FACT SHEET - FEBRUARY 2023

DISABILITY AND ACCESS TO THE NDIS IN RURAL AUSTRALIA

National Rural Health Alliance

Healthy and sustainable rural, regional and remote communities across Australia

People with disability living in rural, regional and remote (rural) Australia experience challenges in accessing the support they need, with fewer providers and less workforce available to deliver care.

- The proportion of the population who live with disability in Australia is higher outside major cities and highest in inner regional areas.
- People with significant disability are supported by the National Disability Insurance Scheme (NDIS), which provides funding for a range of supports, including assistance with everyday activities, help with building independence, and funding for consumables and capital items (such as assistive technology, equipment or home modifications).
- Despite higher need for disability services in rural areas, barriers to access are evidenced by reduced use of funds allocated under the NDIS.
- The availability of a workforce to provide care and support for people living with disability decreases with remoteness, with particular shortages seen across the allied health professions.
- Long travel distances and limited choice of providers also impact on the availability of support for people with disability in rural Australia.

Central to people with disability achieving a high quality of life is the ability to exercise control and choice when accessing support for daily living or participating in social, educational, economic and community life. This is also the case when accessing and using health or social services. Ability to access culturally safe support and services is also integral to empowering people with disability.

People living in rural Australia have poorer access to health and disability services than other Australians. This fact sheet focuses on access to services and supports for people with significant and permanent disability who are current or potential participants of the NDIS – a national insurance scheme that applies a lifelong view to disability support, choice and control.

Disability prevalence and context

Approximately 4.4 million people, or 17.7 per cent of the population, were living with a disability[a] in Australia in 2018.[1] The proportion of the population with any reported disability was 15.4 per cent in major cities, 23.4 per cent in inner regional areas and 19.1 per cent in outer regional and remote areas.[b,1,2]

Prevalence of disability increases with age, with 1.9 million of the 4.4 million people living with disability aged over 65 years. There are also varying degrees of disability. People with profound or severe disability made up 5.7 per cent of those living with disability in 2018.

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[a] The Australian Bureau of Statistics (ABS) definition of disability captures any limitation, restriction or impairment that restricts everyday activities and has lasted, or is likely to last, for at least six months. This is different to eligibility requirements for the NDIS or specific programs/services and across different data sources. The ABS Survey of Disability, Ageing and Carers (SDAC) provides the most comprehensive information.

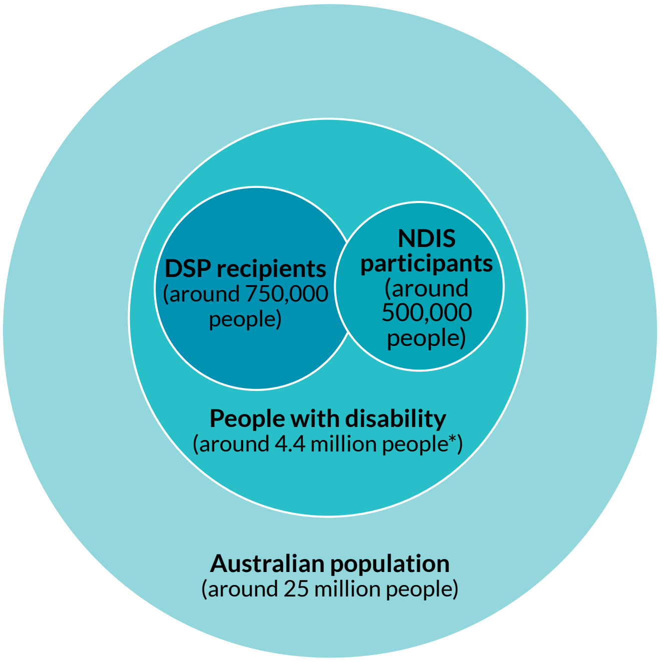
[b] ABS Australian Statistical Geography Standard remoteness structure.

