Rapid Analysis

Barriers to Effective Consumer Participation in Health Policy and Research Development

Produced by: The Obesity Collective

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Executive Summary

Consumer participation in health policy and research development is increasingly recognised as vital to improving health outcomes, system responsiveness, and research relevance. It reflects principles of equity, democracy, and inclusivity by ensuring that the voices of patients, carers, and communities are integrated into decision-making processes. However, translating this ideal into practice remains challenging due to a wide array of structural, cultural, and institutional barriers. This report identifies and critically analyses the key barriers to effective consumer participation, drawing on Australian and international literature, with a specific focus on the unique challenges faced by individuals with lived experience of obesity.

Core challenges include conceptual ambiguity around what constitutes participation, widespread tokenism, entrenched power imbalances, and insufficient institutional support. Other significant barriers include the lack of diversity in consumer representation, logistical and financial constraints faced by consumers, limited capacity-building efforts, and resistance rooted in traditional professional cultures. For people living with obesity, additional significant barriers include pervasive obesity stigma, discrimination, and the psychological trauma associated with these experiences, which discourage engagement. Systemic exclusion, inaccessibility (physical, informational, and financial), and a lack of dedicated organisational support further compound these issues.

The Australian context illustrates both progress and persistent gaps, with national policies promoting consumer involvement but practical implementation remaining inconsistent, particularly in relation to obesity issues. Marginalised groups—such as First Nations communities, those from culturally and linguistically diverse backgrounds, and rural and remote communities—remain underrepresented in engagement initiatives.

Overcoming these barriers requires a systemic shift in how consumer engagement is conceptualised, resourced, and evaluated. This includes clearer frameworks, organisational investment, inclusive practices, training for both consumers and professionals, and stronger mechanisms for accountability. Proposed solutions include comprehensive public awareness campaigns to reduce stigma, promoting and enforcing genuine inclusion from the inception of initiatives, improving accessibility through funding and resources, and developing robust organisational support for lived experience advocates. Only through sustained, equitable partnerships can consumer participation in health policy and research become genuinely impactful and transformative, leading to more equitable healthcare outcomes and contributing to the sustainability of the Australian healthcare system.

1. Introduction

In recent decades, consumer participation has gained prominence among decision-makers as an essential component of representative health policy, programs and research. Consumers (patients, carers, and community members) bring lived experience, values, and contextual insight that adds relevance, acceptability, and ethical integrity of health systems and research. Despite widespread theoretical commitment to consumer engagement, its implementation often remains tokenistic, fragmented, or absent (Brett et al., 2014). Numerous structural, cultural, institutional, and interpersonal barriers undermine meaningful consumer participation in both policy and program development and health research. This report critically examines these barriers, grouped into thematic categories, and draws on international and Australian literature to highlight implications and potential solutions. A particular focus is placed on the specific challenges and proposed solutions for people living with obesity.

The inclusion of Lived Experience consumer narratives in health policy, programs, and research is essential for developing effective services that meet the actual needs of individuals, particularly those living with complex conditions such as obesity (Australian Government, 2025; Brett et al., 2014; Flint et al., 2025). Lived Experience voices are crucial to prioritise and guide initiatives as they provide real-world insights into the challenges and needs faced by individuals, ensuring any health improvement endeavours are relevant, effective and equitable (Consumers Health Forum, 2016). Their inclusion helps combat stigma, reduce power imbalances, promote inclusion and develop meaningful health solutions (Australian Government, 2025; Brett et al., 2014; Consumers Health Forum of Australia, 2025; Farrell et al., 2021).

Improving the effectiveness of obesity management and prevention strategies will help to reduce the development of obesity-related comorbidities leading to improvements on the cost efficiency of health services and reducing the burden on those living with obesity. With effective care, people living with obesity can develop a range of health issues such as physiological disturbances (type 2 diabetes, heart disease, stroke, cancer, mobility limitations) and psychosocial dysfunction (depression, anxiety, social isolation, spiritual disconnect and suicide) (Sarwer and Polonsky, 2016; Wagner et al., 2013; World Health Organisation, 2025). In 2018, obesity-related healthcare costs in Australia were reported to be $11.8 billion, and predicted to rise to >$87 billion by 2032 (Price Waterhouse Cooper, 2015). Effective obesity-related health initiatives can help reduce the time, resources, workload, and financial strain currently impacting the Australian health system.

