



Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Research Report

**Options to improve service
availability and accessibility
for First Nations people
with disability**

Deloitte

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Deloitte is proud to acknowledge the traditional custodians of country throughout Australia, and recognise their continuing connection to this land, its waterways, and the stars in the sky, since time immemorial. It is our privilege to pay respect to their Elders, knowledge holders, and to all the generations of First Nations' peoples who have nurtured their unceded lands for over 80,000 years and continue to do so today

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Pathways to Country

People and Community: This element represents where ceremonies take place. The dots are the people, the multiple circles represent the layers of our community.

Bundjalung And Gomeroi/Euahlayi artist Lee Anne Hall

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Executive Summary

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ('Disability Royal Commission' or simply, 'Royal Commission') represents a once-in-a-generation opportunity to reform the disability sector for First Nations people.

Through deep listening to over 200 stakeholders across Aboriginal Medical Services, Aboriginal Community Controlled Organisations, non-Indigenous health and disability services, Non-Government Organisations, case workers, peak bodies and First Nations academics, we identified a series of recurring themes across the sector that highlighted the unsafe, traumatising and inequitable services received by First Nations people with disability under the National Disability Insurance Scheme (NDIS), and the disability sector more broadly. The summation of what we heard in consultation is in Table 1, below:¹

Table 1. Consultation outcomes summary

Community level capacity building	Implementation of culturally safe services	Service delivery reform	Reporting and accountability
<p>Aboriginal Community Controlled and Aboriginal Community Controlled Health Organisations frequently deliver disability services with inadequate funding and resourcing. Partnerships and shared service delivery arrangements between First Nations and non-Indigenous organisations are often transactional and usually favour the non-Indigenous organisation. Allied health providers often aren't disability specialists and provide inadequate and culturally inappropriate services. First Nations people with disability have a preference to remain on Country and have access to the essential services they require.</p>	<p>Non-Indigenous service providers are more likely to deliver culturally inappropriate services and are less culturally informed about individual and community needs. The ongoing legacy of historical and systemic trauma is compounding for First Nations people with Disability and manifests differently in the sector. First Nations people with disability often feel invisible in the system. The need to support First Nations people to identify and define disability in the community. First Nations people with deafness do not identify as disabled but must fit regulatory definitions to access services.</p>	<p>The need to decentralise the execution of service delivery across States and Territories using regional governance approaches. The need to reconsider the use of guardianship by the public trustee and the unintended consequences it has for First Nations people with disability.</p>	<p>First Nations people are falling through the gaps between complex sector interfaces. There is no national framework guiding quality and assurance and cultural safety; nor is their enforced quality and safety standards embedded in service delivery requirements. The sector spoke to the lack of First Nations representation. Current mandatory reporting is time consuming and compounds pressure on under-resourced and overwhelmed First Nations service delivery organisations. There is no consistent benchmark for cultural accountability and cultural training across the disability sector. First Nations people's NDIS plans are underutilised due to thin markets or unavailability of culturally appropriate services.</p>

Quantitative analysis

Our quantitative analysis of disability services provided under the National Disability Insurance Scheme (NDIS) and Disability Employment Services (DES) program ratified these concerns.

To undertake quantitative analysis on the availability and accessibility of disability services for First Nations people with disability, the Disability Royal Commission obtained administrative data on the NDIS from the National Disability Insurance Agency and on the DES program from the Department of Social Services through exercise of its extraordinary powers under the *Royal Commissions Act 1902* (Cth).

It is important to note that our analysis has been limited in time and scope, it also relies on the accuracy and completeness of the information that has been obtained by the Disability Royal Commission. Specifically, two notable limitations of our analysis are that it does not consider:

1. The potential impact of transition to the NDIS: data covering the timeframe of the NDIS transition from the NDIA was not supplied and analysed in time for this report. As a result, we have not been able to assess the potential impact of the NDIS transition on availability and accessibility of disability services to First Nations people with disability.
2. The broad range of disability services that can be provided: data from the Disability Services National Minimum Dataset was not supplied and analysed in time of this report. As a result, our observations in this report on disability services refer only to those services under the NDIS or as part of the DES program. We have not analysed what others may consider falling in the definition of 'disability services' including but not limited to other community-based disability supports and/or income support payments.

Refer to the full report for further details of the reliance and limitations of this report.

When analysing available data on First Nations people with disability, we found that:

- First Nations people with a disability sit at an intersection of profound disadvantage. When compared with non-Indigenous people with disability, they are more likely to:
 - Have greater levels of need for care and support due to more severe disability
 - Live in regional and remote Australia, and face the challenges associated with thin markets including distance from specialists, difficulties in remote service provision and a lack of choice of providers; and
 - Have personal and community experience of trauma that can increase the need for care and complicate its delivery.
- Crude comparison of population statistics suggest First Nations people with disability are overrepresented in the NDIS, making up close to 7% of all participants compared to First Nations people with disability making up 3.3% of the total Australian population. However, this can be misleading by obfuscating the burden of disability which is faced by First Nations people with disability.

-
- Our analysis explicitly models access accounting for the impact of differences in the experience of disability, geographic and other factors. As a result, we find that First Nations people with disability are under-represented in the NDIS, 28% less likely to receive access to care via the NDIS than other people with a disability. This gap has been closing in recent years, but that progress must be accelerated as a priority due to expected increases in future demand. Access for adults with greater care needs is higher for First Nations people, but average levels of access are still 14% below non-Indigenous levels when an individual's level of care need is considered.

Using our definition² of First Nations-focused providers, our analysis found:

- There is insufficient evidence in patterns of supports provided to conclude that First Nations-focused providers offer a differentiated service to First Nations people with disability compared to mainstream service trends.
- Despite an increasing NDIS population, there was a decline in providers over 2019 to 2021. Providers are servicing a growing number of participants over time, particularly First Nations-focused providers in remote regions.
- After accounting for differences in demographic factors, disability, and geographical region of the constituents they service, participants with First Nations-focused providers receive less NDIS claim payments³ than those with non-Indigenous service providers.
- First Nations-focused providers are a small proportion of NDIS providers but are critical to the delivery of care to people with disability in remote and very remote Australia where choices are limited. Strengthening and growing these providers will be an important priority in meeting the future needs of all people with disability. Additionally, uplifting the cultural skills and standards among all NDIS providers is also critical to ensuring access to care.

When we assessed the current and future workforce requirements, we identified:

- Growth in the First Nations population outpaces the rest of the nation and demand for disability services among First Nations people is growing faster than demand across the total sector. First Nations people participating in the NDIS are expected to grow twice as fast as their non-Indigenous counterparts over the next decade.
- The rapid increase in recipients will have severe implications for workforce demand over time. We suggest an extra 13,000 NDIS workers are needed in the First Nations disability sector by 2031 purely to meet growth in demand from First Nations people with a disability – including providing higher levels of service for those who are already in the NDIS.
- The 'talent pipeline' does not exist to sustain this growth through a First Nations workforce alone. Growing the non-Indigenous workforce is also crucial to quality care outcomes. This means there is an urgent need for the uplift of the whole disability workforce to understand and deliver culturally safe and trauma-informed approaches to care.

These challenges are set to be magnified over time as First Nations people become a larger share of the population living with disability in Australia. The time for reform is now.

Recommendations

The solution is complex. Using the Disability Royal Commission's cultural framework, we propose a set of recommendations to uplift and enhance the sector to meet the quantity and characteristics of the care needed for First Nations people with disability.

The recommendations are framed against the backdrop of the entrenched poverty and profound disadvantage many First Nations people and communities continue to experience. In particular, the recommendations acknowledge First Nations people with disability's long-standing struggle to achieve self-determination and agency over their lives and affairs by creating easy access to appropriate resources and providing them a 'seat at the table' as a decision maker in all stages of their care.

While the full report analyses these in detail, they are summarised in Table 2, below.

Table 2. Summary of recommendations

Cultural framework	Number	Recommendation
Capstone recommendation	1	An Intermediary Body should be appointed and endorsed to govern sector development, improvements in service delivery, quality assurance for the First Nations disability sector and establish a regional governance structure which hears and values the voices of First Nations people with disability.
	2	The Intermediary Body should lead, in collaboration with First Nations people with disability and industry, a First Nations Disability Development Policy to increase and safeguard investment into the First Nations disability sector.
Service delivery reform	3	The Intermediary Body should define and oversee a national Community Connector program to ensure uniform application, responsibility, and availability of the role in each community.
	4	Where the assessment is made that a thin market is unlikely to resolve itself under current market conditions, the NDIA should block fund Aboriginal Community Controlled Organisations or preferred providers for disability service delivery.
	5	The Intermediary Body should investigate the use of guardianship orders by the Public Trustee and expose the impacts and experiences of First Nations people with disability under guardianship orders.
	6	The NDIA should identify unfunded supply to, and undisclosed demand from, First Nations people with disability delivered outside of the NDIS and compensate providers who are bridging the gap.
	7	The NDIA should facilitate cross-sector collaboration to address the unique and holistic needs of First Nations people with disability.
	8	The Intermediary Body should establish a global Community of Practice, most notably with Māori organisations from New Zealand and First Nations organisations from Canada to share learnings and accelerate sector development.

Cultural framework	Number	Recommendation
Community level capacity building	9	The NDIS Workforce Plan 2021-2025 should be revised to include the unique strategies required for the acceleration and growth of a First Nations disability workforce.
	10	The Australian Government, in collaboration with the Intermediary Body, should implement strategies to increase the First Nations disability workforce by 13,000 workers by 2031 to meet projected demand.
	11	The Intermediary Body, in partnership with Aboriginal Community Controlled Organisations, should establish a First Nations disability workers hub which is nationally managed but regionally implemented. It will facilitate support groups, networking, and mentoring programs among First Nations disability workers both within Aboriginal Community Controlled Organisations and within non-Indigenous organisations.
	12	The NDIA, in partnership with the Intermediary Body and Aboriginal Community Controlled Organisations, should design and develop guidance on best practice formal partnerships and engagement between First Nations and non-Indigenous providers and create an identifier for those businesses who meet the guidelines.
	13	The NDIA should, in partnership with First Nations communities, academics and professionals, define and regulate the attitudes, skills and behaviours which encompass a culturally safe, competent, and trauma-informed approach to First Nations health and disability. This agreed standard should be upheld by all registered providers and used as a guideline for providers outside of the NDIS.
	14	The NDIA should form partnerships with ACCOs and regional tertiary institutions to offer flexible course options for disability support accreditations which form pathways to becoming a registered NDIS provider – including those already providing unfunded and unqualified support.
	15	The NDIA should block fund Aboriginal Community Controlled Organisations to deliver educational programs which aim to inform First Nations communities about careers in the disability sector, including possible pathways, accreditation options and career entry points.

Cultural framework	Number	Recommendation
	16	The Intermediary Body, in partnership with the NDIA and industry should design and deploy a professional and capability development program to support community organisations with the skills to manage increased inflows of capital from the First Nations Disability Economic Development Policy.
Implementation of culturally safe services	17	The Community Connector should deliver NDIA assessments in person, in a culturally safe way in community, especially in regional, remote, and very remote areas.
	18	The NDIA should, as a condition of commissioning and procurement for the provision of services to First Nations people with disability, mandate cultural safety training for all non-Indigenous disability service providers.
Reporting and accountability	19	The NDIS Quality and Safeguards Commission should appoint a First Nations Disability Commissioner (mandated identified position).
	20	Federal and jurisdictional governments should invest in a First Nations Community Controlled Disability Research and Data Agenda, as outlined by First Peoples Disability Network.
	21	In the next revision of the Commonwealth Implementation Plan for the Closing the Gap Target, outcomes should explicitly include First Nations people with disability.
	22	The First Nations NDIS Quality and Safeguards Commissioner, in partnership, should design a National Quality Assurance and Cultural Framework to guide sector development and to clearly define quality and safety standards.

Any roadmap must be led by First Nations people with disability - through the voice of the First Peoples Disability Network (and later, the Intermediary Body). However, an indicative phased approach is presented in Figure 1, below.

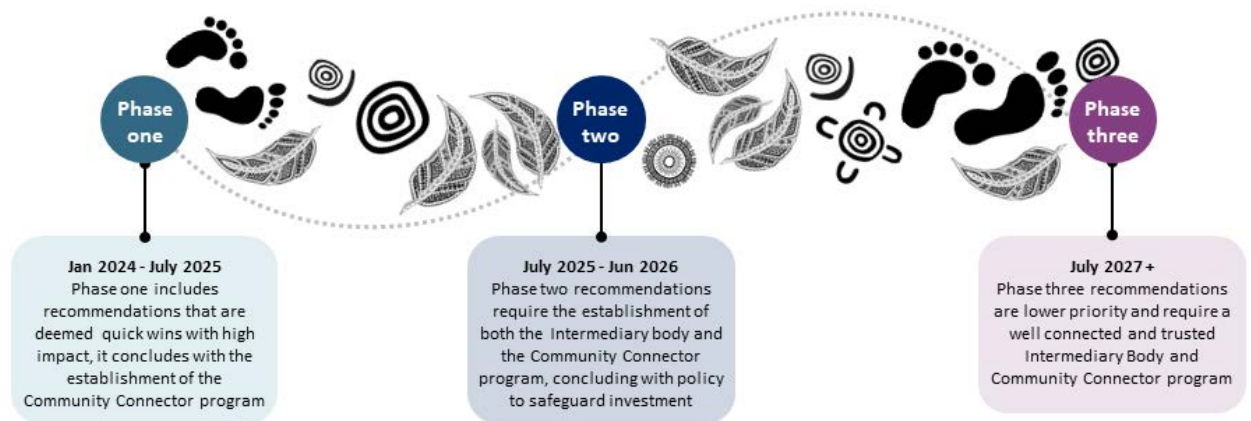


Figure 1. Roadmap to implementation of recommendations

The report provides analysis and further detail of the implementation of individual recommendations.

