Centres offer a unique, integrated primary health care model that addresses a wide range of physical and mental health needs that women present with, as well as the social determinants of health and the health impacts of violence against women. Key components of WHC's service model include individual and group counselling, chronic disease prevention and management, integrated care and referral support for domestic, family and sexual violence (DFSV), women's health clinics providing sexual and reproductive health services, and health education and health promotion to equip women to participate in their own healthcare and wellbeing.

We appreciate the opportunity to provide feedback on the National Safety and Quality Health Service Standards. We welcome the strengthened emphasis on person-centred practice throughout the draft. The recognition that high-quality care requires an understanding of the person as a whole - their values, preferences, goals, cultural context and lived experience - is an important step forward.

I wish to recommend one further refinement: the explicit recognition of stigma within the section on person-centred practice. I therefore provide the following information on stigmatised health conditions, gender bias and medical misogyny and lastly case study examples demonstrating lived and practice experience to illustrate the importance of this addition.

Stigma as part of person-centered care

We know that there are a number of different identities, conditions and practices that are stigmatised, and that many people in the Australian population - and globally - might be living with any number of those.

Stigma is the discrediting characteristic that reduces a person 'from a whole and usual person to a tainted, discounted one'. 'It is a process whereby the societal reaction to a person or his condition negatively alters the individual's normal identity' and devalues him in the eyes of others. Health-related stigma refers to stigmatisation of an illness, which can be applied to an individual or a group of people with the illness, as well as to the illness itself and populations more generally. It is not uncommon for people to internalise negative beliefs expressed explicitly or implicitly through people's biases impacting their self-belief, understanding of their health needs and ability to self-advocate and access healthcare. Stigma involves labelling, stereotyping, separation, status loss and discrimination. Attitudes can manifest in various ways such as dismissive behaviors, unconsciously perpetuating stereotypes, lack of empathy, inadequate provision of services and overt forms of discrimination being the experience of unjust treatment or unequal opportunities. All ultimately exacerbates a person's condition and discourages them from seeking further help. (1)

Person-centred care depends on clinicians understanding and responding to the individual in front of them. Stigma undermines this by acting as a filter through which people are perceived, assessed and treated, replacing an understanding of the individual with assumptions based on a health condition, identity or life circumstance. In this way, stigma can influence communication, clinical assessment, decision-making, trust, disclosure and ongoing engagement with care.

Stigma is also a barrier throughout the entire care journey. Previous experiences of stigma within healthcare can discourage people from seeking care, reduce trust and honest disclosure, undermine engagement with treatment, and make people less likely to return for future care. These effects are not covered by inclusion of bias in the Standards; bias focuses on the worker and organisation – not the experience of the patient. Because most people will experience one or more stigmatised conditions, identities or life circumstances during their lifetime, addressing stigma is relevant across the health system and benefits all patients, while helping to reduce inequities experienced by those most affected.

For this reason, addressing stigma should be regarded as an essential enabler of person-centred care. For example, stigma is centrally relevant to the goal of building respectful and trusting relationships (p31) and the goal of caring for the whole person (addressing an individual's psychological, cultural and social needs) (p33). Attention to stigma would also strengthen the Standard's goals of high-quality care, particularly minimising unwarranted variation in care.

Recognising stigma within the Standards would reinforce that delivering person-centred care requires both clinicians and health service organisations to identify and address individual, interpersonal, organisational and structural forms of stigma that may influence care. Because stigma is embedded not only in individual interactions but also in organisational policies, procedures and cultures, reducing stigma requires a systems approach rather than relying solely on individual behaviour change.

This reflects a substantial and growing evidence base demonstrating that stigma contributes to poorer access to care, inequitable experiences of care and worse health outcomes across a wide range of health conditions, identities and life circumstances. It also aligns with emerging international thinking that understands stigma as a quality-of-care issue - one that should be addressed through the same quality improvement systems used to improve other aspects of safety and quality.

Rather than trying to eliminate every personal bias, healthcare services and workers should focus on ensuring all people are treated with dignity, respect and professionalism regardless of their identities, health conditions or life circumstances.