Similar to other marginalised populations, people living with obesity often face consistent systemic exclusion, unequal access to healthcare, hindered employment or educational opportunities, and social disadvantage due to unwarranted obesity stigma and discrimination (Caliendo and Lee, 2013; Hill et al., 2021; Puhl and Brownell, no date; Venegas Hargous et al., 2025). Persistent discrimination impacts psychosocial health and dissuades people living with obesity from participating in many facets of life (Flint et al., 2025; Brewis, 2014; Lawrence et al., 2022; Puhl, 2023; The Obesity Collective, 2024; World Obesity Federation, 2022). Without the inclusion and participation of people living with obesity in decision-making processes, cycles of disadvantage, stigma, and discrimination are further perpetuated, making it even harder to access appropriate obesity-related health support and resources.

The objective of this report is to identify the significant barriers to and potential solutions for people living with obesity in participating in policy, research, and program development decision-making processes, while also contextualising these within broader challenges to consumer participation.

2. Conceptual Ambiguity and Tokenism

A major barrier to effective consumer participation is the continuing conceptual vagueness surrounding the term itself. “Consumer engagement” represents a spectrum of action which may encompass consultation, collaboration, partnership, or co-production, yet these terms are often used interchangeably without clarity about the depth or purpose of involvement (Carman et al., 2013). This ambiguity permits institutions to claim engagement while retaining decision-making power.

A number of assessments have also identified tokenism (superficial or symbolic form of involvement) as a similar barrier. Consumers may be invited late in processes, given little context, or engaged in ways that have no influence on outcomes (Brett et al., 2014). In research, tokenism is often manifest in the inclusion of consumers solely to meet funding requirements, rather than as active partners shaping study design, methods, and dissemination (Boivin et al., 2014). People living with obesity, often report involvement is tokenistic, coercive, or a last-minute ‘sign-off’, perpetuating exclusion and power imbalance (Brett et al., 2014; Venegas Hargous et al., 2025). This leads to further mistrust and hinders engagement for people living with obesity (Venegas Hargous et al., 2025; Ryan et al., 2024).

3. Power Asymmetries

Power imbalances between professionals and consumers are deeply entrenched in health systems and research cultures. Health policy and scientific inquiry are historically dominated by expert authority, and consumer perspectives are often dismissed as anecdotal, emotional, or lacking scientific merit (Williams et al., 2014).

Consumers may experience exclusionary language, challenging information formats, and hierarchical meeting structures that reinforce professional dominance (Schlesinger et al., 2013). The absence of transparent decision-making processes further limits consumers' ability to influence outcomes. When consumers are outnumbered or outvoted in committees, their participation lacks substantive power (Fredriksson and Tritter, 2017). For people living with obesity, this barrier of exclusion perpetuates feelings of paternalistic treatment and engenders a lack of agency in obesity care or policy change. Excluding the consumer voice reinforces the bias that consumer voices are not important in changing health policy or research creating a major barrier to engagement (Ayton et al., 2022). A lack of appropriate consumer representation in policy, program, or research system levels widens the power imbalance, delays meaningful health system improvements, and worsens patients' already poor quality of life experiences (Venegas Hargous et al., 2025; Ryan et al., 2024). Exclusion barriers also include the lack of insider support when attempting to navigate foreign and often complex research, medical, or policy spaces.

4. Lack of Diversity and Representation

Effective consumer participation requires the inclusion of diverse voices, particularly those from marginalised and underrepresented communities. However, many engagement processes attract “the usual suspects”—often well-educated, middle-class, and articulate individuals who are unrepresentative of broader populations (Paul et al., 2015).

Barriers to participation for Indigenous peoples, people with disabilities, culturally and linguistically diverse (CALD) communities, and those with low socioeconomic status include mistrust, previous experiences of discrimination, language barriers, and logistical challenges including distance and availability and access to technology (Kendall et al., 2017). These groups may view institutional processes as unwelcoming or irrelevant to their concerns, and their participation is often hindered by inadequate support structures (Dawson et al., 2021). People living with obesity are frequently excluded from decision-making processes and lack representation in policy, program and research contexts. Such systemic exclusion perpetuates a cycle of marginalisation and jeopardises obesity management and prevention efforts as well as quality of life for individuals (Weight Issues Network, 2022; Hill et al., 2021; Public Health Association, 2024; Venegas Hargous et al., 2025).