An urgent call to action

The disability sector requires urgent reform for it to better provide for First Nations people with disability. For many years there have been consistent calls by leading First Nations advocates to repair a broken sector. This critical sector is unable to provide services with the qualifications, quality and cultural safety standards in the numbers and locations required - and the evidence clearly demonstrates this is compounding every year. First Nations people with disability deserve better. For too long their unique needs and requirements have been ignored and neglected. It's now time to get serious and commence the substantive reform that answers the call from First Nations people. **The time for talk is over. The time for action is now.**

Glossary

Term	Definition
<p>Australian Institute of Health and Welfare (AIHW)</p>	<p>The Australian Institute of Health and Welfare (AIHW) is an independent statutory Australian Government agency with more than 30 years of experience working with health and welfare data. The AIHW's role is to provide meaningful information and statistics for the benefit of the Australian people by:</p> <ul style="list-style-type: none"> Developing, maintaining, and promoting statistical information standards for the health, community services and housing assistance sectors Collecting and managing data on health and welfare issues, including from state, territory, and federal government agencies Analysing and releasing a range of health and welfare products (data and reports) to key policy areas, to support better policy and service delivery decisions Enhancing data resources with the addition of new health and welfare data assets to the AIHW's data holdings to fill data gaps in the health and welfare sectors Modernising the presentation and availability of national health and welfare products to meet the needs of diverse audiences such as state, territory and federal government agencies, universities, research centres, and non-government organisations.⁴ <p>Of specific relevance, the AIHW has since 1991, collected and reported data on disability support services in Australia has been provided under four national disability agreements:</p> <p>The Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS) collection was set up as a 'snapshot' data collection in 1994, following the signing of the first CSDA in 1991.</p> <p>The second CSDA, signed in 1998, reflected significant changes which meant the CSDA MDS collection needed to be redesigned, including changing the collection to be a full year data collection.</p> <p>In 2002-03, the redeveloped CSDA MDS became the Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA NMDS), and the first full financial year of data collection took place between 1 July 2003 and 30 June 2004.</p> <p>The National Disability Agreement (NDA) replaced the CSTDA on 1 January 2009. As a result of the implementation of the NDA, from 2009-10 the CSTDA NMDS was renamed the Disability Services National Minimum Data Set (DS NMDS).</p> <p>From 1 July 2013, state and territory-based disability support services provided under the NDA were progressively transitioned over to the National Disability Insurance Scheme (NDIS). This has meant that 2018-19 was the last year for which DS NMDS data was collected and reported.⁵</p>

Term	Definition
Aboriginal Community-Controlled Organisation (ACCOs/ ACCHOs)	<p>To be an Aboriginal Community-Controlled Organisation (ACCO) or Aboriginal Community-Controlled Health Organisation (ACCHO), the organisation is required to meet the following criteria. It must be: an independent, not-for-profit organisation, that's incorporated as an Aboriginal and/or Torres Strait Islander organisation and/or is a registered community service initiated, based, government and operated by the local Aboriginal and/or Torres Strait Islander community accountable to its local community, and facilitate local Aboriginal and/or Torres Strait Islander peoples to have input into service design, delivery, and performance; and endorsed by the local community leadership to deliver holistic and culturally appropriate services or activities that benefit Aboriginal and/or Torres Strait Islander communities and people, including empowerment and building strength.</p> <p>These criteria are based on Clause 44 of the <i>National Agreement on Closing the Gap</i>.</p>
Convention on the Rights of Persons with Disabilities (CRPD)	<p>The Convention is intended as a human rights instrument with an explicit, social development dimension. It adopts a broad categorisation of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced.⁶</p>

Term	Definition
Department of Social Services (DSS)	<p>The Department of Social Services provides targeted supports and service for people with a disability to improve their independence and participation in community and economic life.</p> <p>The Disability Employment Services (DES) program helps people with disability find work and keep a job. Through Disability Employment Services, people with disability, injury or health condition may be able to receive assistance to prepare for, find and keep a job.</p> <p>Providers of Disability Employment Services are called DES Providers. DES Providers are a mix of large, medium, and small for-profit and not-for-profit organisations experienced in supporting people with disability, as well as helping employers to support employees with disability in the workplace.</p> <p>Disability Employment Services has two parts:</p> <p>Disability Management Service is for job seekers with disability, injury or health condition who need assistance to find a job and occasional support in the workplace to keep a job; and</p> <p>Employment Support Service is for job seekers with permanent disability who need help to find a job and who need regular, ongoing support in the workplace to keep a job.</p>
Disability Royal Commission	<p>The Disability Royal Commission was established in April 2019 in response to community concern about widespread reports of violence against, and the neglect, abuse, and exploitation of, people with disability. These incidents might have happened recently or a long time ago.</p> <p>The Disability Royal Commission will investigate:</p> <ul style="list-style-type: none"> Preventing and better protecting people with disability from experiencing violence, abuse, neglect, and exploitation Achieving best practice in reporting, investigating, and responding to violence, abuse, neglect, and exploitation of people with disability; and Promoting a more inclusive society that supports people with disability to be independent and live free from violence, abuse, neglect, and exploitation.⁷
First Nations	<p>This report uses the term ‘First Nations’ for respectfully referring to all Aboriginal and Torres Strait Islander people and in recognition of the various language groups as separate and unique sovereign nations with their own governance, laws and traditions.</p>
First Peoples Disability Network (FPDN)	<p>The First Peoples Disability Network is a national organisation of and for Australia’s First Peoples with disability, their families, and communities. FPDN is governed by First Peoples with lived experience of disability.⁸</p>

Term	Definition
Free, Prior and Informed Consent (FPIC)	<p>FPIC is a set of principles protected by international human rights standards that state ‘all peoples have the right to self-determination’ and ‘all peoples have the right to freely pursue their economic, social and cultural development’.⁹</p> <p>The elements of FPIC can be defined as follows:</p> <p>Free – the consent is free, given voluntarily and without coercion, intimidation, or manipulation. A process that is self-directed by the community from whom consent is being sought, unencumbered by coercion, expectations or timelines that are externally imposed</p> <p>Prior – the consent is sought sufficiently in advance of any authorisation or commencement of activities</p> <p>Informed – the engagement and type of information that should be provided prior to seeking consent and as part of the ongoing consent process; and</p> <p>Consent – collective decision made by the right holders and reached through a customary decision-making process of the communities.¹⁰</p>
Indigenous Data Sovereignty (IDS)	<p>IDS is the right of First Nations peoples to govern the creation, collection, ownership, and application of data about their communities, peoples, lands, and resources. The enactment mechanism is Indigenous Data Governance (IDG), which is built around two central premises: the rights of First Nations over data about them, regardless of where it is held and by whom; and the right to the data First Nations peoples require to support nation rebuilding.¹¹</p> <p>The Australian set of IDG protocols and principles are the right of Aboriginal and Torres Strait Islander people to:</p> <p>Exercise control of the data ecosystem, including creation, development, stewardship, analysis, dissemination, and infrastructure</p> <p>Data that is contextual, disaggregated, relevant, empowers sustainable self-determination and effective self-governance, protective, and respects individual and collective interests</p> <p>Data structures that are accountable to Indigenous peoples and First Nations¹²; and</p> <p>Effective IDG empowers Aboriginal and Torres Strait Islander peoples to make the best decisions to support their communities and people in the ways that meet their developmental needs and aspirations. IDS is outlined in the UNDRIP, of which Australia has declared its support.</p>

Term	Definition
National Disability Insurance Agency (NDIA)	<p>The National Disability Insurance Agency (NDIA) is the independent statutory agency established by the Australian government to implement the National Disability Insurance Scheme (NDIS).</p> <p>The NDIA employs people to help you understand the NDIS and determine whether you are NDIS eligible. The NDIA provides funding through the NDIS to help support a better life for Australians with disability and their families and carers.¹³</p>
National Disability Insurance Scheme (NDIS)	<p>The National Disability Insurance Scheme, also known as the NDIS, is run by the National Disability Insurance Agency, also known as the NDIA. The NDIS comprises:</p> <p>The provision of services or activities that are in the nature of coordination, strategic or referral services or activities; and</p> <p>Funding for persons or entities to enable them to assist people with disability to participate in economic and social life; and</p> <p>Individual plans under which reasonable and necessary supports will be funded for certain people, called participants.¹⁴</p> <p>‘Reasonable’ means the support is most appropriately funded or provided through the NDIS. And ‘necessary’ means something a person needs that is related to their disability.¹⁵</p>
Participant	<p>Refers to people who receive funded care under the NDIS.</p>
Self-determination/ decision-making	<p>Self-determination describes an ‘ongoing process of choice’ to ensure that First Nations can meet their social, cultural, and economic needs¹⁶. Without self-determination it is not possible for Indigenous Australians to fully overcome the legacy of colonisation and dispossession,¹⁷</p> <p>Most First Nations peoples in Australia want self-determination within the existing nation. This would require recognition by the Government of their distinct cultures and forms of social organisation, governance, and decision-making. It would mean transferring responsibility and power for decision-making to First Nations communities so they can make decisions that affect them. The Federal Labour Government led by Gough Whitlam adopted the policy of ‘self-determination’ for Indigenous communities in 1972. This policy was described as ‘Aboriginal communities deciding the pace and nature of their future development as significant components within a diverse Australia’, It recognised that Aboriginal people had a right to be involved in decision making about their own lives.¹⁸</p> <p>The international community has recognised the significance of the right to self-determination to Indigenous peoples in the <i>Declaration on the Rights of Indigenous Peoples (UNDRIP)</i>, which was supported by the Australian Government in April 2009.¹⁹ The right to self-determination is enshrined in the <i>UNDRIP</i>, to which Australia is a signatory.</p>

Term	Definition
Thin Markets	Areas in which few NDIS providers operate, limiting the choices available to people with a disability and reducing the benefits of competition which help to increase the quality and efficiency of services over time.
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)	The UNDRIP establishes a universal framework of minimum standards for the survival, dignity, and well-being of the indigenous peoples of the world and defines the individual and collective rights of indigenous peoples, including their ownership rights to cultural and ceremonial expression, identity, language, employment, health, education, and other issues. ²⁰

1 Introduction

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ('Disability Royal Commission') represents a once-in-a-generation opportunity to reform the disability sector for First Nations people.

The Disability Royal Commission is now at its most critical stage, providing opportunity to consider serious reform to the disability sector and better provide for First Nations people with disability. As such, the Disability Royal Commission required an experienced and trusted provider to partner with to research, analyse and present options for meaningful change.

1.1 Scope of report

The scope of this report is to:

- Provide current and future forecast of service demand for disability services for First Nations people with disability with consideration to location, level and type of service support required now, and in the future
- Provide a current and future forecast of workforce skills and capability to support culturally appropriate services for First Nations people with disability from a national and local perspective
- Provide an analysis of the number and type of services currently delivered by First Nations-focused providers under the National Disability Insurance Scheme; and
- Provide critical analysis of suggested system changes and service planning regarding:
 - How effective these changes would be in achieving culturally appropriate services for First Nations people with disability
 - A practical and incremental implementation pathway including timeline, implementation challenges and relevant government costing to achieve the transition implementation and ongoing cost of such changes; and
 - Workforce considerations and clear outline of how workforce capacity could be increased to meet demand for such system changes.
- The project took a First Nations centric approach, led by First Nations people and supported by the technical capability of Deloitte; leveraging expertise across economics, workforce design, actuarial and data science. In accordance with our commitment for strong First Nations leadership throughout this engagement, Deloitte established a First Nations consultative group specifically for this research. This group are key knowledge holders and leveraged existing understanding of key issues and expert lived experience in developing this report. This group included First Peoples Disability Network (FPDN) executives and our own Deloitte Indigenous Leadership.

1.2 Guiding principles

Our research and design phases were conducted in alignment with FPDN core principles.²¹

This formed the basis for a culturally sensitive set of principles and informed the ways of working during this engagement. FPDN's core principles are:

1. Working within a social model of disability, which recognises that disability is produced by barriers to equality and participation for people with impairments that must be dismantled
2. Working with First Peoples with disability, their families, and communities across Australia, to ensure that our work reflects their diversity and priorities
3. Working with all First Peoples communities to create and maintain a safe and secure place for the exchange of ideas, the building of alliances, and the formulation of priorities, between and across community divides
4. Being passionate, determined, and committed to our work
5. Leading change, not react to it
6. Being innovative, creative, and solution focused; and
7. Being accountable in all aspects of our work to First Peoples with disability and their families, our communities, and to the community generally.

We also honoured the Disability Royal Commission's theoretical approaches of human rights, disability theory, intersectionality, and life course approach.²²

1.3 First Nations and human rights frameworks

The current state of support for First Nations people with disability has failed to uphold First Nations rights and interests in operations and service provision. It is inconsistent with several First Nations principles as set out in the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*²³, which establishes a universal framework²⁴ of minimum standards for the survival, dignity, and well-being of the Indigenous peoples of the world.

The approach, analysis and recommendations within this report all align to the principles within *UNDRIP* and *Convention on the Rights of Persons with Disabilities (CRPD)*²⁵ and support the uplift of the NDIS to not just meet the minimum requirements but to become a future-fit, culturally informed, and adequately resourced scheme.

1.4 Alignment with the Disability Royal Commission cultural framework

The report and analysis align with the cultural framework designed by the Disability Royal Commission (see Figure 2, below). The framework provides a structure to guide the categorisation and practical implementation of recommendations for reform.

The four elements of the cultural framework represent the four major structural areas of reform for the First Nations disability sector. The framework is based upon the advice and insight from Commissioner Andrea Mason OAM, advice from First Nations people with disability and the First Nations policy team at the Disability Royal Commission.



Figure 2. Disability Royal Commission Cultural Framework

2 Our Approach

Deloitte used key findings from the consultation phase, insights from the literature review and key quantitative data sources to recommend strategic reform for services to First Nations people with disability.

2.1 A Structured Approach

This report must meet the following criteria:

- Provide current and future forecast of service demand for disability services for First Nations people with disability with consideration to location, level and type of service support required now and, in the future²⁶
- Provide a current and future forecast of workforce skills and capability to support culturally appropriate services for First Nations people with disability from a national and local perspective
- Provide an analysis of the number and type of services currently delivered by First Nations-focused providers under the NDIS
- Provide critical analysis of the suggested system changes and service planning is required with regard to:
 - disability
 - A practical and incremental implementation pathway including timeline, implementation challenges and relevant government costing to achieve the transition implementation and ongoing cost of such changes
 - Workforce considerations and clear outline of how workforce capacity could be increased to meet demand for such system changes.

To provide a critical analysis of the suggested system changes and service planning, the First Nations led project team conducted analysis across three phases (see Figure 3, below):

- Understand – Understand the current state of disability services for First Nations people with disability, the existing best practice in current disability and service delivery, community and system need and the projected demand for these services
- Determine – Determine the key issues that are causing the issues identified within the consultation findings, the literature review and the quantitative data and forecasts; and
- Assess – Identify and assess the possible solutions to the key issues and make evidence-based recommendations. This includes the identification of an implementation plan and reform roadmap according to the recommendations.

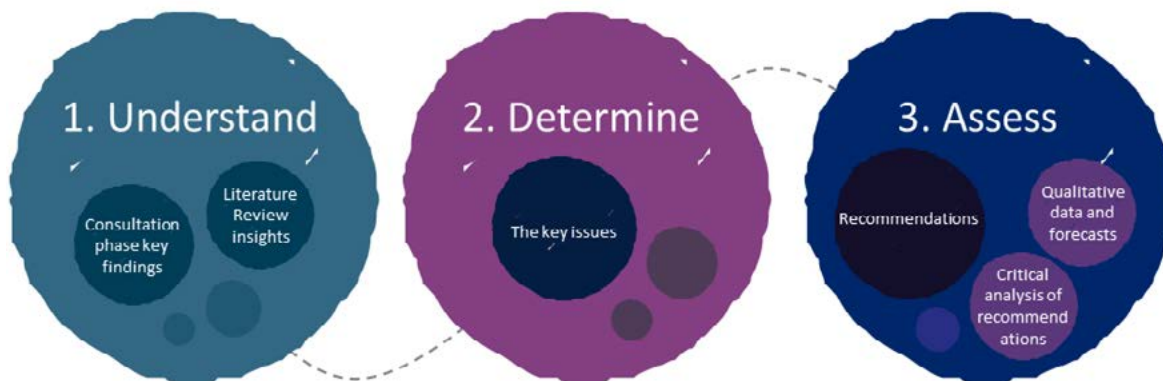


Figure 3. Overview of the three phased methodology adopted by the team and corresponding outputs (Deloitte, 2022)

2.2 Phase one: Understand



A comprehensive database of research, both qualitative and quantitative.

Literature Review

Our literature review²⁷ uncovered the empirical challenges that First Nations people face in access to care, as well as their experiences within the system. The review leveraged existing supporting documentation, artefacts, data and grey literature relating to First Nations disability domestically and internationally. It also incorporated all previous public submissions to the Disability Royal Commission concerning First Nations people with disability.

First Nations consultations

Deloitte conducted deep listening with community through an extensive qualitative consultation phase. The consultations were guided by the stakeholder engagement plan (completed in stage one) and our four community engagement principles; deep listening, community defined, meaningful partnerships and strengths based.

Figure 4, below outlines a summary of Deloitte’s qualitative consultation phase. Due to the data sovereignty and confidentiality principles that Deloitte maintains throughout all engagements, this report will not detail the individual stakeholders consulted.