Reflective practice encourages health workers to examine their own beliefs, behaviours and decision-making, and consider how these may influence patient experiences. Treating everyone the same does not necessarily address existing inequities. Different communities face different barriers. Some people experience multiple forms of stigma. Others may require tailored support to access care safely and effectively. It is therefore important to create consistent standards for welcoming, respectful care while remaining responsive to individual circumstances. Reducing stigma is not solely the responsibility of clinicians, rather it requires systematic reform that includes all staff from all levels of the organisation, from those working in executive and leadership positions to those delivering health care, working in reception, and so on. (2)

This can be aided by promoting reflective practice creating opportunities for all involved in healthcare to critically examine their own beliefs, behaviours and decision-making, and consider how these may influence client experiences, and how they can respond differently. This could be aided by the value of involving people with lived experience in training, service design, governance and decision-making. Indeed, having lived experience embedded from the beginning of any initiative, with genuine diverse lived experience representation is key to tackling stigma. (2)

We provide the following information from our experience working with women for over fifty years including those who are marginalised and underrepresented, who we hear from and witness the experience of stigma and the impact on their access and experience of health care services.

Stigmatised health issues

Women's Health Centres concur with literature that identifies several stigmatised health conditions experienced by women that are particularly prone to stigma. This can be further compounded by the intersections of race, gender, sexual orientation, class, geography and occupation.

Stigma influences help-seeking by discouraging disclosure, shapes diagnostic processes that normalise or dismiss symptoms, delays accessing services and affects treatment outcomes by undermining engagement, adherence and continuity of care. Even whether a person elects to have a My Health Record. Negative beliefs and biases can be internalised as well as manifesting into discrimination with people experiencing unjust treatment or unequal opportunities, negatively impacting their overall quality of life, health and wellbeing.

Additionally, the following public policies, amongst others, identify stigma and its impact; National Plan to End Violence Against Women and Children 2022-2023, National Drug Strategy 2017-2026,

National Mental Health Workforce Strategy 2022-2032, Australian Cancer Plan 2023, National Obesity Strategy 2022-2032, National Preventive Health Strategy 2021-2030 and the National Women's Health Strategy 2020-2030.

We provide this summary of stigmatised conditions WHC's commonly see.

- *Mental Health.* Stigma operates across multiple stages of the mental health care continuum. Conditions include anxiety, depression and mood disorders, schizophrenia, social ideation, self-harm, eating disorders, neurodevelopmental disorders, antenatal and post-natal depression and psychosis amongst others. People living with a mental illness may be labelled as 'attention seeking', viewed as incompetent, unable to work or live independently or may not be empowered to claim their rights and even the enactment of protective laws such as the Mental Health Act and protective orders. Treatment related stigma can include concerns about being seen entering clinics, disclosing medication use or having diagnoses documented. This extends to those experiencing post-natal depression and perinatal anxiety and other mental ill-health experienced by parents concerned that should they seek help they might come to the attention of child protection. Stigma and concerns of seeking healthcare extends beyond specialised mental health services with people reporting GPs and health professionals in emergency departments confounding their physical health issues with their mental health diagnoses. The 2026 National Stigma and Discrimination Report Card produced by the National Mental Health Commission found more than a quarter of people reported stigma or discrimination when seeking care for their physical health, and 20% for their mental health. Health professionals were most reported as being dismissive or sceptical (61%) or lacking understanding of the person's mental health problems (38%). (3)
- *Alcohol and other drug use.* Substance use including intoxication, injecting of illicit substances, dependence and being engaged in treatment attract near universal stigma and marginalisation. Stigma occurs as drug use behaviour becomes conflated with the person and people are labelled as 'drug users' or 'addicts', rather than the person with substance use issues being seen as having a health issue like with other conditions. Drivers underpinning the stigma includes the belief that drug use behaviour is immoral, illegal and deviant. The alienation of people who use illicit drugs or experience dependence can lead to poorer mental and physical health outcomes. Some people who use drugs have a fear of being treated differently, expectations of being dismissed or rejected, and experience feelings of internalised shame and a loss of self-worth. These can result in people delaying treatment which can lead to increased harms from substance use, and subsequent mental and physical health impacts. (5)
- *Domestic, family and sexual violence.* Perceived stigma and fear of discrimination can lead to a lack of trust in healthcare professionals, which in turn reduces the likelihood of disclosing DFV experiences. Healthcare providers' attitudes, fear of judgement, lack of trust and associated stigma, frequently in response to poor experiences when disclosing such as blame, shame, dismissal/denial, not being believed, having their experiences downplayed or where others 'look away' are major barriers to healthcare