Geographic disparities (higher rates outside of major cities) persisted when data was analysed by age and degree of disability. Of people living with disability aged 0 to 64 years, 16.8 per cent live in inner regional areas and 12.9 per cent live in outer regional and remote areas, compared to 10.4 per cent in major cities.[1]

In all geographic areas, the rates of people living with disability were higher for Aboriginal and Torres Strait Islander people, with the highest rate in inner regional areas.[3] Among Aboriginal and Torres Strait Islander people in 2018 (within the scope of the analysis[c]), 8.8 per cent experienced profound or severe limitation.[3]

For context on the NDIS and disability, Figure 1 shows key disability cohorts in the Australian population, as illustrated by the Australian Institute of Health and Wellbeing (AIHW).[4]

Figure 1: Key disability cohorts in the Australian population



*Notes:
Of the 4.4 million people with a disability, around 1.4 million have severe or profound disability.
DSP = Disability Support Pension.
People with disability may access specialist and/or mainstream services.

Source: People with Disability in Australia 2022 | AIHW.[4]

Australians who live in rural areas enjoy the benefits of living in smaller communities with a strong sense of community spirit, less congestion and, depending on location, more affordable housing. However, people living in rural Australia have poorer access to health and disability services than other Australians, with the number of health professionals – including nurses and midwives, allied health and general practitioners (GPs), medical specialists and other health providers – decreasing as geographic isolation increases. Per capita, rural areas have up to 50 per cent fewer health providers than major cities. As a result, on average, Australians living in rural areas have shorter lives, higher levels of disease and injury, and poorer access to and use of health services, compared with people living in metropolitan areas.[5]

People under 65 years of age who live with disability in households in outer regional and remote areas are less likely to see a GP, medical specialist or dentist than those living in major cities. At the same time, they are more likely to visit a hospital emergency department.[4]

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Royal Commission) commenced in April 2019, in response to widespread concern about mistreatment of people with disability, and is set to continue until September 2023. More than 5,000 submissions had been provided to the Royal Commission by mid-2022, with a submission deadline of 31 December 2022 providing opportunity for many more.[6] The *Interim Report* (released in 2020) highlighted that people with disability living in rural areas experience a number of barriers to accessing support. This is particularly the case for Aboriginal and Torres Strait Islander peoples. The lack of intersectional approaches that recognise diversity among people with disability was reported (including people with a disability who are also Aboriginal or Torres Strait Islander, culturally or linguistically diverse, LGBTIQ+ or young people).[7,8] This includes ensuring culturally safe services.

Examples reported to Commissioners of difficulties experienced by people with disability living in rural areas included attitudinal barriers and a lack of affordable and accessible housing options. Aboriginal and Torres Strait Islander people living with disability reported racism and ableism as barriers to health care. For those living in remote areas, concerns raised included a lack of access to medical services that meant the need to leave Country to access care or, alternatively, go without appropriate health care.[9]

The National Disability Insurance Scheme

The NDIS provides a range of supports to people aged under 65 years with significant and permanent disability.[10,11,12] The NDIS is based on an individualised approach to planning and support, with funding provided to individual participants[d] for supports to meet their goals[e] and needs.[13] Participants have choice and control over the supports and services they access and are able to use their funding in a way that best meets their needs and circumstances.

The NDIS funds a broad range of supports, including:

- **Core supports** that help a participant with activities of daily life, such as supported independent living (to support participants to live in their own home or in a group setting), social and community participation, and transport.[14]

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[c] The ABS 2018 SDAC survey excluded those in very remote areas and discrete Aboriginal and Torres Strait Islander communities.

[d] People who meet the NDIS access requirements are called *participants*.

[e] Goals represent areas that participants want to pursue now or in the future. Examples include working or studying, doing more things themself, or recreation activities.