Figure 4. Summary of the qualitative consultation phase (Deloitte, 2022)

Figure 5, below visually represents the geographic spread of qualitative data collected during consultations. Consultations were categorised into jurisdictions to ensure accurate representation of issues facing First Nations disability service delivery across Australia.²⁸

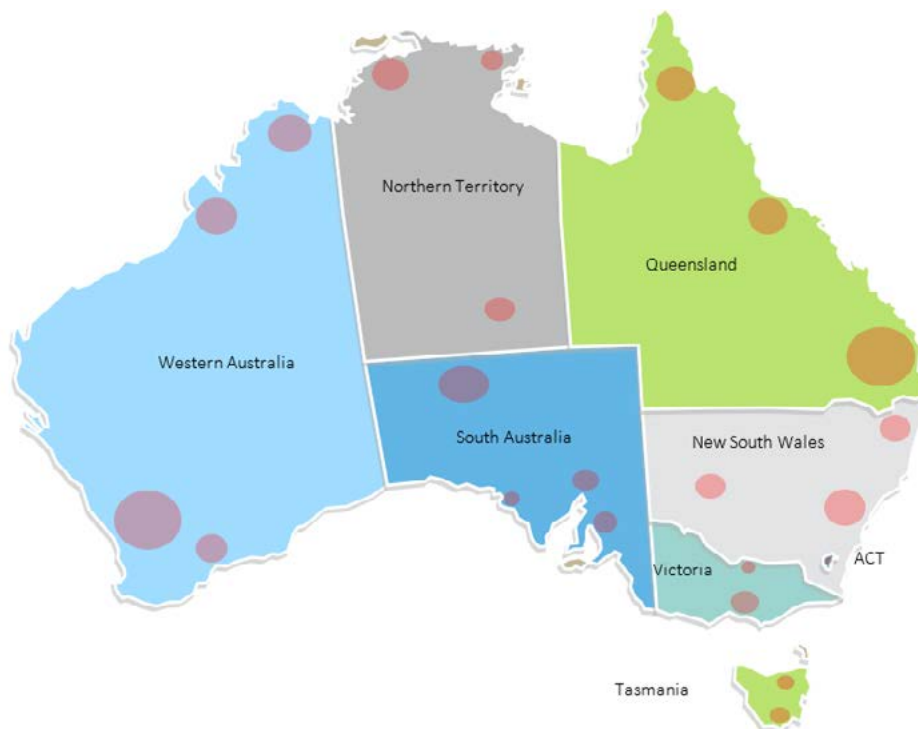


Figure 5. Geographic representation of consultations (Deloitte, 2022)

Key findings from the consultation phase

Due to COVID-19 restrictions and commitment for sustainable data collection, we met via online methods in most cases. We conducted several on-country visits which were essential in understanding the ‘on the ground’ situation for many providers. All consultations were conducted in accordance with culturally safe engagement principles detailed below in Figure 6. This report was exempt from ethics review.²⁹

Standardised questions, bespoke delivery that suits community needs	Accounted for and respected community timeframes	Ensured Free, Prior and Informed Consent (FPIC)
Deep Listening – suspended judgement, heard unspoken needs	Ensured data sovereignty and closed the information loop	Acknowledged lens of place and space

Figure 6. Consultation principles (Deloitte, 2022)

The key insights shared during the consultations have been summarised against the Disability Royal Commission’s Cultural Framework. The full summary of consultations is found at Appendix A.

The findings from the literature review, combined with consultation insights will provide a foundation to inform the recommendations (as detailed in later sections of this report).

2.3 Phase two: Determine – ‘the key issues’



A uniform approach to disability services often does not meet the unique and sometimes complex needs of First Nations people with disability, nor could the breadth of the consideration required be provided in a single report. To ensure we focused on solutions that would have maximum impact, we honoured the voice of the First Nations disability community, the academic literature and the data to identify the issues that were common and repeated across all three.

It is important to acknowledge data limitations, and this was weighted accordingly.

Figure 7 shows the three main sources of information collected during phase two of the project. Together these indicate the key issues faced by First Nations people with disability in Australia.

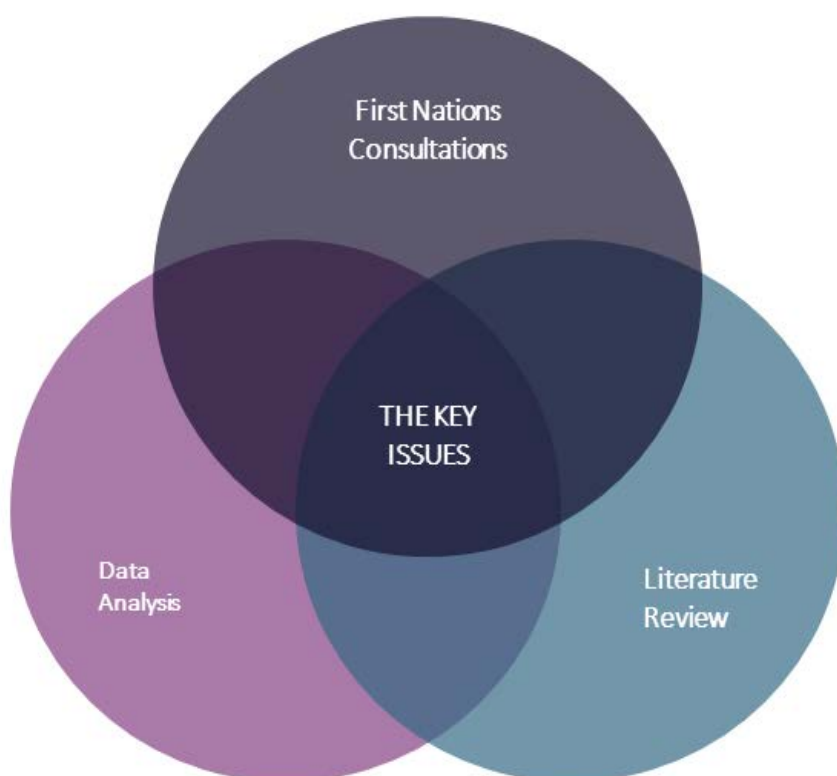


Figure 7. Phase two - intersection of key issues

2.4 Phase three: Assess – our recommendations



A set of recommendations have been designed and assessed which will improve access to culturally appropriate and safe disability services for First Nations people with disability. These recommendations have undergone thoughtful and comprehensive assessment to ensure they will best address the key issues.³⁰

We have detailed an implementation and reform roadmap which is practical, incremental and provides an urgent and highly needed pathway to reform. The roadmap identifies the key challenges, relevant broad costings to achieve the transition to implementation and the projected ongoing cost.

Key questions guiding our analysis include:

- Current and future forecast of service demand for disability services for First Nations people with disability
- Analysis of the number and type of services currently delivered by First Nations-focused providers under the NDIS; and
- Current and future forecast of workforce skills and capability to support culturally appropriate services for First Nations people with disability.

The data supports the evidence found within the Summary of Key Findings. The project team has undertaken robust analysis of current and future forecasts of service demand for First Nations disability support services, current and future workforce skills and capabilities and the number and type of services currently delivered by First Nations-focused providers under the NDIS. To forecast current and future service demand, the team leveraged the insights from consultation through a range of analytical tools.³¹

We focused our quantitative analysis on data obtained by the Disability Royal Commission from the NDIA and DSS on the NDIS and DES program.³² The Disability Royal Commission provided actual claims data and participant demographics received from both sources. For the NDIS, data was also provided on committed supports (i.e., budgeted funding commitment) at the participant level.

To compare overall disability service participation, we have projected the number of people with each combination of characteristics for each year between 2016 and 2030. This projection is predominantly informed by the ABS Estimates and Projections, Aboriginal and Torres Strait Islander Australians for First Nations populations, the ABS Survey of Disability Ageing and Carers for population wide disability data and our own internal Deloitte Access Economics modelling.

Once future service demand was understood, the project team then assessed a current and future forecast of workforce capacity and capability, including:

- Understanding the future of work and workplace – leveraging findings and insights developed in future service demand and complemented with external research
- Understanding future workforce requirements – using service demand models we identified demand scenarios on workforce capacity and capability requirements; and
- Determining current workforce skills and capability – through consultations and utilising the relevant data sets available.

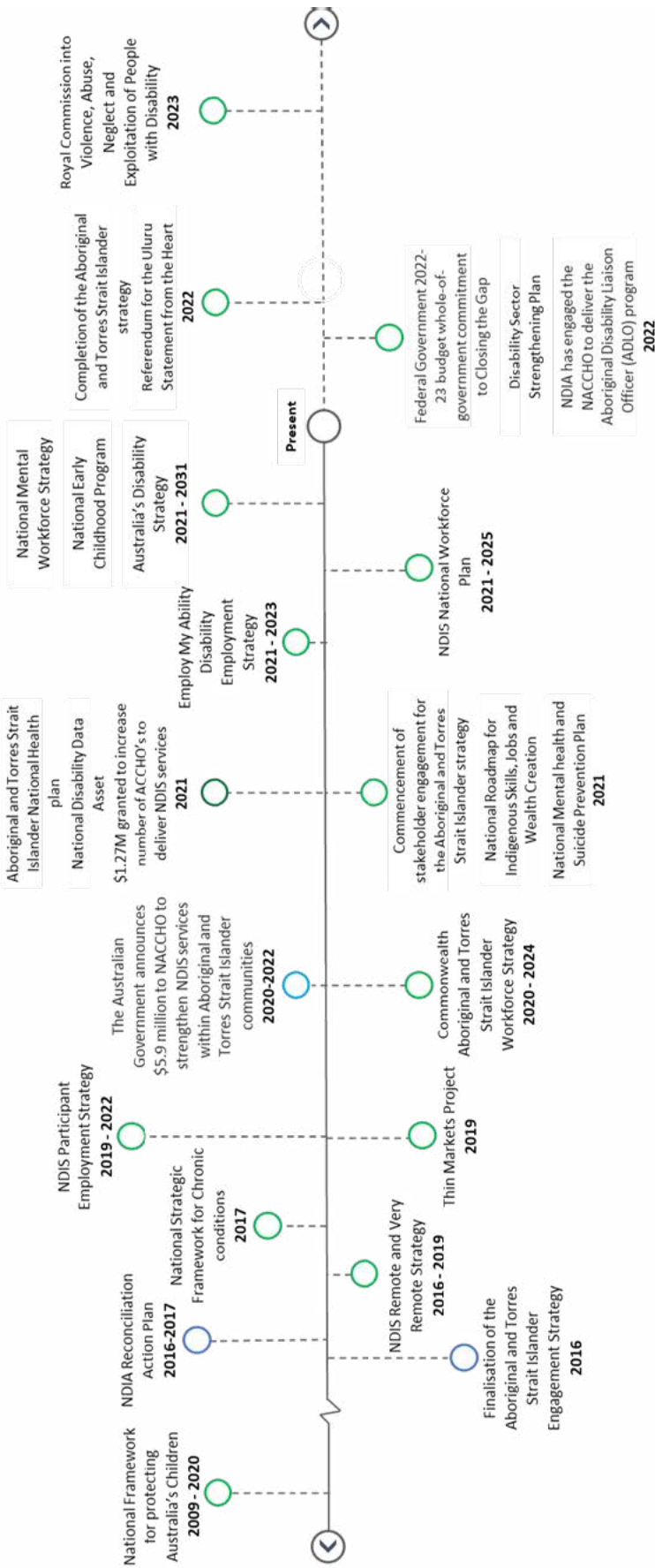


Figure 8. A timeline of First Nations specific disability service sector development (Deloitte, 2022)

Despite the efforts of governing bodies to redevelop the First Nations disability sector (as seen in Figure 8, above) broadly, disability care systems and policy were not explicitly designed to provide culturally safe or effective services for First Nations people - many of these reports do not reference outcomes for First Nations workforces or NDIS participants. Access to disability support services is made more difficult by geographical or social isolation, poverty/digital exclusion, and difficulty navigating complex application systems.

Barriers to accessing the NDIS and existing thin markets have resulted in under-utilised disability scheme packages and a lack of data around the true service demand for First Nations people with disability. With the limited available data, it is evident that sector is inadequately funded, disconnected from the people it serves, overwhelmed by demand, lacking in infrastructure to meet such a demand and is -in areas- culturally insensitive.

This is not the first report to consider First Nations disability sector reform. First Nations academics and organisations have published extensively on this topic as there is a known need for capacity and capability uplift at the segment and system level.

So why is there still so little progress in this area?

The time for deep listening and reform is now.

3 Analysis

3.1 Quantitative analysis of the First Nations disability sector

Acknowledgement of limitations in assessing service demand for disability services

Demand for disability services is a complex concept that is difficult to define and measure with precision.

Demand for services is related to an underlying 'need' for assistance but can also vary greatly- both for individuals over time and across individuals with similar medical conditions.

There is limited data on 'need' or demand for disability services, and it is challenging to link that demand to the receipt of care through specific programs or supports.

What we can observe is the level of service provided to people with a disability under specific government programs. This measure reflects both the demand for services and the supply of those services under the program.

Our analysis uses data on services that are delivered to people with a disability to analyse their experience. It recognises that services that have been provided reflect demand, but do not account for unmet demand which may exist in the community – both for people with a disability who do not access the program and those for whom provided services are insufficient.

The data used within this report is based on administrative data collections produced by the NDIA and DSS. Publicly available data (e.g., from the ABS and NDIS) and internal Deloitte resources were also used to build an initial picture of availability and accessibility of the National Disability Insurance Scheme (NDIS) and Disability Employment Services (DES) programs today and into the future.

Further remarks on our approach:

- We are unable to provide a comprehensive view of all disability services provided to First Nations people with disability, our analysis considers only those services provided by the NDIS or DES program. This is a direct consequence of the approach taken for the analysis.
- These datasets use definitions of disability based on limitations on core activities or on assessed levels of function. We acknowledge these definitions are not borne out of or reflective of the experiences, perspectives and worldviews of First Nations people with disability.
- Demand has been measured with regard to historical service provision on the NDIS with specific focus on payments rather than a ratio of the committed supports offered on these programs. Demand outside of these programs is not accounted for. Due to limited data fields

obtained in the data collection and reporting limitations we are unable to accurately assess the underlying need for disability services for First Nations people with disability including for example unmet demand.

- The historical service provision metric used for DES has focused more on participant counts than payments made (as with our analyses of the NDIS), due to the nature of services offered on DES. A participant who is active on the NDIS may not be receiving any disability related services if they are not utilising their committed supports, making the amount they have actually claimed a better measure for demand of services. In contrast, a participant on DES will receive quarterly service fees for simply being active in the program (and with a provider). As such, they are receiving disability related services regardless of whether they achieve any education or employment outcomes.
- We are unable to analyse or conclude the impact (if any) that transition to the NDIS may have on First Nations people with disability and the availability / accessibility of disability services as AIHW could not provide data within a timeframe to meet project timelines, consequently the Disability Royal Commission could not obtain the data within the necessary timeline.

Uncertainty of projections and forecasts:

Our analysis includes projections and forecasts, like all projections/forecasts these are inherently uncertain, they reflect dynamics which have been observed historically and are based on certain specified assumptions. Actual future experience can and should be expected to vary, for example:

- Historical activity is not necessarily an accurate predictor of future activity
- Service model, operating environment, political landscape, or other external factors may change
- Future experience may differ to those selected assumptions
- The projections and forecasts have been prepared for the specific purpose and scope of this report, they may not be appropriate for other purposes. Caution should be exercised in extrapolating these projections for any other purpose.

Refer to 'Reliance's and Limitations' and 'Data sources and key assumptions' sections for further details on key assumptions and reliance's driving the quantitative analysis.

Additional detail

The main body of this report provides our key analyses and observations. Annexures D- F provide further detail supporting these analyses, namely:

- The sources of data, the statistical approach used to analyse service demand and determination of key assumptions (Appendix D – Quantitative Analyses)

- Descriptive statistics pertaining to the Torres Strait Islands (Appendix E – Torres Strait Islands)
- A selection of tabular statistics on the demographic and payments information, split by various groupings such as age, remoteness, state, primary disability, support class across time (Appendix F – Descriptive Tables).

3.2 Current and future demand of services

Overview

First Nations participation in the NDIS has been growing faster than the scheme. In 2020-21 there was the largest observable share of First Nations participants within the NDIS, as seen in Figure 9 below.