5. Institutional and Organisational Constraints

Institutions often lack the infrastructure, policies, and the appropriate culture to support sustained consumer engagement. Many organisations do not prioritise consumer involvement or allocate insufficient funding, time, or staff to facilitate it (Palmer et al., 2019).

Bureaucratic processes can be rigid and slow, discouraging consumer involvement. Even where policies mandate engagement, their implementation may be inconsistent due to competing organisational priorities. Staff may lack training in participatory methods, and leadership may be ambivalent about sharing control (Ocloo and Matthews, 2016). In research settings, the academic reward system rarely recognises consumer engagement. Success is measured by publication and grant outcomes rather than community impact or inclusiveness (Jagosh et al., 2012). This disincentivises meaningful consumer involvement and co-production.

For people living with obesity, there is a significant power imbalance in policy, program, and research contexts, where people with obesity have limited influence and representation (Lawrence et al., 2022; Weight Issues Network, 2022). This imbalance can lead to policies, programs and research that do not adequately address their needs or perspectives, further entrenching their marginalisation (Weight Issues Network, 2022; Venegas Hargous et al., 2025). Additionally, obesity is frequently framed as an issue of personal responsibility or willpower rather than a complex, multi-faceted health condition (Lawrence et al., 2022). This oversimplification disregards the diverse social, environmental, and biological factors that contribute to obesity (Australian Government Department of Health and Aged Care, 2022). Consequently, affected individuals are often excluded from meaningful policy discussions, reinforcing misconceptions and limiting opportunities for systemic change (Ayton et al., 2022).

Advocacy efforts in this field remain fragmented, lacking unified leadership or a coordinated strategy. Unlike other significantly funded health or consumer groups, such as those focused on mental health or disability (Lived Experience Aus, 2025; AFDO Australian Federation of Disability Organisations, 2017; Disability Representative Organisations, 2024; Mental health sector organisations, no date; Care, 2025), few community-led or institutional bodies exist to amplify the Lived Experience voices of obesity. This absence of organisational infrastructure forces many advocates to navigate complex systems, such as government processes, ethics approvals, and academic research settings, without adequate financial compensation, emotional support, access to information or logistical assistance; making sustained participation unrealistic for many people living with obesity. Without coordinated mentorship, professional networks, or recognition as legitimate contributors, individuals struggle to develop the skills and confidence needed to participate effectively in health decision-making. Additionally, minimal structural support and inadequate remuneration for people with lived experience devalue their expertise and discourage their participation. These systemic and organisational shortcomings collectively limit agency, reinforce stigma, and prevent meaningful collaboration with those most affected by obesity.

6. Financial and Practical Barriers

Participation requires time, energy, and resources; costs that disproportionately affect consumers, particularly those who are socioeconomically disadvantaged. Lack of compensation or reimbursement for travel, childcare, and lost income discourages sustained consumer involvement (Snape et al., 2014).

Rigid scheduling, inaccessible venues, and lack of access and skills in digital systems further limit who can participate. Many engagement processes are held during business hours, with little flexibility. Online participation, while promising, may exclude those without digital literacy or internet access (Locock and Boaz, 2019).

For Lived Experience experts in obesity, multiple levels of inaccessibility are prevalent. High costs, inaccessible terminology and insufficient resources limit the ability of individuals with obesity to participate in advocacy and policy-making (Brett et al., 2014; Weight Issues Network, 2022; Ayton et al., 2022). Physical environments, including meeting spaces and healthcare settings, often fail to accommodate the needs of people with higher-weight bodies (Weight Issues Network, 2022; Kukielka, 2020). This includes not only infrastructure (e.g., seating and mobility) but also social and emotional safety (such as stigma), which together contribute to exclusion and discomfort in professional or public settings (Weight Issues Network, 2022; Bennett et al., 2024). These barriers can prevent meaningful engagement and perpetuate a cycle of exclusion.

Specifically, people with Lived Experience who engage in advocacy often do so as unpaid volunteers with limited time, resources or institutional support (Brett et al., 2014; Weight Issues Network, 2022; Ayton et al., 2022; Gee et al., 2016). Barriers such as restricted access to key information platforms—academic journals behind paywalls—and a lack of administrative tools (e.g. Zoom subscriptions and professional support) make meaningful participation of consumers difficult. The use of technical or policy-specific jargon further marginalises potential advocates by creating a communication gap in discussions and decision-making (Ryan et al., 2024; Gee et al., 2016). Additionally, many policy, program, and research environments are not psychologically or physically safe and inclusive for people living in larger bodies, with inadequate seating, medical equipment, or inaccessible venues (Weight Issues Network, 2022; Kukielka, 2020). These environments reinforce obesity stigma and may trigger painful recollections of past bad experiences. The complex and opaque nature of health and policy systems, combined with a lack of clear entry points or guidance, makes it challenging for advocates to engage in these processes.