- **Capacity building supports** that help participants to build skills and capacity in a range of areas, such as finding and keeping a job, building social or independent living skills, and accessing therapy services to maintain or improve functional capacity.[14]
- **Capital supports**, such as assistive technology, vehicle and home modifications, and specialist disability accommodation (SDA) for participants with extreme functional impairment or high support needs.

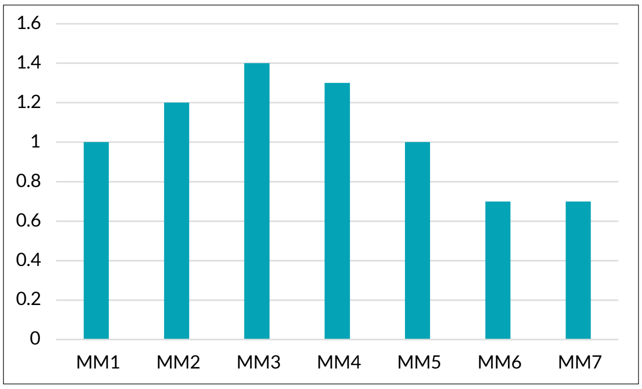
Access to and use of the NDIS in rural Australia

There is a shortage of disability support workers across Australia that affects access to and use of the NDIS across geographic areas. Limited supply of health workers in rural areas, such as allied health professionals, also has an impact on access to and use of the NDIS.

NDIS participants

Relative to the rest of Australia, using the Modified Monash Model (MMM)[f] remoteness classification, regional centres (MM2), large rural towns (MM3) and medium rural towns (MM4) have the **highest prevalence of NDIS participants**, compared to the national average. For example, the proportion of NDIS participants in large rural towns (MM3) is 1.4 times the average across Australia, whereas the **lowest prevalence of participants** is in very remote communities (MM7) at 0.7 times the national average.[15]

Figure 2: Ratio of NDIS participants compared to national average, across remoteness regions, June 2020



Source: Participants across remoteness classifications | NDIS.[15]

Table 1 illustrates the number of NDIS participants by MMM area, across states and territories of Australia. It illustrates variation across jurisdictions by remoteness, particularly in relation to remote (MM6) and very remote (MM7) areas.

Table 1: Proportion of NDIS participants by MMM region, by state or territory, June 2020

	ACT %	NSW %	NT %	QLD %	SA %	TAS %	VIC %	WA %	Total %
MM1	2.9	32.9	0.0	16.1	10.1	0.0	28.5	9.5	100
MM2	0.3	9.1	4.4	43.0	1.8	13.2	23.9	4.3	100
MM3	0.0	50.1	0.0	8.6	8.7	5.2	21.3	6.1	100
MM4	0.0	42.8	0.0	17.0	3.7	0.1	34.1	2.3	100
MM5	0.0	32.6	0.3	19.1	12.2	4.5	25.8	5.5	100
MM6	0.0	9.9	18.8	19.0	18.3	2.6	1.8	29.7	100
MM7	0.0	4.4	35.9	29.1	12.9	0.9	0.0	16.9	100

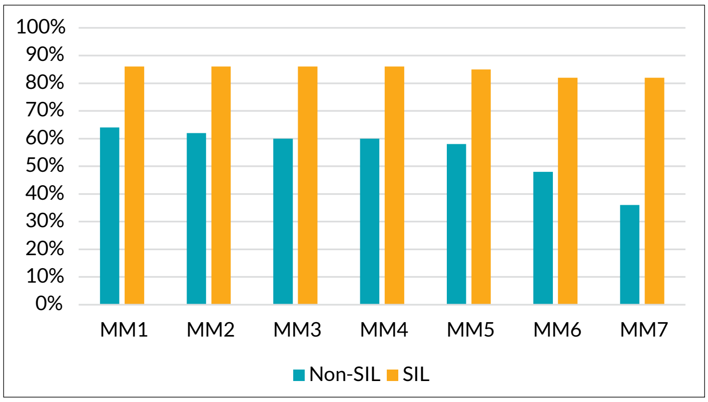
Source: Participants across remoteness classifications | NDIS.[15]