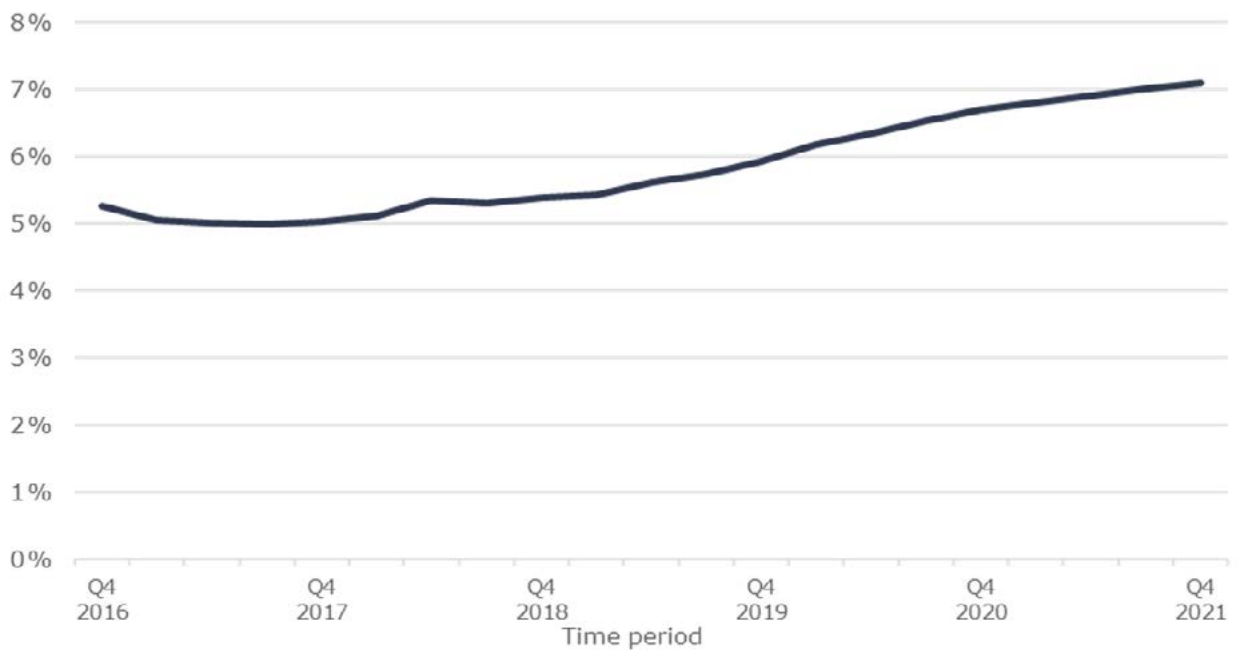


Figure 9. Proportion of First Nations Participants in the NDIS (NDIS, 2021)

Of the 499,426 (First Nations and non-indigenous) individuals receiving support under the NDIS in December 2021, a relatively large proportion sit in the younger age groups. This is especially true for First Nations participants, whose average age is younger than the scheme average, reflecting both a younger population overall and a slightly different interface with the aged care sector.³³

The overall skew of younger people within the NDIS (in Figure 10 below) reflects the higher prevalence of several specific conditions among children as well as high rates of receipt for certain conditions due to those conditions qualifying under early access under the NDIS – particularly autism, which makes up the largest group of participants in the scheme across both First Nations and non-Indigenous people. Similarly, the increased prevalence of

Developmental Delay (a disability almost entirely affecting young people) among First Nations people also contributes to the overall younger skew. This pattern of higher participation among children relative to adults may shift in coming years, with NDIS participants continuing in the scheme as they age.

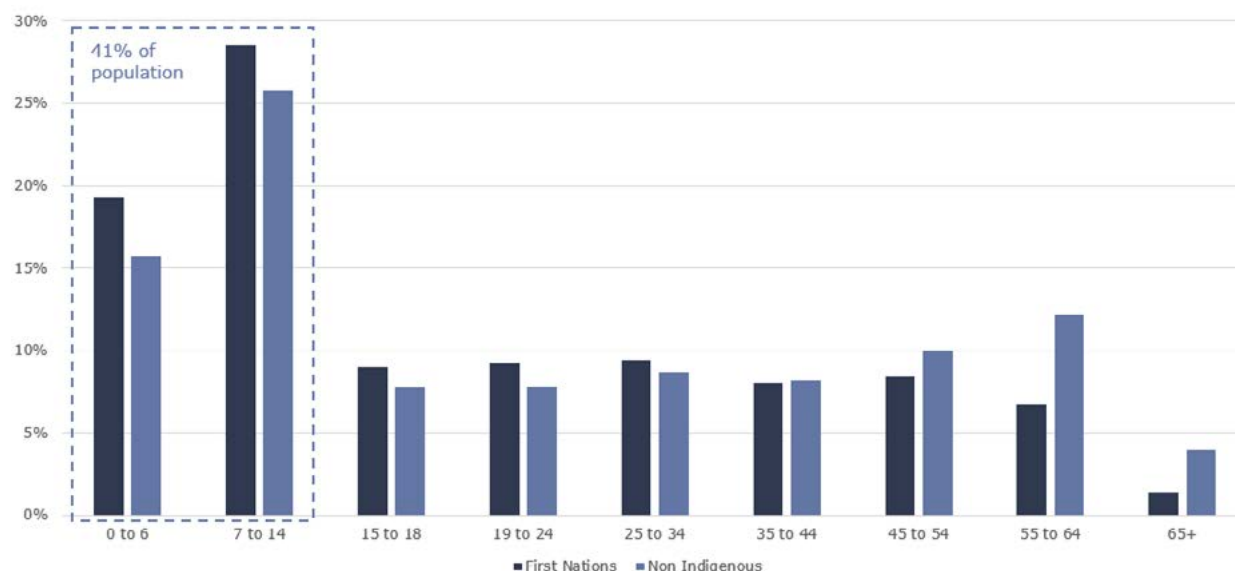


Figure 10. Percentage of people by age group in NDIS split by First Nations status at December 2021 (NDIS, 2021)

Consistent disability support outcomes for First Nations children are important. Any gaps in support in this age group can create lifelong disadvantage, compounding existing inequity, while placing further strain on already overwhelmed families and kinship who have care responsibilities for First Nations children.

Disability Employment Services help people with disability find work and keep a job. Through DES, people with disability, injury or health conditions may be able to receive assistance to prepare for, find and keep a job. Disability Employment Services has two parts:

- Disability Management Service (DMS) is for job seekers with disability, injury or health condition who need assistance to find a job and occasional support in the workplace to keep a job.
- Employment Support Service (ESS) is for job seekers with permanent disability who need help to find a job and who need regular, ongoing support in the workplace to keep a job.

DES is accessed via Centrelink and JobAccess, the national hub for workplace and employment information for people with disability, employers and service providers.

Disability Employment Services (DES) support a total caseload of 315,926 individuals as of December 2021.

The characteristics of Individuals receiving DES services reflect mutual obligation requirements and other aspects of the transfer system – particularly in relation to the interaction between disability, income support and employment.

In contrast to the NDIS, DES has a concentration of older individuals. This is due to several reasons, including that DES focuses on employment and employment related education (certifications, Job Aids etc.) which is not required for children, increases in the proportion of people with a disability in older age groups and the higher need for additional assistive services for individuals at older ages to obtain employment.

Figure 11, below visualises the percentage of people by age in DES within both First Nations populations and non-Indigenous populations. In earlier age bands, there are larger proportions of First Nations people receiving support from DES, which changes as non-Indigenous individuals become the majority in later age bands. The higher proportion of First Nations individuals under the age of 25 years may be due to First Nations young people entering the workforce earlier to financially support themselves and their families, thus being less engaged in education in their 20s though we note the data is unable to specify what share of this this is due to an earlier entry to the workforce by First Nations people or an under-representation of older ages. This burden could be reduced with the recommendations in this report which provide increased financial support to vulnerable communities who require costly infrastructure and supports that are not always covered by the NDIS. Several recommendations also provide employment opportunities for individuals of all ages and abilities, making employment easier for older individuals seeking culturally and ability safe workplaces.

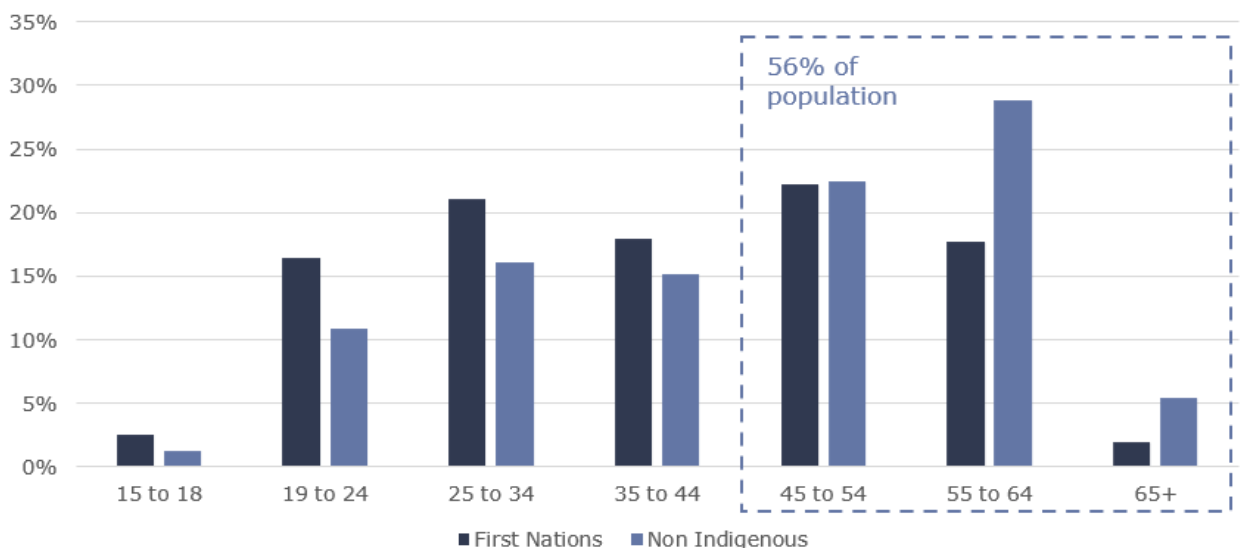


Figure 11. Percentage of people by age group in DES split by First Nations status at December 2021 (Department of Social Services, 2021)

While the nature of conditions reported by First Nations people with a disability under the NDIS is similar to the average across the scheme, there are some differences reflecting specific challenges facing First Nations communities.

Figure 12, below portrays the distribution percentage of First Nations people and non-Indigenous people in each primary disability group under the NDIS, as of December 2021. There are 17 distinct primary disability types in the NDIS, of which Autism, Intellectual Disabilities, Psychosocial Disabilities and Developmental Delay account for over 68% of all participants and are more prevalent in children. With each primary disability group requiring different types of support for a unique set of needs, a high performing support services industry requires many capabilities and specialists.

Developmental delay and intellectual disability are more prevalent among First Nations NDIS participants, partly reflecting conditions such as Foetal Alcohol Spectrum Disorder³⁴ and other dimensions of disadvantage among First Nations communities. In contrast, autism, hearing impairment and neurological conditions make up a smaller share of First Nations participants in the scheme compared to non-Indigenous participants. This may partially reflect different levels of diagnosis of these conditions in both of these communities.

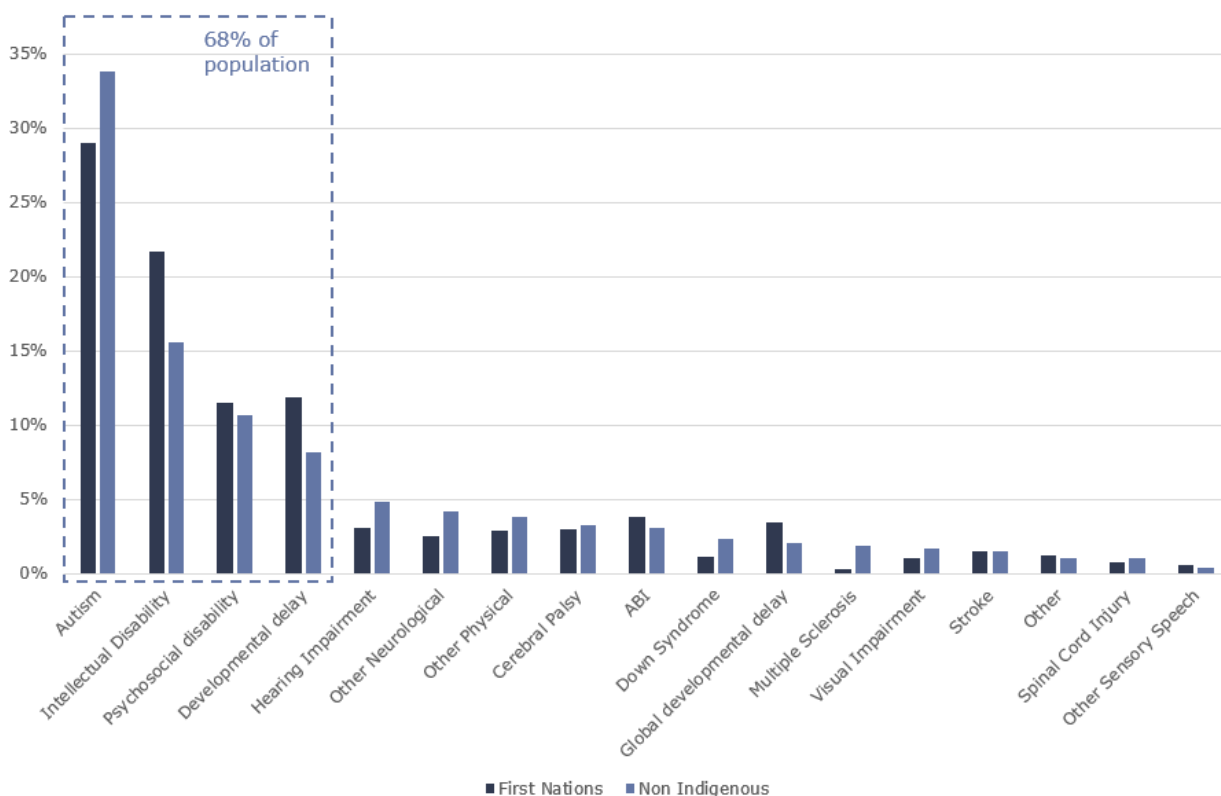


Figure 12. Percentage by primary disability group in the NDIS, split by First Nations status at December 2021 (NDIS, 2021)

We heard during community consultations that specialists are not evenly distributed and often require individuals to travel long distances to access support. Recommendations have been made that support First Nations individuals with disability to pool funds in remote and very remote areas which will aid in better catering for overlapping needs and to realise economies of scale. Additionally, recommendations will support a workforce that can cater for multiple categories of need, upskill and employ those who are already providing support informally to become registered providers and to address thin markets in areas that require more diverse options for appropriate care.

Disability groupings within the DES program are different to those in the NDIS population, reflecting the different objectives and participants of the two programs. Figure 13, below portrays the percentage of First Nations individuals and non-Indigenous individuals in each primary disability group in the DES program as of December 2021. There are 11 distinct primary disability types in DES, of which Physical Disabilities and Psychiatric Disabilities represent over 83% of all DES participants. Of those in DES, the share of First Nations people across primary disability group are broadly like the share of non-Indigenous participants indicating that First Nations and non-Indigenous individuals with Physical Disabilities and Psychiatric Disabilities are seeking employment or undertaking rehabilitation activities to enhance their ability to obtain employment.

During the community consultations it was made clear that the service providers within the disability services sector are overwhelmed, understaffed, and underfunded. Recommendations in this report have been designed to support these individuals in finding employment, as services providers within the disability service sector desperately require support. As an outcome of the recommendations, individuals with disability will provide direct services that understand and reflect the needs of others experiencing similar disabilities, uplifting the quality of services and subsequent delivery.