access. This extends to health professionals who may exhibit unprofessional behaviour receiving responses that are unethical or go against right to competent care. Women experiencing DFV presenting in mental health crisis perceived that healthcare professionals labelled them as ‘crazy’ women, resulting in feelings of invalidation, further entrenching the entrapment that women experience when being controlled by their abuser (6). This can prolong the cycle of abuse and make it harder for survivors to access the resources they need to escape their situation and begin healing. Literature shows many victim-survivors will not disclose their trauma outside of receiving crisis support because of anticipated stigma and so their trauma and future needs may remain unresolved. (7, 8)

- *Cancer.* Even though many cancers can be cured or effectively treated and controlled, it remains a highly stigmatised condition, with some types of cancer more stigmatised than others. Fear of transmission, perceptions of disfigurement, attributions of blame for contracting disease, guilt, shame and being linked with death all contribute to the stigma that many experience. Some specific cancers are more associated with stigma due to their location, cause of transmission and deeply personal bodily functions e.g. bowel and reproductive cancer such as cervical, breast, ovarian and uterine cancers. Differences in religion and culture and perceived responsibility can be driving factors and barriers to screening, help seeking and treatment. As is documented in the literature WHCs hear from women of diverse communities concerns of invasive procedures, privacy and modesty as with cervical and breast cancer screening. (9)
- *Reproductive and sexual health.* Political ideologies, social and cultural expectations around gender equality, reproductive choices, and sexuality perpetuate stigma and threaten sexual and reproductive health. Amongst healthcare providers stigma impacts decisions on referral, disclosure and treatment. Examples where stigma has the greatest impact is HIV, sexually transmitted infections, abortion and contraception. Individuals from stigmatized groups such as LGBTIQ+ people, sex workers and injecting drug users, attempting to access the health system may be denied care or experience delays in receiving care. They may also be provided lower-quality care, receive care that is not culturally appropriate, or experience mistreatment such as discrimination, verbal and physical abuse, and denial of care. Collectively, this can result in dissatisfaction and loss of trust in the health system, resulting in a vicious cycle of delaying care or not seeking care at all. (10)
- *Obesity and body weight.* A leading contributor to weight stigma is the misconception that obesity is caused by factors solely within an individual’s control. However, this disregards the complex nature of overweight and obesity and the obesogenic environment in which people find themselves. A range of Australian and international studies have found high levels of both explicit and implicit weight bias among health professionals, with more than half exhibiting some form of weight bias towards people living with obesity. Experiences of weight stigma are associated with physical and mental health consequences including depression, body image concerns, reduced

quality of life and increased mortality risk with reduced participation in preventative health screenings and disordered eating. (11)

- *Disability.* Community attitudes play a critical role in shaping the everyday experiences of people with disability, influencing their inclusion, independence, access to healthcare and opportunities. Stigma, unconscious bias, and limited understanding of disability remain persistent barriers for many people with disability, particularly for non-visible disabilities and the experiences of First Nations and culturally and linguistically diverse (CALD) people with disability. These attitudes are often deeply embedded in both social and professional settings, affecting how people with disabilities are treated and supported. Studies into the barriers to healthcare for people with disabilities show that stigma is a major factor to poor access to healthcare and that women with disabilities are more likely to have unmet healthcare needs than women without disability. Women's feeling of stigma was related to other factors such as poverty, inability to buy health insurance, receiving public assistance, internal sense of inefficiency and health providers disrespectful interactions with WWD. (12) accumulation of mutually reinforcing determinants of health not only amplifies the health and social disadvantage experienced by persons with disabilities but is further compounded by the unique experience of ableism. Examples provided include people with intellectual disabilities not having equitable access to sexual and reproductive health information and care, lack of clinical guidelines and disability-specific data for pregnancy care for women with physical disabilities, the availability communication aids and translators for Deaf people and those with intellectual disabilities and cognitive impairments, inaccessible healthcare environments and lack of adaptive equipment. (13,14)