There were 16,417 Aboriginal and Torres Strait Islander participants in the NDIS at 30 June 2019, making up 5.7 per cent of all active NDIS participants. The proportion of Aboriginal and Torres Strait Islander NDIS participants living in remote or very remote areas (11 per cent) was much higher than non-Indigenous Australians (1 per cent).[9]

Use of NDIS participation plan funding

NDIS data highlights potential gaps in the availability of disability care and support in rural areas across Australia. For both supported independent living (SIL) participants and non-SIL participants, the **utilisation of plan funding declines with remoteness**, as shown in Figure 3. This decline is more pronounced for non-SIL participants. Non-SIL participants in remote (MM7) areas utilise only 35 per cent of their allocated plan value, on average, compared with 62 per cent for non-SIL participants in metropolitan (MM1) areas.[15] Non-SIL supports include assistance with social and community participation, transport and capacity building. Allied health professionals are part of the workforce delivering non-SIL plan supports to NDIS participants.

Figure 3: Average utilisation of supports in NDIS participant plans, June 2020



SIL:	*includes help or supervision with daily tasks, such as personal care or cooking meals. It is for people with higher support needs, who need some level of help at their home all of the time.*
Non-SIL:	*includes assistance with social and community participation, transport, capacity building supports and capital supports.*

Source: Participants across remoteness classifications | NDIS.[15]

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[f] The MMM model classifies metropolitan, regional, rural and remote areas according to geographical remoteness and town size. More information on the classification is available here: www.health.gov.au/resources/publications/modified-monash-model-fact-sheet

Availability of providers

NDIS data also suggests that there are lower numbers of providers per participant in rural areas. The NDIS Markets Insight Dashboard indicates that there are **fewer providers in rural areas**, with 80 per cent of the NDIS' thinnest markets[g] located in rural Australia. This indicates that thin markets are a significantly greater issue in rural areas, compared to metropolitan areas. It is important to note that this data includes a range of provider types, from very large providers through to sole traders, making it difficult to get a clear picture of the services available to rural people.[16]

In recent years more work has been occurring, as part of delivering the NDIS, to enable more flexible approaches to address market challenges, including:

- evaluation of thin market trials[h,17]
- strengthening NDIS service in Aboriginal and Torres Strait Islander communities[i,18]
- collaboration between the Australian Government Department of Social Services (DSS), National Disability Insurance Agency (NDIA) and Department of Health and Aged Care (DHAC) to develop an integrated care model that proposes more innovative and coordinated approaches to better support the needs of regional and remote communities.[j,19]

However, there is currently limited information available publicly on these market challenge mitigation measures.

Workforce challenges

The disability care and support workforce is made up of a variety of professionals, with approximately 138,000 full-time equivalent workers across Australia. This workforce includes disability support workers (66 per cent), allied health practitioners (10 per cent) and other workforce, such as coaches, fitness instructors and counsellors (24 per cent). Of these, 79 per cent of permanent staff work part time and 21 per cent work full time. Twenty-two per cent are casually employed.[20]

The available **workforce declines with remoteness**, impacting the ability of providers to deliver care and support in some areas. The greatest shortage is for allied health professionals. In addition to workforce shortage, there is also higher demand for NDIS services in regional centres and large and medium rural towns (MM2 to MM4), which have higher relative numbers of NDIS participants than metropolitan (MM1) areas.[14,21] This creates further service gaps in addition to those due to workforce shortages.

The supply of allied health professionals available to provide disability care and support (and health and aged care services) in rural Australia is limited, for example numbers of **dietitians, audiologists, speech pathologists and social workers** are lower in remote and very remote areas.[22]

Table 2 outlines **occupational therapists, physiotherapists** and **podiatrists** available per 1,000 people by MMM region.[23] Note, these figures are for selected allied health professions registered with the Australian Health Practitioner Regulation Agency (AHPRA) and do not relate to the disability sector specifically.