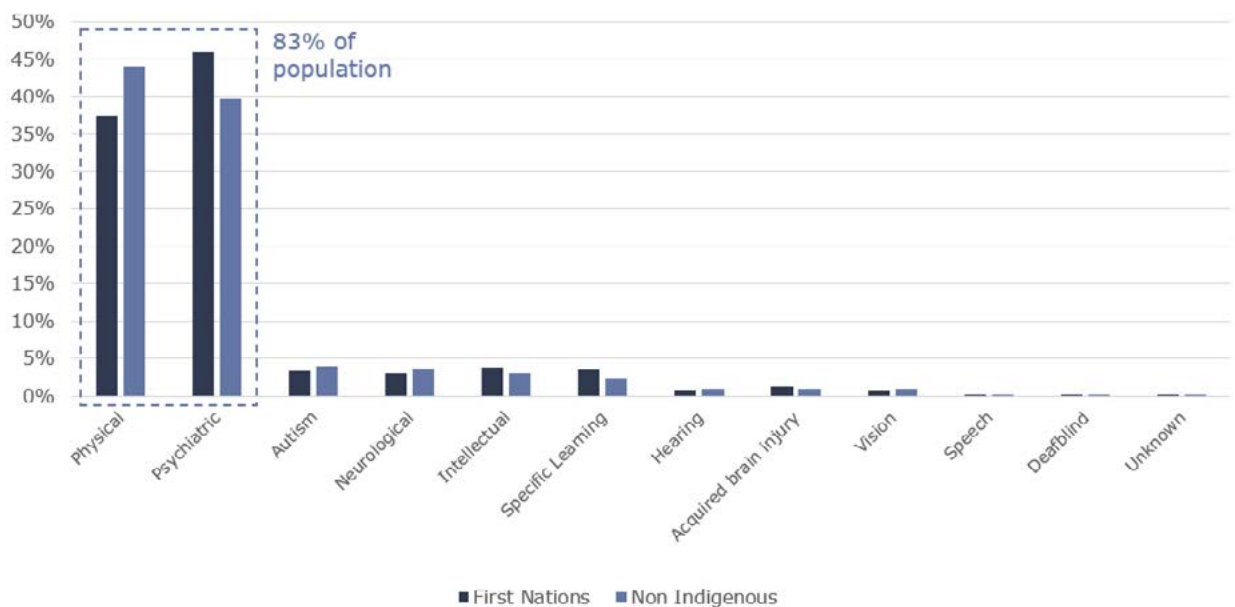
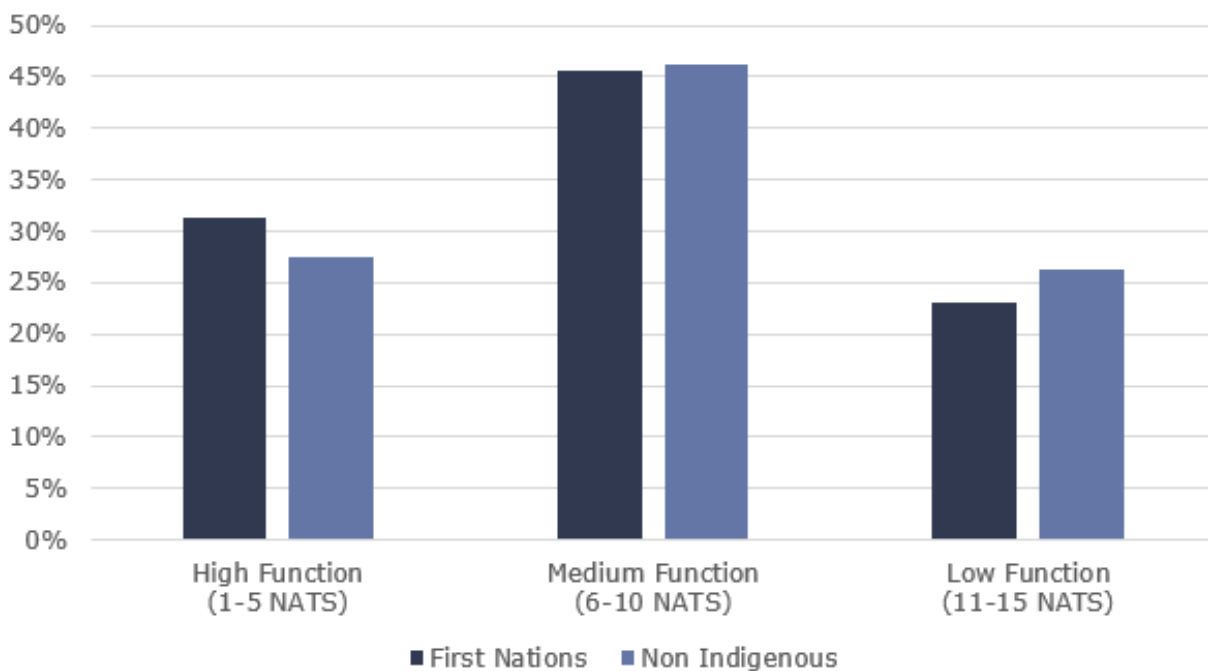


Figure 13. Percentage of primary disability group in DES, split by First Nations status at December 2021 (DSS, 2021)

Figure 14, below describes the percentage distribution of level of function³⁵ of First Nations and non-Indigenous people under the NDIS as of December 2021. First Nations individuals in the NDIS have a high proportion of disabilities presenting with low to medium function (69%). This is not dissimilar to the non-indigenous population but highlights serving such a community requires a workforce that understand the needs of First Nations communities, is highly skilled and is culturally competent. A number of recommendations have been outlined that ensure quality and culturally safe services are upheld by all services providers. By creating a culturally safe workplace that can support all abilities, the disability support services sector will become a more attractive workplace for First Nations people with disability.

This also means that First Nations communities are likely to require greater levels of infrastructure for support. These communities will be supported to access and fund this support through the recommendations in the report.



*NATS: Normalised Assessment Tool Score.

Figure 14. Percentage of people by level of function (per NATS*) in the NDIS, split by First Nations status at December 2021 (DSS, 2021)

Figure 15, below shows the percentage of First Nations and non-Indigenous people in DES by the Jobseeker Classification Instrument (JSCI)³⁶ score as of December 2021. Figure 15 suggests that First Nations individuals in DES have lower levels of function than non-Indigenous individuals with disability in the DES.

We note that there are some differences in level of function and disability severity collection methodology between the NDIS and DES. While the NDIS Normalised Assessment Tool (NAT) score is based on assessment supporting documentation on file, the DES JSCI score is based on metrics largely self-reported by the participant. As such, in conjunction with the different assessment target (level of function in NDIS, and capacity to work in DES), it may not be appropriate to directly compare level of function or disability severity directly between the two programs.

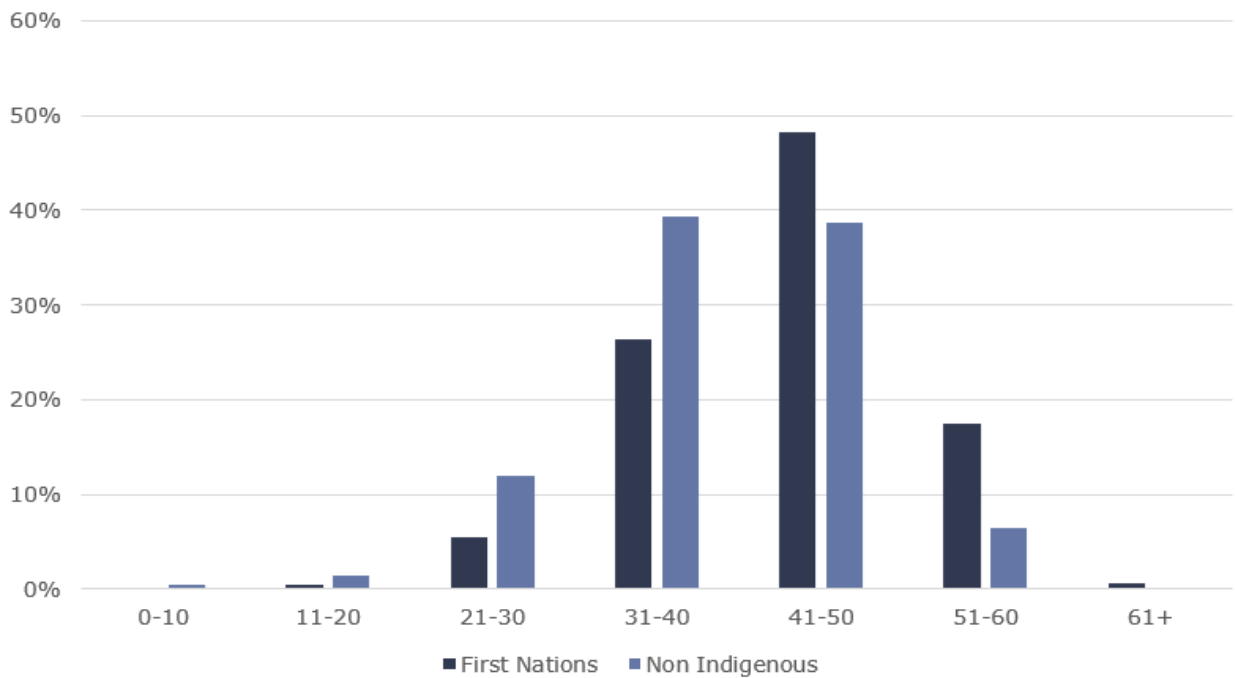


Figure 15. Percentage of people by JSCI score in DES split by First Nations status at December 2021 (DSS, 2021)

Figure 16, shows the share of participants in each state/territory in the NDIS across time. In December 2016, NSW and ACT accounted for 47% and 9% of participants in the NDIS respectively, compared to 32% and 2% representation in the population at that time. This is largely reflective of the initial rollout conditions of the NDIS, with services and providers first being introduced in large numbers in NSW and the ACT. As the scheme has matured, the representation of states in the NDIS have become more reflective of the population splits, with NSW and ACT now accounting for 30% and 2% respectively. Figure 17 shows the corresponding graph of First Nations NDIS participants by state/territory across time, noting the uptake of participants in Queensland and Western Australia over time corresponds with NDIS roll outs in more regions in these states and in general the higher proportion of participants from the Northern Territory.

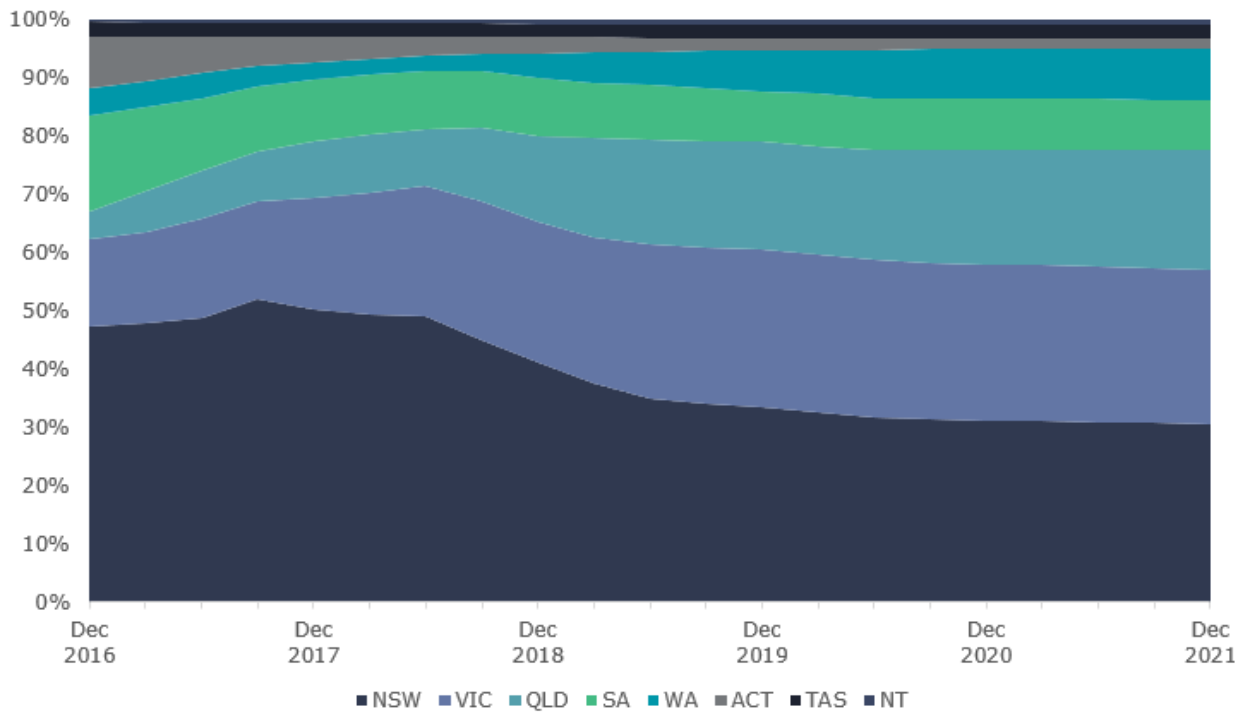


Figure 16. Percentage of participants in each state across time (NDIS)

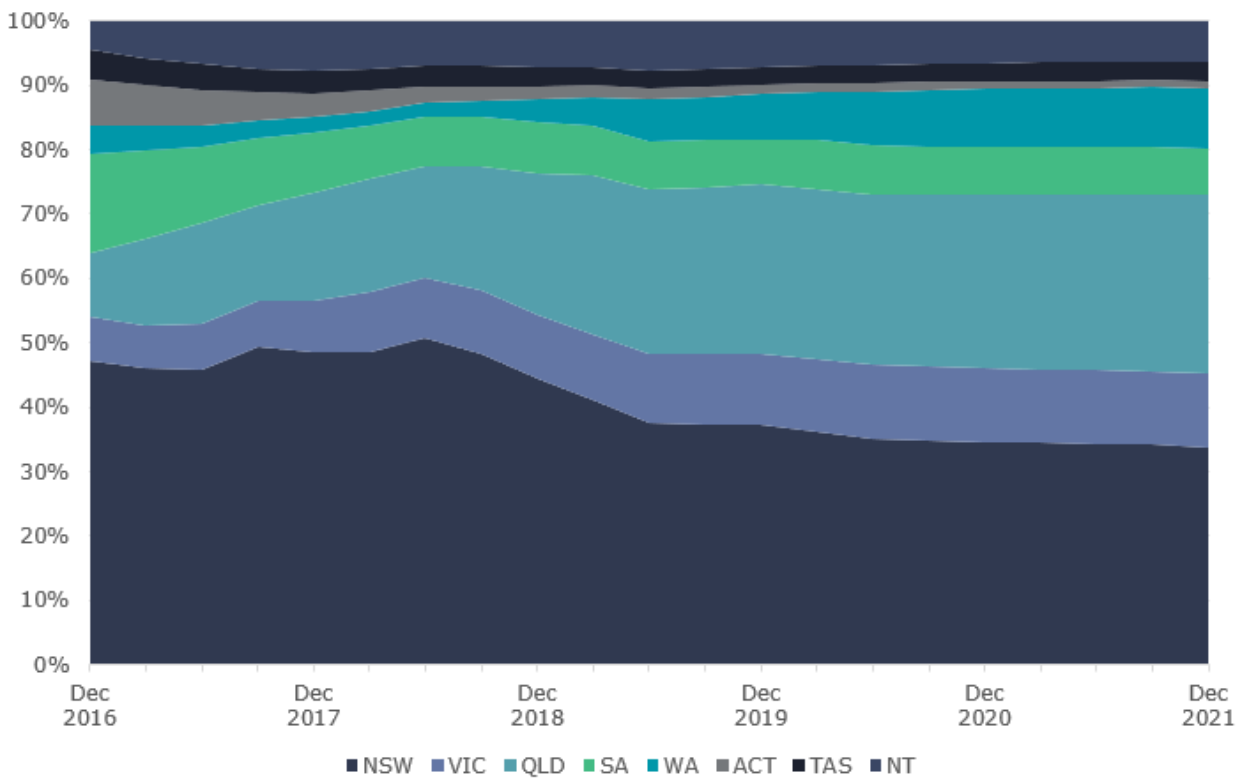


Figure 17. Percentage of First Nations participants in each state across time (NDIS)

On the DES program, we can see in Figure 17 above that the proportion of participants in each state or territory has remained relatively constant throughout the same time period (Dec 2016 to Dec 2021). NSW and VIC have decreased as a proportion slightly from 31% and 27% in December 2016 to 29% and 25% in December 2021. SA and WA have increased as a proportion slightly from 9% and 6% in December 2016 to 11% and 8% in December 2021. Figure 18 below shows the corresponding graph for First Nations participants on DES.