Gender bias and medical misogyny

For women gender bias and medical misogyny underlies their experience of healthcare and of forementioned stigmatised conditions. Gender bias in healthcare is widespread, and women, doctors, researchers and administrators can all hold biased views about gender impacting the healthcare experience of women. This is further heightened where people have intersecting minority experiences such as ethnicity, visa status and socio-economic disadvantages.

Restrictive gender norms and biases reinforced within health care systems frequently result in experiences of stigma and gendered health discrimination. Gender bias in health care is responsible for a range of disparities between men and women, across diagnosis, treatment and access to care. The National Women's Health Strategy 2020-2030 (NWHS) identifies stigma experienced by women in accessing healthcare as a core component of eliminating gendered stigma and health discrimination. (3) The Australian Women's Health Alliance in their Eliminating Gendered Health Discrimination policy brief outlined the following ways gender-based stigma and discrimination can have a profound impact on all aspects of health and wellbeing for women. (4)

- Women experience dismissal of their pain and symptoms, physical and verbal abuse or violence, involuntary treatment, institutionalisation, breaches of bodily autonomy, breaches

of confidentiality and/or denial of autonomous decision-making, and lack of free and informed consent. For example, women are consistently provided with less support for pain management than men, despite reporting higher levels of it, due to a perception that they are “more sensitive”, are “overly emotional” or that they ‘overreact.’

- Medical misogyny also encompasses gendered structural barriers to accessing healthcare leading to delayed or misdiagnoses and access to treatment. Endometriosis, for example, affects one in ten women, but can take up to ten years to diagnose. The causes of this wait include long waiting lists for diagnostic surgery and high out-of-pocket expenses. Similarly, inconsistencies in the availability of abortion sometimes force Australian women to travel outside their local area or pay significant out-of-pocket expenses. (15)
- Medical misogyny is linked to poorer mental health outcomes and experiences of medical trauma. Medical trauma, discrimination and stigma can significantly impact women’s future interactions with services and dissuade future health seeking behaviour.
- Women’s greater life expectancy, together with lifetime differences in earnings and workforce participation, means that many older women experience economic vulnerability.
- Institutionally it results in chronic underfunding of women’s health services and items under Medicare, gender hierarchies that see men secure a greater share of medical-research funding than women, undervaluing feminised health workforces and underrepresentation in leadership positions.

Case Study Examples

We provide three case study examples from women’s health centres to illustrate the impact of stigma experienced by women accessing healthcare.

Client A

Client A resides in a regional area. She attended ED after a sexual assault. Client A has history of mental health, suicidal ideation/attempts, self-harm, and intravenous drug use – was in recovery phase at time of event.

Client A has a history of childhood abuse, neglect, poor parenting etc, that impacted her ability to parent and remain well whilst trying to navigate community. She was in rehab as a teenager where she was groomed by a worker who later fathered two of her children, who he sexually assaulted. He is now in prison, and she has been compensated under the redress scheme after demonstrating her eligibility.

Late 2025 she engaged in consensual sex, that then became nonconsensual and she was sexually assaulted. At this point in time, she had very limited relapses with her drug use. She presented as ED haemorrhaging vaginally from the injuries inflicting upon her and discussion was had as to whether she may need a transfusion and/or surgery. The doctor at ED when she presented had read her medical history, which outlined some of the history above and on presentation for the initial consult

with him he stated, 'a bit of fun gone wrong'. Additionally, she reported her examination was cruel and painful.