Table 2: Number of selected allied health professionals by MMM region per 1,000 people, 2020

Profession	MM1	MM2	MM3	MM4	MM5	MM6	MM7
Occupational therapist	6.2	6.1	6.1	4.2	1.8	3.8	2.5
Physiotherapist	9.9	7.2	7.4	6.0	3.0	4.9	3.6
Podiatrist	1.5	1.5	1.7	1.3	0.5	0.9	0.5

Source: National Health Workforce Dataset | DHAC.[24]

Other health professionals, for example **pharmacists**, also play an important role in medication management and safety for people with disability and people living in rural areas.

People living with disability and seeking to access the NDIS are asked for evidence of disability and functional impairment as part of completing the access request form. Health professionals play an important role in documenting the evidence for this request. Reduced access to, for example, medical practitioners (GPs, other medical specialists), means additional barriers to initial access to the NDIS, especially in outer regional and remote areas.

There is a significant shortage of **disability support workers** across Australia.[24,25] While shortages of disability support workers have been reported, there is limited data available that indicates the number by MMM area.

Issues affecting disability support in rural Australia

The experiences of NDIS providers, participants and their families and carers, and the disability care and support workforce in rural Australia differ from those in metropolitan areas. These experiences are shaped by several barriers to the provision of, and access to, disability care and support in rural areas. These include:

- **Thin markets, limited local provider options and capacity**: this means that, while NDIS participants may have funding to spend on disability care and support, a lack of provider capacity in rural areas means that this funding cannot be utilised.[26,27]

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[g] In the NDIS context, thin markets exist where there is a gap between participant needs and their use of funded supports.

[h] In December 2019, the Disability Reform Council (DRC) agreed to use a more flexible approach to address market challenges. DRC agreed that each state and territory will host a thin market trial and these are now underway. Since then, other thin market projects have been identified and commenced.

[i] DSS funded the National Aboriginal Community Controlled Health Organisation to increase the number of Aboriginal Community Controlled Health Organisations delivering NDIS services in remote areas and thin markets. This project was to help build capacity for organisations to transition to and operate as NDIS providers.

[j] DSS, in correspondence with the Alliance, outlined recent activities in regard to thin markets, including advice that DSS is working with the NDIA and DHAC to address the issue.

- **Considerable travel distances to access or deliver services**: this increases the cost of service delivery (noting that the NDIS does accommodate increased costs in their pricing and also funds some travel time and costs), which may limit workers' willingness to travel to a person's home or community to deliver services. Similarly, long distances and lack of appropriate or accessible transport and support may also reduce participants' ability to travel to and from service locations.[28]
- **Limited competition among providers and limited choice for participants**: large providers may be the only providers in an area, which means that there is little choice for participants and less competitive tension among providers (which may impact on their responsiveness, customer focus and quality).[29]
- **Issues with workforce recruitment and retention**: this leads to shortages of disability support workers and allied health professionals.[30,31]
- **Increased complexity of accessing the NDIS in rural areas**: this is due to a lack of available information and advice.[32]
- **Lack of professional support and supervision for workforce.**[32]

While this fact sheet is focused on the NDIS and the need to address the differential access for rural and metropolitan residents, there is much that can be done to improve support for people living with disability more generally.

An increasing proportion of people with a disability are staying in emergency departments (EDs) for prolonged periods, in large part due to the lack of access to appropriate accommodation into which they can safely be discharged for stable in-home care. Addressing the need for suitable accommodation for people with disabilities is important so individuals do not need to stay in hospital after treatment has been completed. This is especially true when the person with a disability is unsupported to navigate this issue, either because they are ineligible for the NDIS, NDIS funding is inadequate, or because they do not have a carer or family member to assist them.[32]

The Alliance is cognisant of the importance of early intervention and ongoing treatment for children accessing allied health services in rural and remote Australia.[33] Early and comprehensive screening for disorders that will affect children's ability to participate fully in the school environment is imperative given travel distances encountered in rural areas limit choice of schools for rural students; for those with specific learning needs, choice is compromised further.