7. Lack of Capacity Building and Support

Consumers often require training, mentorship, and information to contribute effectively to complex policy and research discussions. However, such support is rarely provided in a systematic or ongoing way (Brett et al., 2014).

Without adequate preparation, consumers may feel intimidated or underprepared, leading to reduced confidence and passive participation. Likewise, professionals may lack skills in facilitation, inclusive communication, and an appreciation of co-design methods (Ocloo et al., 2021). The absence of mutual capacity-building contributes to mistrust and frustration around consumer involvement on both sides.

8. Cultural Attitudes and Resistance

Cultural norms within medicine, academia, and government often favour expert-driven decision-making and hierarchical models. Some professionals perceive consumer engagement as a threat to their autonomy or as a distraction that reduces their efficiency (Gibson et al., 2012).

Scepticism about the value of lived experience, especially when it contradicts scientific or policy orthodoxy, can lead to resistance or tokenistic inclusion. This is exacerbated in cultures where dissent or disagreement is discouraged, or where consumer advocacy is perceived as confrontational (Williams and Popay, 2001).

For people living with obesity, persistent and pervasive stigma and discrimination undermine their psychological safety and deter engagement in many facets of their lives. Obesity stigma contributes to further physical and psychosocial health issues, often leading to avoidance of certain situations to prevent more harm (Brewis, 2014; Flynn et al., 2024; Lawrence et al., 2022; The Australian Prevention Partnership Centre, 2025; Puhl, 2023; The Obesity Collective, 2024; World Obesity Federation, 2022). Obesity stigma is a predominant sociocultural norm in Australia, whether conscious or unconscious.

Specifically, obesity stigma is a barrier to engagement as it leads to an avoidance of health, policy or research settings due to fear of experiencing more stigma, harm or disrespect (Brewis, 2014; Flynn et al., 2024; Lawrence et al., 2022; Puhl, 2023). Stigma can be experienced in many ways and can be significantly traumatic for some. People living with obesity can potentially experience weight-related stigma or trauma as a result of advocacy or policy engagement efforts (Weight Issues Network, 2022). This stigma can hinder engagement into advocacy, as people living with obesity may lose confidence, and feel psychologically or physically unsafe to engage with advocacy.

9. Evaluation and Evidence Gaps

Although evidence suggests that consumer involvement can improve policy responsiveness and research relevance, robust evaluations remain limited. There is no universally accepted framework for measuring the impact or quality of engagement (Mockford et al., 2012).

The lack of systematic evaluation perpetuates uncertainty about what works, for whom, and under what circumstances. This in turn feeds professional scepticism and undermines the development and acceptance of effective engagement practices (Domecq et al., 2014).

10. Legislative and Policy Limitations

While many jurisdictions have policies encouraging consumer involvement, few make it a legal or enforceable requirement. Even where national frameworks exist (such as Australia's National Safety and Quality Health Service Standards), they are often vague in specifying mechanisms for meaningful participation (Australian Commission on Safety and Quality in Health Care, 2021).

In research, funding bodies may require consumer involvement (e.g. the National Health and Medical Research Council’s Statement on CCI), but enforcement is weak and reporting is inconsistent. Without accountability mechanisms or incentives, compliance often remains superficial (Boaz et al., 2018).

11. Ethical and Epistemological Tensions

Consumer engagement raises important ethical and epistemological questions about authority, representation, and knowledge production. Whose knowledge counts? Who gets to speak on behalf of whom?

Research often privileges objective, generalisable knowledge, while consumer insights are seen as subjective or context-bound (Greenhalgh et al., 2019). This artificial hierarchy of knowledge marginalises the views of consumers and questions the legitimacy of their contributions.

There is also an ethical tension between inclusion and protection. Overburdening consumers, especially those who are vulnerable or have experienced trauma, without adequate support raises concerns about exploitation and harm (Lemke et al., 2011).