As a result of this stigmatising experience, she has relapsed and is using a significant amount of methamphetamines (injecting), has increased her use of online gambling, shoplifting, struggles with her activities of daily living, has come to the attention again of DCJ regarding her 8 year old son, and is experiencing increased suicidal ideation and self-harm. She is working with sexual assault, alcohol and other drugs and local women's health centre teams. When the Women's Health Centre does safety and wellbeing check ins, what is discussed more than anything is not the actual sexual assault but the flashback of the doctor and his comments. The WHC has also worked to find a bulk-billing doctor she is comfortable seeing for her severe prolapse of the bladder, bowel and uterus which was severely impacted by this assault and her substance use.

Client A has attempted to make a complaint to the hospital and gain a copy of her discharge notes which were never provided in the first instance.

This presentation illustrates stigma experienced because of multiple lived experiences including illicit substance use and dependence, dependence, mental health conditions including suicidal ideation and self-harm, childhood abuse and sexual assault. Additionally living in a regional area, with limited finances and presenting reproductive and pelvic region all contributed to biases and negative beliefs expressed by health professionals in their interactions and treatment, and her subsequent health and recovery. It also highlights the importance of listening to women's descriptions of their pain and functional limitations, recognising invisible disability, providing trauma-informed care, and ensuring women with persistent pelvic or other chronic pain have access to appropriate investigation, referral and ongoing multidisciplinary support.

Client B

Client B sought GP care from an inner-city women's health centre. She was living with longstanding chronic pain following a serious motor vehicle accident involving significant pelvic, spinal and head injuries. Her history was further complicated by prolonged domestic and family violence and associated legal stress. She felt her DFV trauma had not been considered in her healthcare prior to accessing the WHC, where she felt safe to discuss her experiences, the emotional impacts and linked to recovery services.

The client required longer appointments and trauma-informed care that took into account her trauma and stress of active DFV legal matters for continuity of care.

Her presentation illustrates the intersection between chronic physical pain, trauma, psychological wellbeing and experiences of violence and how negative experiences with health services in the past and internalised stigma and delay help-seeking.

Client C

A woman living with Ehlers-Danlos syndrome (EDS) and Postural Orthostatic Tachycardia Syndrome (POTS) presented to a women's health centre with widespread joint and musculoskeletal pain, fatigue, dizziness, heavy legs, significant exercise intolerance and low mood.

Ehlers-Danlos Syndrome (EDS) is a group of connective tissue disorders that affect the skin, joints, and blood vessel walls. Despite being relatively rare, its impact on patients' lives can be profound. However, due to its often-invisible symptoms, EDS is frequently misunderstood and stigmatized. She reported feeling her symptoms had worsened following COVID-19 but had been met with doubt with one health professional saying 'you don't look sick' leading her to question her experience and if she was exaggerating her condition or asking too much of health services. One concern in caring for women with complex presentations is the risk that physical symptoms may be attributed too readily to anxiety, stress or psychological distress. Mental and physical health can coexist and interact, and women still require appropriate assessment of their physical symptoms.

Her experience highlights the challenges of living with conditions where disability and functional limitations may not be immediately visible. Listening to her account of her symptoms and limitations was therefore extremely important and highlights what a woman is able to demonstrate during a short medical consultation may not reflect the impact her condition has on everyday functioning and support needs. Living with multiple chronic conditions, disability, financial disadvantage or other social pressures, access to safe, affordable and ongoing care can be challenging.

Recommendation:

We ask that the Standards incorporate explicit recognition of stigma within the section on person-centred practice. This would encourage the use of appropriate, non-stigmatising language, embed practices to reduce stigma and health discrimination and therefore potential access barriers, normalise conversations around health conditions that are known to be stigmatising and help to embed the expertise of lived experience.

Importantly, the amendments suggested do not introduce a new concept into the Standards. Rather, they strengthen the existing intent of person-centred practice by making explicit one of the most significant barriers to achieving it. Accreditation standards are among the most powerful drivers of organisational improvement. They influence what health services measure, govern, prioritise and continuously improve. Explicitly recognising stigma would create a clear expectation that health services identify, monitor and address stigma as part of delivering safe, high-quality, person-centred care.

I appreciate the Commission's consideration of these suggested changes and the opportunity to contribute to the development of the third edition of the Standards.

Yours sincerely,

Denele Crozier



Denele Crozier AM

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Women's Health NSW

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