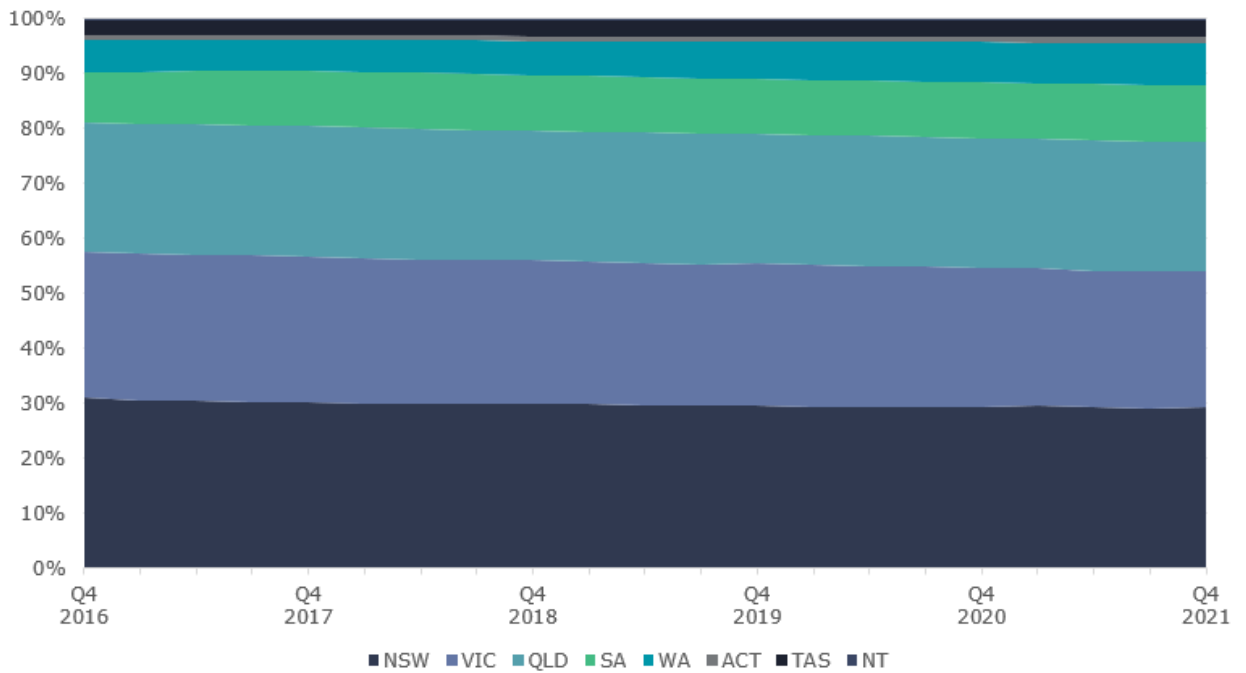


Figure 18. Percentage of participants in each state across time (2016-2021)

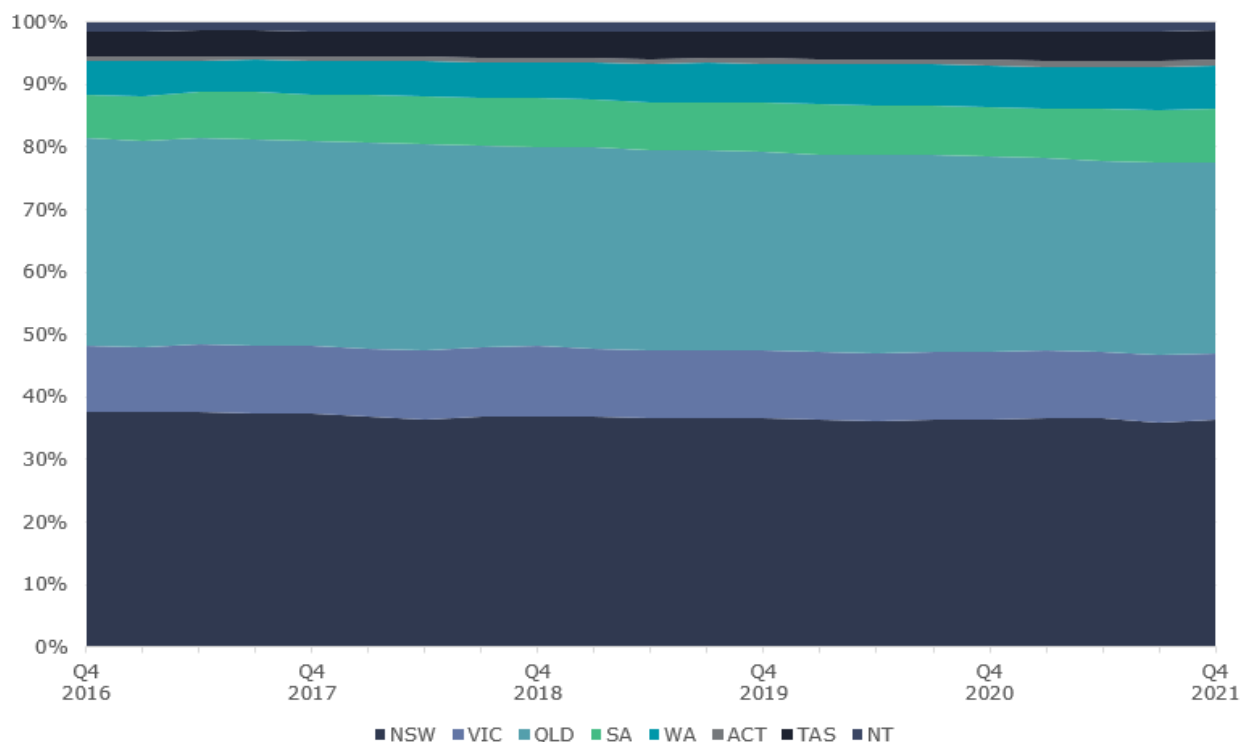


Figure 19. Percentage of participants in the NDIS and DES in each state compared to overall Australian population split (DES and NDIS, 2021)

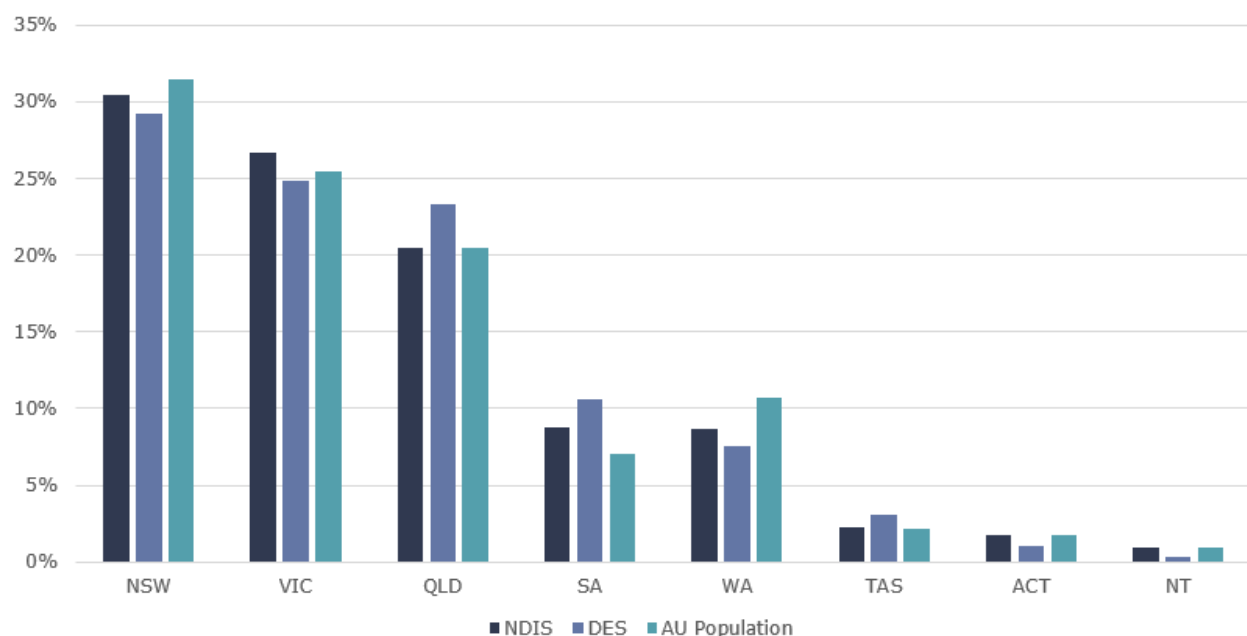


Figure 20. Percentage of participants in the NDIS and DES in each state compared to overall Australian population split (DES and NDIS, 2021)

Figure 20 shows that at December 2021, the NDIS population split by state is quite reflective of the total Australian population with a slight under representation in New South Wales and Western Australia and slight over representation in Victoria and South Australia.

For DES, we can see that Queensland, South Australia and Tasmania have a higher proportion of participants when compared to the spread in the Australian population, while New South Wales, Western Australia, Australian Capital Territory and Northern Territory have lower proportions.

Below we compare the representation of First Nations people in each State and Territory and across the NDIS and DES.

First Nations representation in each State and Territory on the NDIS and DES, is greater than the respective First Nations representation in the population across each State and Territory, shown in Figure 21, below but like for like across program. This effect is especially evident in the Northern Territory with 50% of NDIS participants in 2021 being First Nations people (versus 32% of those in the Northern Territory with a disability identifying as First Nations). Noting however, the small population size of the Northern Territory in general (a population of around 249,300 at December 2021).³⁷

The share of DES First Nations participants in each state and territory in 2021 is directionally like those represented on the NDIS, with the exception of the Northern Territory, where the proportion of First Nations DES participants in the Northern Territory is 26% (6% lower than First Nations people with a disability represented in the Northern Territory overall).

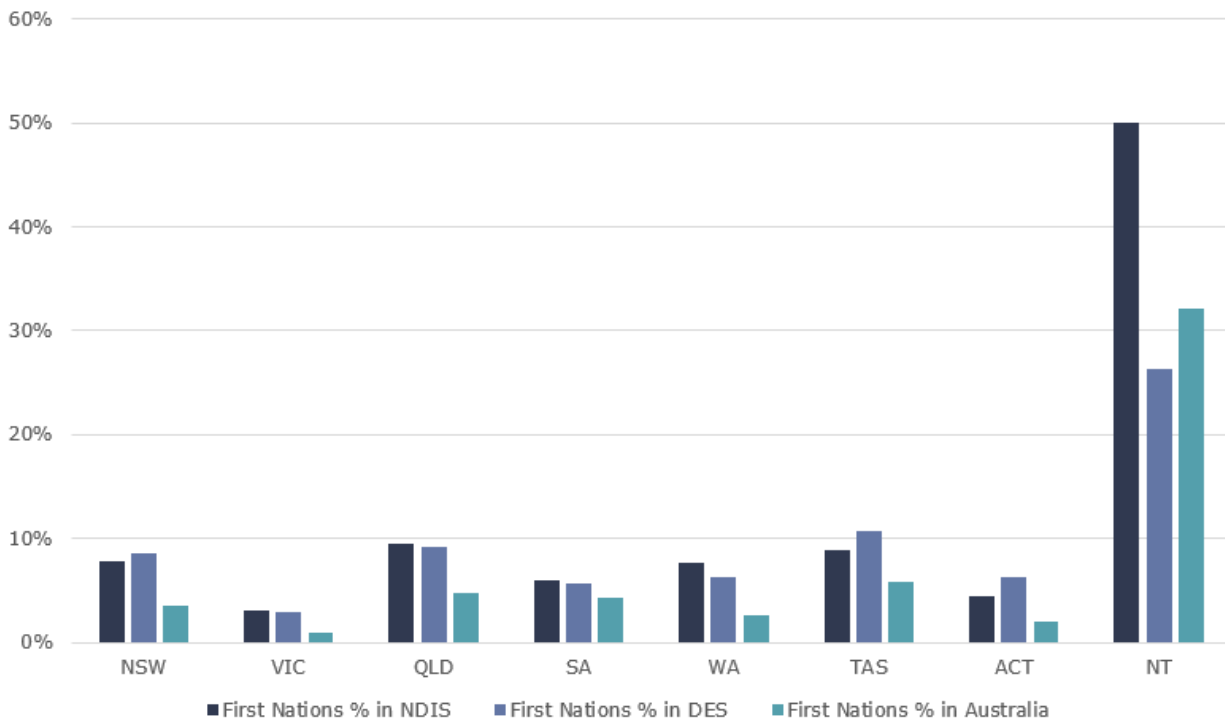


Figure 21. Proportion of First Nations participants on the NDIS and DES in each state compared to Australian population (DES and NDIS, 2021)

State and Territory divisions give limited insight on where people are situated relative to the main centres of population. The Modified Monash Model (MMM) remoteness index has seven classifications ranging from metropolitan to very remote (Figure 22, below). Figure 23, below, shows the distribution of remoteness of First Nations and non-Indigenous people participating in the NDIS using the MMM remoteness index.

The data suggests that just 55% of all First Nations people with disability under the NDIS live in regional, rural, remote and very remote areas and reflects the distribution of First Nations population throughout the country. This differs from the distribution of where non-Indigenous people reside (i.e., more than 70% in the NDIS in metropolitan areas) and is a reminder that the challenges of distance and remoteness fall disproportionately on First Nations people and their providers.

While the data suggests First Nations people are accessing NDIS supports, if eligible, it does not infer anything about equality of access or that the quality of services that can be provided with a given level of funding is consistent or that access is the same across remoteness. Our analysis does not and was not able to consider the quality of service, only whether the service was provided, and at what cost. We heard during community consultations that these people are receiving services that are culturally unsafe, ineffective and further entrenching the profound disadvantage experienced by First Nations people with disability.

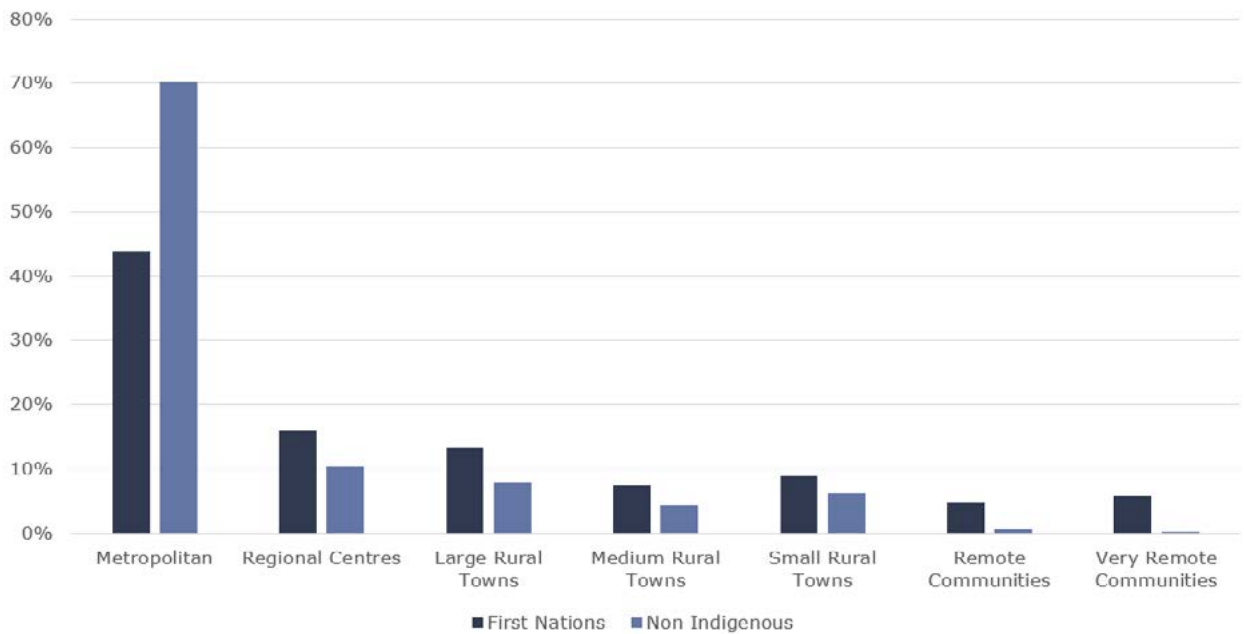


Figure 22. Percentage of people by location in the NDIS, split by First Nations status at December 2021 (NDIS, 2021)

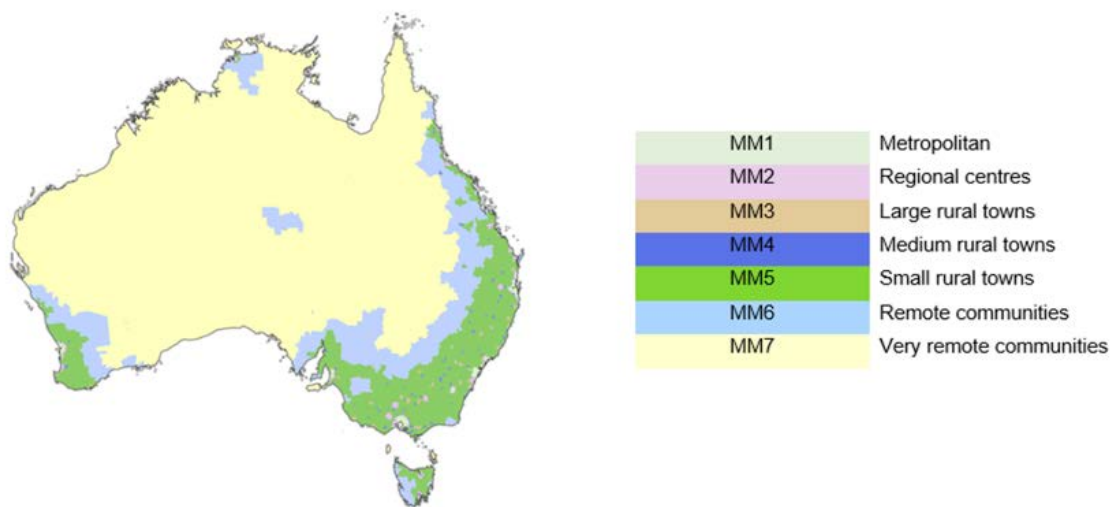


Figure 23. Graphical representation of remoteness and descriptions under the Modified Monash Model (MMM 2019) (Australian Government Department of Health, 2021)

Figure 24, below shows the distribution of remoteness of First Nations people and non-Indigenous people participating in DES, as of December 2021. It is particularly interesting that in DES, remote and very remote communities have very low levels of representation potentially reflecting a lack of employment opportunities,³⁸ while small rural towns have higher representation compared to medium rural towns. The latter may indicate that participants in DES who are originally from remote areas and who have capacity for employment may be relocating to utilise employment services provided in small rural towns.