12. The Current Situation in Australia

Australia provides a useful national context for exploring these barriers in practice. Consumer participation is endorsed in national strategies such as the National Health Reform Agreement and the Australian Charter of Healthcare Rights. Agencies like Consumers Health Forum of Australia (CHF) and Health Consumers NSW promote improved community and consumer engagement and play active roles in policy advocacy and developing research partnerships.

However, implementation remains uneven. A 2022 review by CHF found that consumers frequently experience tokenism, lack of feedback, and confusion about their role (Consumers Health Forum of Australia, 2022). Indigenous and CALD populations are underrepresented, and many rural consumers report poor access to engagement opportunities (Duckett et al., 2020).

In research, initiatives such as the MRFF Consumer Engagement Strategy and NHMRC Statement on Consumer Involvement signal progress, but barriers remain in institutional cultures, training, and evaluation mechanisms (National Health and Medical Research Council, 2021). The challenges faced by people with lived experience of obesity in Australia are particularly illustrative of these broader issues, highlighting the need for targeted and sensitive approaches.

13. Proposed Solutions to Enhance Participation

Addressing the multifaceted barriers to effective consumer participation requires a comprehensive and systemic approach. The following proposed solutions integrate general strategies with specific considerations for individuals with lived experience of obesity.

13.1. Reduce Obesity Stigma

Comprehensive public awareness campaigns are required to educate the public about the complexities of living with obesity, help identify internalised or externalised stigma or personal bias towards people living with obesity and ways to reduce discrimination (Lawrence et al., 2022). Such campaigns should include a multi-pronged approach to reach all levels of society, policy, program, research and education sectors across Australia. They should promote a holistic understanding of obesity that goes beyond current personal responsibility paradigm and address the complex array of systemic factors that drive the development of obesity.

Appropriate strategies:

- Develop Educational Programs: Generate and disseminate comprehensive education about the complexities of living with obesity, including the physiological, psychological, social, environmental, political and stigmatising factors. Education should be tailored to different target groups (Weight Issues Network, 2022; Banfield et al., 2025).
- Promote Positive Media Representation: Encourage media outlets to portray people with obesity in a respectful and non-stigmatising manner (Lawrence et al., 2022; Weight Issues Network, 2022; The Obesity Collective, 2022). This can be achieved by partnering with media organisations to develop guidelines for inclusive and accurate reporting on obesity. Development of these guidelines should also include the Lived Experience consumer voice.
- Healthcare Provider Education: Health professionals require specific education and training to help them recognise and address stigmatising practices in health care setting (Lawrence et al., 2022; Hill et al., 2024). Obesity is a precursor for many health conditions and thus stigma training is relevant to nearly all primary, secondary

and allied health professions. Tertiary education institutions should engage with lived experience representatives and integrate obesity healthcare and obesity stigma education into health-related curriculums (McKenzie et al., 2016). This would enable healthcare providers to recognise and address their own biases and to encourage them to provide compassionate care and communication when engaging with people living with obesity.

- Support Groups: Establish support groups for individuals with obesity to share experiences and strategies for coping with and addressing stigma and discrimination. These groups can also provide a safe space and emotional support as well as enabling the provision of advocacy training (Weight Issues Network, 2022).
- Policy Advocacy: Advocate for policies that protect individuals living with obesity from discrimination in healthcare, employment, and other areas (Brown et al., 2024). This includes lobbying for anti-discrimination laws and appropriate workplace design.

13.2. Promote and Obligate Inclusion

Ensure meaningful inclusion of people with obesity throughout all health and obesity policy, program and research discussion and decision-making processes (Brown et al., 2024). Specifically, include the lived experience voices from inception of any policy, program or research idea so the formulation of the research aim is aligned with the needs of people living with obesity (Ayton et al., 2022; Barbara et al., 2025). This will help to reduce wasted time, resources and funding on initiatives that will be unhelpful or likely fail because they are not aligned with consumer needs.

Appropriate Strategies:

- Create Advisory Panels: Establish sustainable advisory panels that include lived experience consumers to provide input on policy, program and research decisions. These panels should have real decision-making power and not be merely symbolic (Brown et al., 2024).
- Ethical Engagement: Develop ethical guidelines for engaging with lived experience experts to ensure their involvement is psychologically and physically safe, as well as meaningful (Gray, 2022; Dray et al., 2024). These guidelines should be enforced by all organisations involved in obesity-related work and developed with consumers to ensure appropriateness.
- Financial Remuneration: Provide appropriate financial compensation for the time and expertise from individuals with obesity who participate in advocacy and decision-making (Banfield et al., no date).