It has been argued that while transition to the NDIS has improved support for many Australians with psychosocial disability, for others it saw removal of access to services outside the NDIS. Mental Health Australia note that, in 2020, the Productivity Commission estimated around 154,000 people were not able to access the psychosocial support services they needed.[34]

The Royal Commission process and its future findings will provide a range of advice across all geographic areas and settings on a wide range of matters. In addition, the Joint Standing Committee on the NDIS Inquiry into the Capability and Culture of the NDIA, which commenced in 2022, will provide advice for improving NDIA's delivery of the NDIS.

Improving access to care in rural Australia

There is no single solution to improve access to care and support services for current or potential NDIS participants in rural Australia. A range of policy levers are needed to address the complex and multifaceted issues facing people with disability in rural Australia. These may include:

- Joint service planning between health, aged care and disability sectors and providers, to develop common goals and locally appropriate solutions. Such solutions rely on better workforce planning to ensure there are sufficient health professionals and care workers. This further relies on appropriate planning *within* professions, together with governments and education providers – planning that takes account of clinical supervision capacity and the need to grow a rural heath workforce with skills, breadth of practice and supervisory capability to deliver high-quality services to people with disability.
- Local workforce planning to highlight opportunities for better resourcing and to draw on cross-sector resources and skills.
- Incentivising providers to enter the market, by ensuring funding adequately covers the higher costs associated with delivering support in rural areas.
- Flexible or alternative funding models, such as different reimbursement arrangements for NDIS providers in rural areas, to guarantee supply and availability of NDIS supports.
- Enabling better workforce recruitment and retention through more coordinated strategies and campaigns specifically targeting rural areas.
- Overcoming professional, financial and social barriers to working rurally, by implementing integrated models of multidisciplinary care that address local needs through community-driven solutions.
- Community engagement to ensure that services align with local needs and strengths, are person-centred and inclusive, and reflective of the diversity of people living with disability.
- Strengthening data collection to promote informed decision making within the disability sector (noting that any additional data collection is a burden on providers, which may be counterproductive).

Addressing data gaps

Improvements to information about the circumstances and experiences of people living with disability, that addresses priority data gaps, is important. The AIHW, in their 2022 report summarising information from a wide range of sources, commented on ways of addressing data gaps, including:

- enhancing existing data sources to better capture intersectionality in the disability population, including for those with disability living in rural Australia
- filling gaps where no data currently exists, for example information about mainstream services of critical importance to some people with disabilities (such as allied health services like speech therapy).[4]

Another data gap nationally is information on specialist disability services outside the NDIS. This is important for understanding how the NDIS and other services, such as health services, interact with people living with disability. Despite challenges such as data quality and representativeness of data for population subgroups, any such data improvements could, as much as possible, include information by remoteness areas.

From the perspective of the Alliance, there is a need for more nuanced information on providers, including by profession or occupation and geography, especially because, in thin markets, allied health professionals may be working simultaneously across health, disability and aged care.

Conclusion

People living with significant and permanent disability in rural Australia face more barriers to receiving the support they need than those living in metropolitan areas. Solutions must focus on delivering an integrated and joined-up approach to workforce and service provision, incentivising providers to enter the market, addressing workforce shortages and improving workforce planning – in order to ensure people with disability are supported to thrive regardless of where they live.

Enabling integrated, locally delivered care and support services, where local needs are addressed through community-driven solutions that are responsive to consumer needs, will be central to effective solutions in rural Australia where markets are thinner and workforce supply is scarcer.

To maximise choice and control for rural people with disability, solutions should also ensure people have the knowledge and support to navigate the NDIS system and access the services they are eligible for. Further, solutions should ensure that, whether rural people with disability are NDIS participants or not, they are able to navigate access to support when needed and that health services received are person-centred, safe and enabling.

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