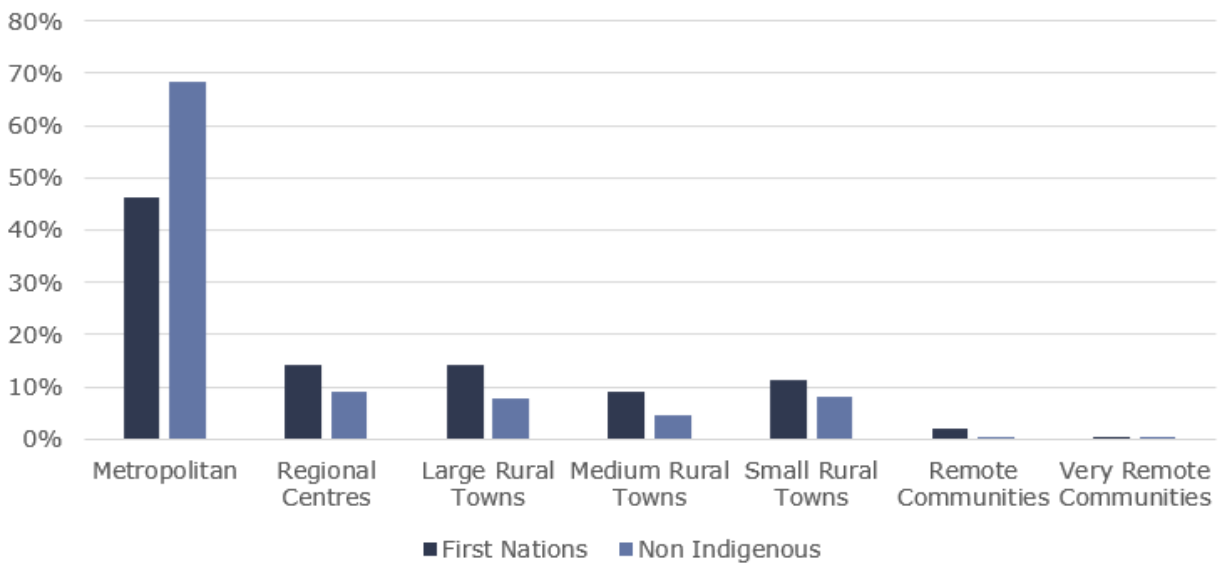


Figure 24. Distribution of DES participants by location in DES split by First Nations status at December 2021 (DES, 2021)

Figure 25 below shows the distribution of participants in each MMM remoteness level within in each state and territory. The trends in the proportions of NDIS participants in each remoteness level, are largely reflective of the remoteness distributions in the wider population of each state or territory. NSW, VIC, SA, WA and ACT are urbanised with over 70% of NDIS participants in these states and territories being in Metropolitan regions. Queensland has slightly lower proportions of Metropolitan participants at around 60%. Tasmania and Northern Territory do not have any Metropolitan participants, with the largest cohort being participants in Regional Centres. Notably, NT has a very large proportion of participants in Remote and Very Remote Communities. Of the around 7,600 total NDIS participants in Remote and Very Remote Communities, a quarter (around 1,900) are from NT. Figure 26, below shows the remoteness distribution in each state for First Nations participants only. All states share the trend of First Nations people being more likely to reside in more remote regions.

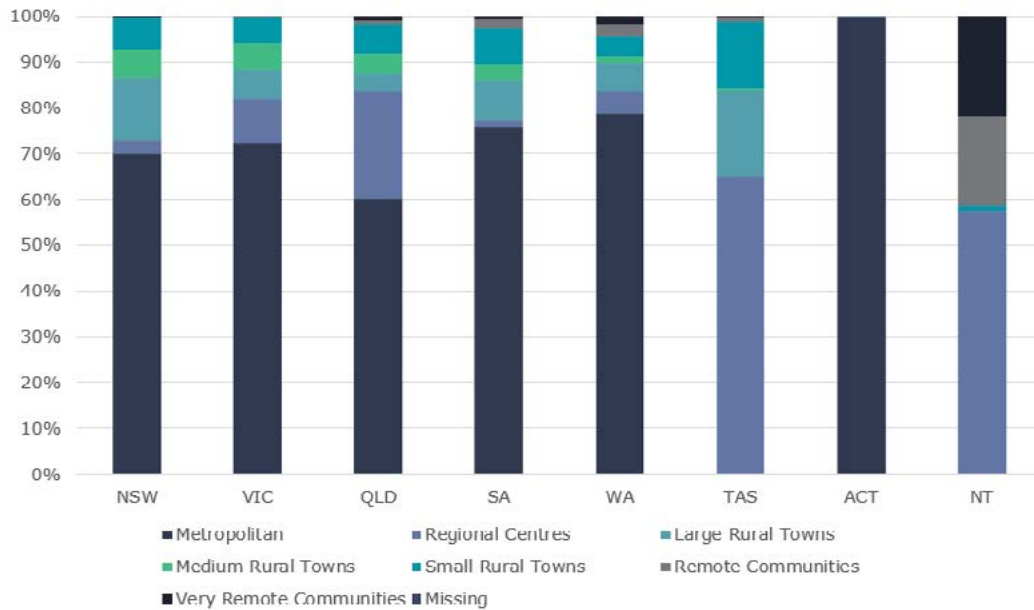


Figure 25. Distribution of MMM Index Remoteness level in each state and territory in the NDIS (NDIS, 2021)

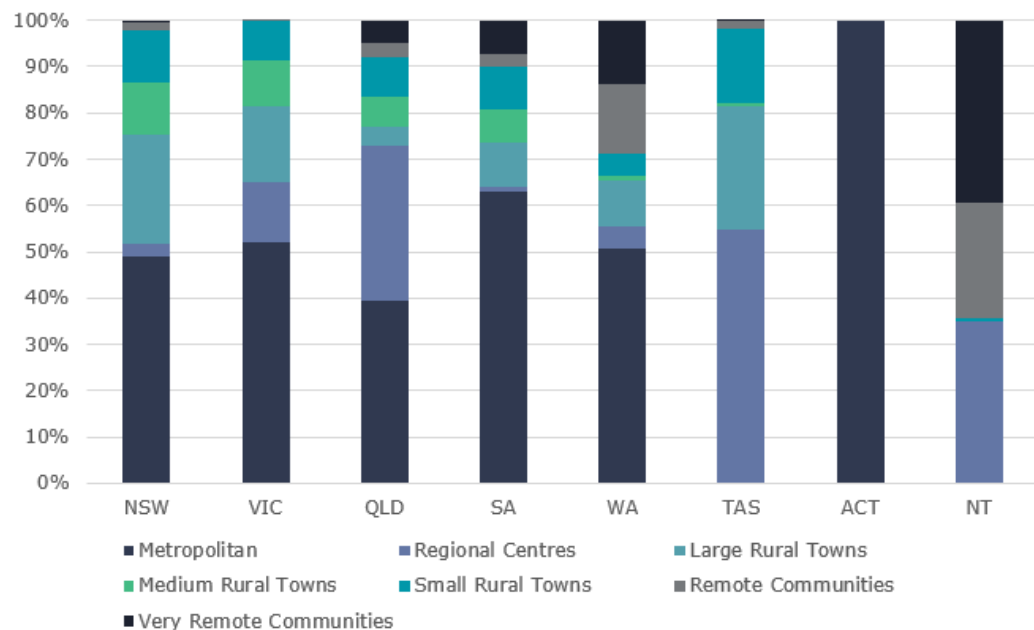
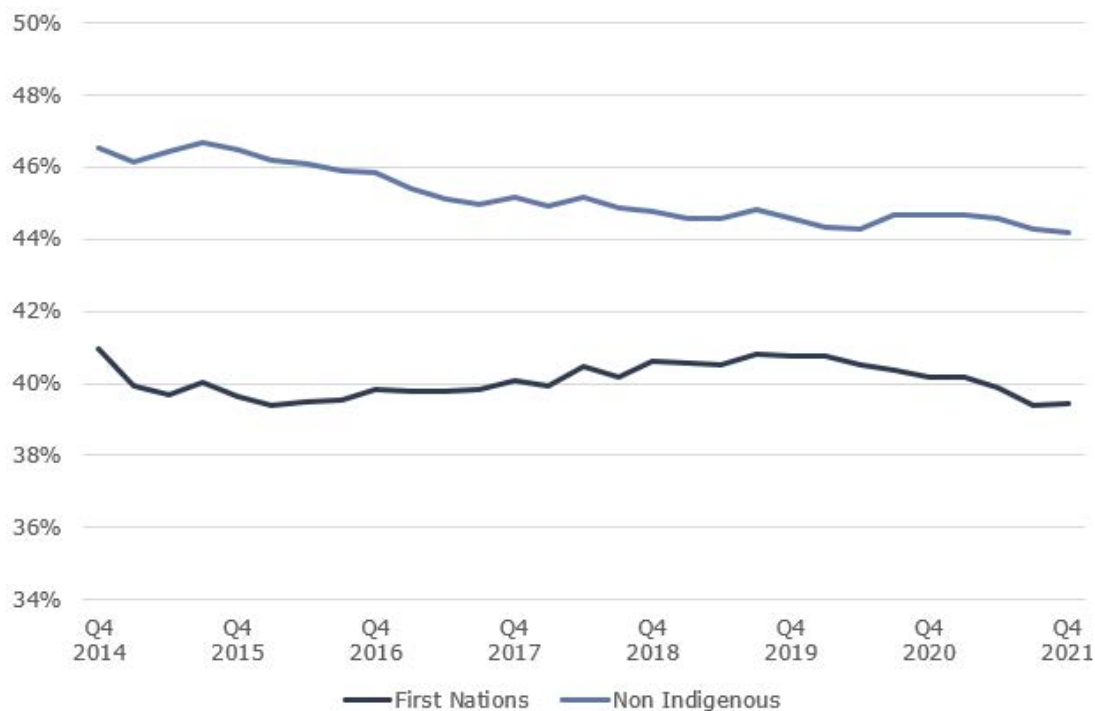


Figure 26. Distribution of MMM Index Remoteness level in each state and territory for First Nations participants in the NDIS (NDIS, 2021)

Figure 27 and Figure 28, below show the proportion of First Nations and non-Indigenous participants in each of the funding level programs. For First Nations participants across time, around 40% are in DMS compared to around 45% of non-Indigenous participants. Correspondingly, around 60% of First Nations and 55% of Non-Indigenous participants are in ESS. This split between DMS and ESS has been relatively stable across time for First Nations participants. In contrast, the proportion of non-Indigenous participants in DMS has been decreasing from around 47% in 2014 to 44% in 2021.



*Note: the lines are to be interpreted independently (i.e., at Q4 2021, 39% of First Nations participants are in DMS, and 44% of non-Indigenous participants are in DMS).

Figure 27. Percentage of participants in DMS by First Nations status (DES)

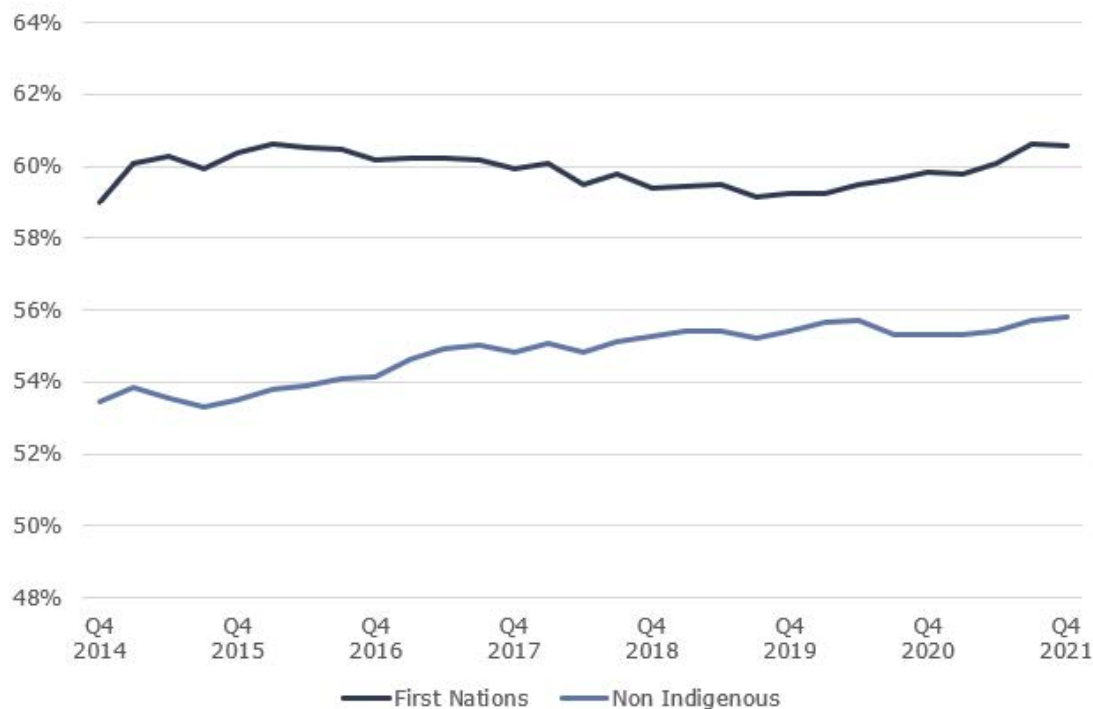


Figure 28. Percentage of participants in ESS by First Nations status (DES)

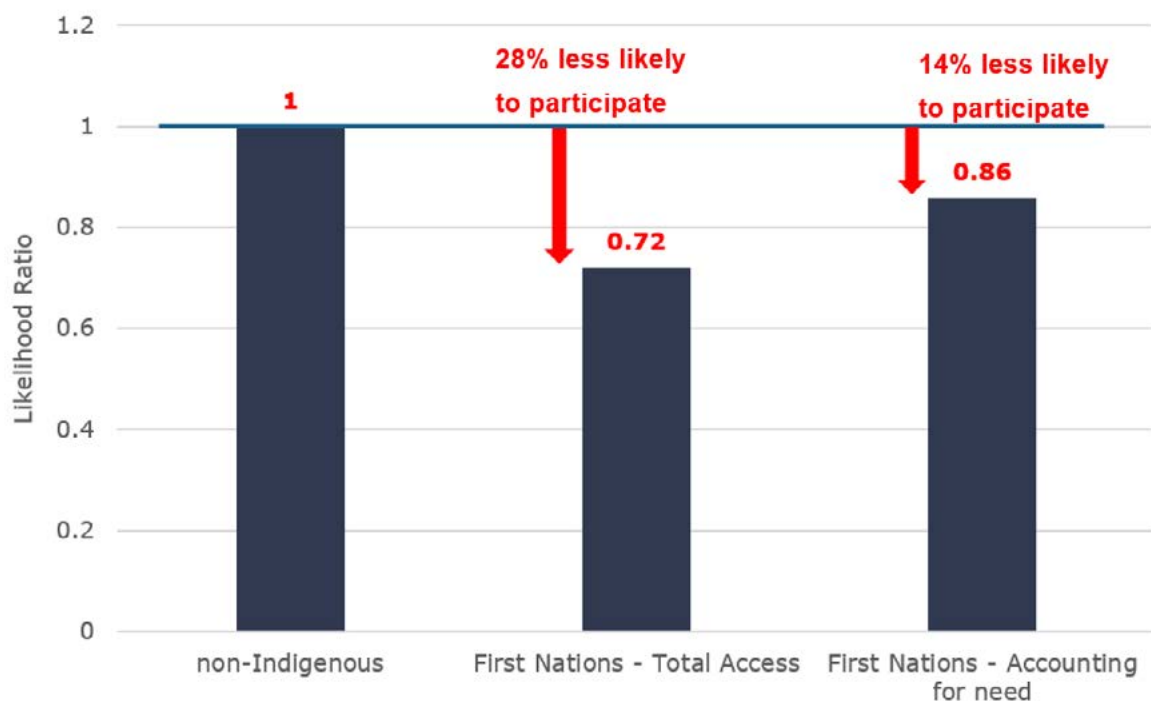
Current

Using a multivariate statistical model, we have broken down the factors impacting participation on the NDIS to determine the likelihood of First Nations people to receive disability services via the NDIS. Understanding this provides and inaction of existing demand.