- Support/Mentorship Programs: Develop mentorship programs to support individuals and lived-experience advisory boards or panels navigating policy, program and research environments. Supporting lived-experience volunteers through inclusion and targeted training leads to better and more sustained consumer involvement (Brown et al., 2024; Barbara et al., 2025).

13.3. Ensure Accessibility

Potential Solution: Improve accessibility by reducing barriers for advocacy engagement and provide resources to support advocacy efforts. This includes planning to ensure equitable opportunities, access to funding support, creating appropriate environments (physical or online), and ensuring the use of plain language for effective engagement.

Strategies:

- Funding and Resources: Provision of funding to offset the costs, such as transportation, childcare and stipends for advocates to attend discussion and decision-making meetings. Appropriate remuneration for participants demonstrates the value and respect for participants engaging in advocacy efforts (Banfield et al., 2025; Dray et al., 2024) as this is often a volunteer role conducted on-top of regular work and responsibilities.
- Accessible Environments: Ensure that meeting spaces and healthcare settings are physically accessible and provide accommodations for individuals with larger bodies. This includes appropriate seating, mobility aids, medical equipment and accessible buildings (Kukielka, 2020).
- Simplify Terminology: Use plain language in policy, program and research documents to make them more accessible to non-experts. This can be achieved through development of glossaries and staff training around clearer communication with consumers (Gray, 2022).
- Digital Access: Provide access to digital platforms and tools, such as Zoom subscriptions and online resources, to facilitate participation. This includes ensuring that digital content is accessible to people with disabilities through captioning and transcripts (Weight Issues Network, 2022).
- Support Networks: Establish support networks to help individuals with obesity navigate advocacy environments providing emotional and logistical support. These networks can offer peer support, training and resources (Weight Issues Network, 2022; Barbara et al., 2025).

13.4. Develop Organisational Support and Resources

Potential Solution: Address power imbalances and improve cultural competency within organisations by including the lived experience voice in planned activities (Venegas Hargous et al., 2025; Dray et al., 2024). Work with consumers to build and support community-led organisations dedicated to obesity advocacy, empowerment and agency (Dray et al., 2024).

Strategies:

- Obesity Health Training and Cross-Sector Collaboration: Build understanding of obesity as a complex condition through implementation of ongoing, lived-experience-informed training for policymakers and professionals (Venegas Hargous et al., 2025; Banfield et al., no date; Brown et al., 2024). Foster partnerships between obesity advocates and other health and consumer groups to amplify impact and address shared health priorities.
- Inclusive Policy Development: Embed the Lived Experience voice in policy-making with feedback and accountability mechanisms to ensure meaningful participation (Australian Government, 2025; Barbara et al., 2025).
- Safe and Respectful Engagement Spaces: Create stigma-free environments through codes of conduct and respectful communication training to support safe advocacy participation (Weight Issues Network, 2022; Hill et al., 2024).
- Empowerment Through Skills and Resources: Provide accessible tools, advocacy training and system navigation resources to build confidence and capacity for lived experience experts (Banfield et al., 2025).
- Sustainable Funding and Remuneration: Secure dedicated funding, grants, and fair payment for advocates' time and expertise to ensure sustained and respectful engagement (Banfield et al., 2025).
- Targeted Advocacy Training: Offer training for Lived Experience experts in public speaking, media, policy analysis, and research to strengthen advocacy capabilities (Weight Issues Network, 2022).

14. Conclusion

Despite policy and organisational commitments and a growing awareness of its benefits, consumer participation in health policy and research development faces a range of entrenched barriers. These include conceptual ambiguity, power imbalances, institutional inertia, lack of diversity, and insufficient capacity-building. For people with lived experience of obesity, these general barriers are compounded by pervasive stigma, discrimination, and a lack of dedicated, culturally competent organisational support.

Addressing these barriers requires systemic change: embedding consumer engagement in organisational structures, funding mechanisms, and professional training; ensuring diversity and equity; and developing robust evaluation frameworks. The specific strategies outlined for reducing obesity stigma, promoting genuine inclusion, ensuring accessibility, and building organisational support are crucial steps towards fostering truly meaningful participation. Only then can participation move beyond tokenism to a genuine partnership in shaping health systems and knowledge, leading to more equitable healthcare and research outcomes and contributing to the sustainability of the Australian healthcare system.

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