After accounting for differences in disability, age and geography, First Nations people are less likely to receive NDIS services than their non-Indigenous counterparts as seen in figure below.³⁹

In 2021 we estimate there was a 28% access gap for First Nations people across the NDIS. After accounting for the individual's need of support, the estimate for access gap is 14%.⁴⁰ These gaps are driven by accessibility issues primarily in certain age groups, and secondarily certain geographical locations.

Figure 29 and Figure 30, below are graphs illustrating 'Odds Ratio' (or Likelihood) derived from the statistical model. Cohorts are compared to a reference group. The reference group will vary between the charts but will always present with an odds ratio of 1. A ratio greater than 1 indicates a higher likelihood of participating in the NDIS for a particular cohort relative to the reference group, and a ratio lower than 1 indicates a lower likelihood of participating in the NDIS.⁴¹ Figure 29 shows that compared to non-Indigenous participants (and keeping all else equal), First Nations participants are on average 28% (100%-72%) less likely to participate in the NDIS.



*Note: The interpretation should read as 'Compared to the reference group and keeping all else equal, this cohort is on average x% more/less likely to participate in the NDIS'.

Figure 29. Likelihood of First Nations and non-Indigenous people accessing disability support via the NDIS, with and without accounting for need

This gap has been closing over time as the NDIS matures and First Nations people make up a larger share of recipients, but it remains a major inequity in disability support provision in Australia. Much of the difference in access is due to fewer First Nations children with a disability accessing the NDIS, as seen in Figure 30, below. Children are a large cohort of NDIS participants, but First Nations children are significantly less likely to access disability services through the NDIS than non-Indigenous people (see Figure 31, below).

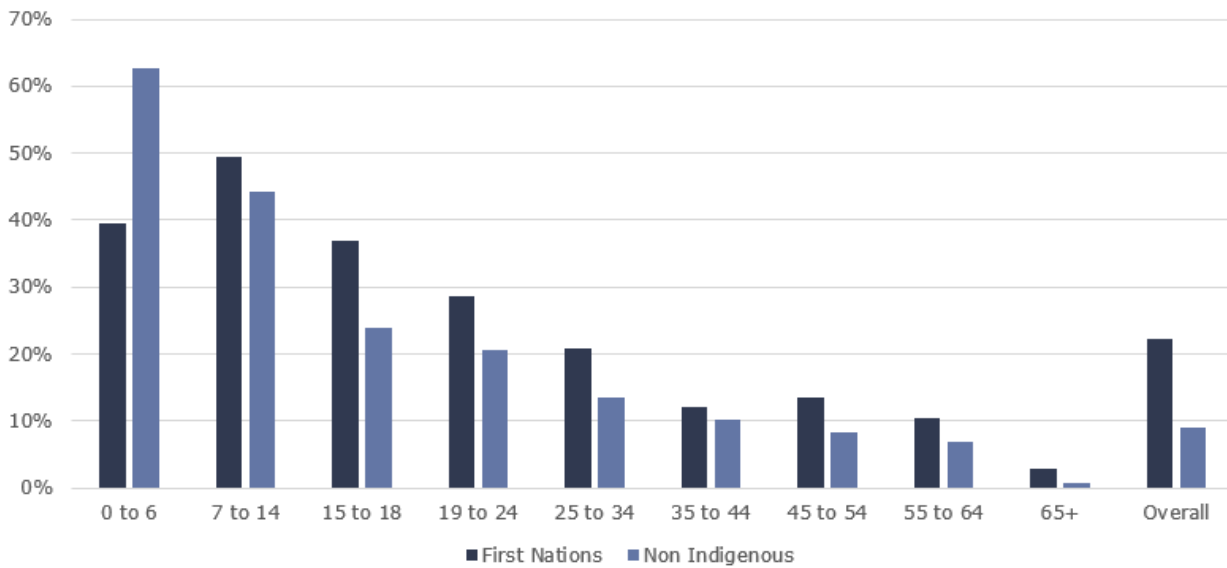


Figure 30. NDIS representation relative to the population with a disability, split by First Nations and non-Indigenous cohorts (NDIS, 2021)

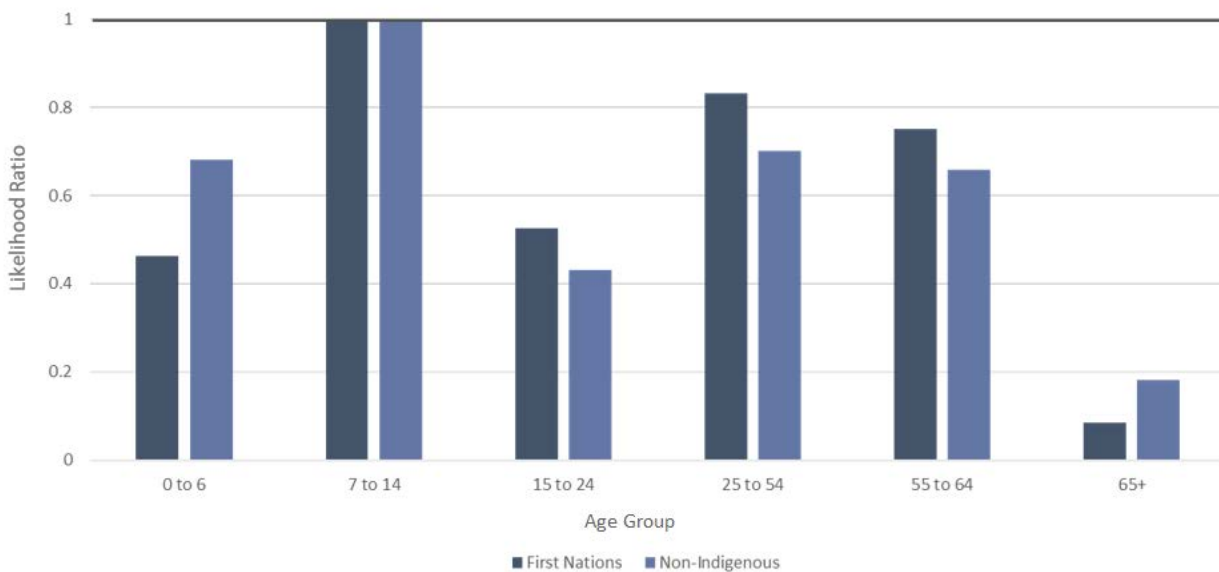


Figure 31. Likelihood of First Nations and non-Indigenous people accessing disability support via the NDIS, by age, with reference to age band 7-14 years (NDIS, 2021)

First Nations children age zero to six years are 54% less likely to be on the NDIS compared to seven - to 14-year-olds. In contrast, this figure is only 32% for non-Indigenous 0- to 6-year-olds so this suggests a gap between First Nations children and non-indigenous children. In age groups 7-64, the likelihood of participation is lower across all people relative to 7–14-year-olds but First Nations people are more likely to participate than their non-indigenous counterparts.

Some reasons why the access gap might be happening:

- Poor access to early childhood education leading to late diagnosis of some conditions, missing out on early intervention opportunities that are on offer to non-Indigenous children. These children are likely to be diagnosed in the first year or two of school, which might be why the 7–14-year-old representation is stronger.
- Lack of specialists and providers to diagnose issues and act as pathways to support.
- Difficulty navigating NDIS processes which can be intimidating and often fail to consider challenges around language and literacy.
- Mistrust by First Nations peoples to access services that may invite scrutiny to other aspects of individual and family circumstances
- Diagnostic tools do not account for cultural needs.

Further, the locations in which First Nations people live contribute to the gap in NDIS participation. Figure 22 (earlier in the report) shows that the total non-Indigenous population with a disability, 30% live in non-Metropolitan regions. This figure is much higher, at 55% for First Nations people. Accounting for influences in other demographics, generally the more remote a region, the weaker the NDIS participation.

Participation in the NDIS in regions outside of major cities is a particular concern for First Nations people, with those living in more rural locations such as Regional Centres, Large Rural Towns, Medium Rural Towns, being less than half as likely to participate in the NDIS compared to those in cities (Figure 32). In contrast, non-Indigenous people living in these locations have comparatively similar participation rates to those in cities.

Hence, some of the 28% participation gap for First Nations people is explained by the combination of concentrations in remote regions along with the weaker NDIS participation in these regions.

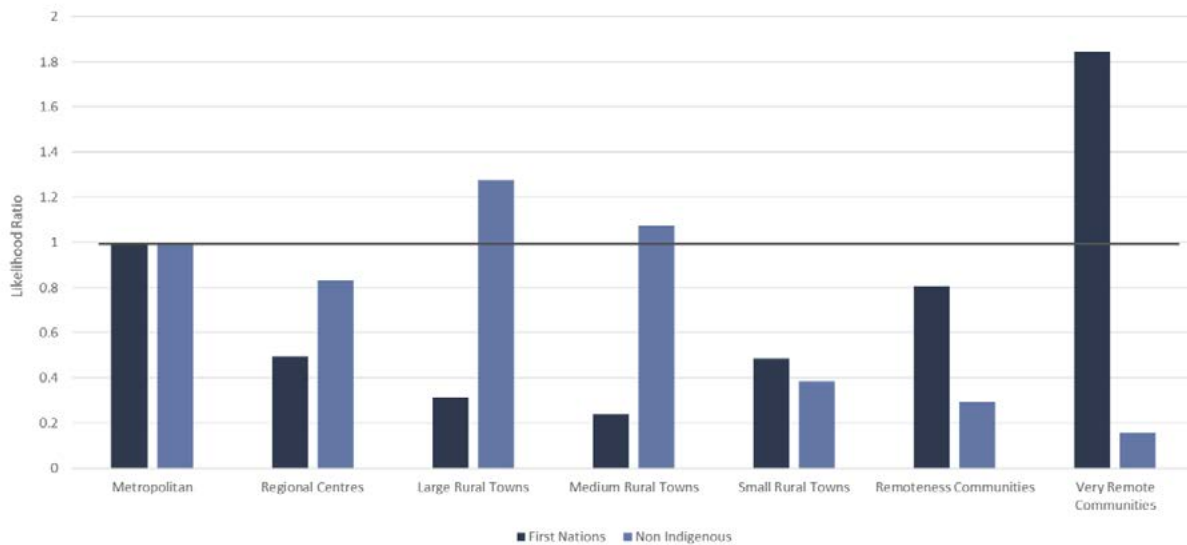


Figure 32. Likelihood of First Nations people participating in the NDIS compared to non-Indigenous people (NDIS, 2021)

Analysis of payments by services per participant in the NDIS

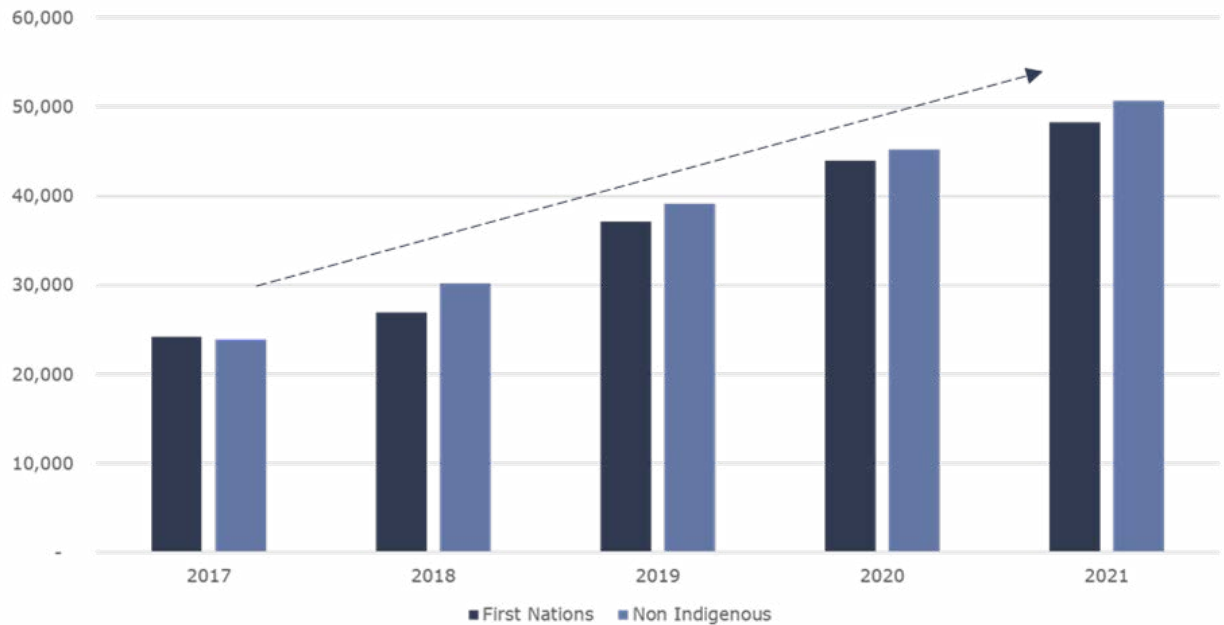
Overall, the average payments received by First Nations people on the NDIS are \$2,216 below those of non-Indigenous participants on the NDIS⁴². This is driven by First Nations peoples' large representation in the younger age categories and significant representation in metro areas and small to large rural areas.

On average, First Nations children aged zero to six years receive 12% lower NDIS payments annually compared to their non-Indigenous counterparts due to higher representation of disabilities, such as developmental delay, which tend to receive less funding on average. In all other age bands First Nations people receive higher payments on average in the NDIS than non-Indigenous people and attributed to higher volumes of disabilities which require higher level of needs, such as intellectual disability.

By region, First Nations NDIS participants receive higher payments on average in regional centres, remote and very remote communities when compared to non-Indigenous NDIS participants. For regional centres, this could be due to First Nations participants receiving better access to NDIS compared to other regions. In remote and very remote communities, we observe a high prevalence of disabilities which have higher support needs in First Nations NDIS participants compared to non-Indigenous participants.

We will explore these observations in further detail in this section.

The average annual payment per NDIS participant has been growing steadily at a rate of approximately 20% per annum (significantly higher than medical inflation), increasing from circa \$24,000 per participant in 2017 to circa \$50,500 per participant in 2021 (Figure 33, below).



Note that the Average payment shown in the graphs that follow will differ from the NDIS scheme actuary report ('PB NDIS Annual Financial Sustainability Report 2021-22').⁴³

Figure 33. Average payment per participant in the NDIS per calendar year, split by First Nations status (NDIS, 2021)

By age, First Nations participants in the NDIS submitted higher NDIS claim payments than non-Indigenous participants in each age group, except for ages zero to six years. Given the large representation of First Nations children, the gap in claim payments has a large influence on the overall average claim payment level seen below.

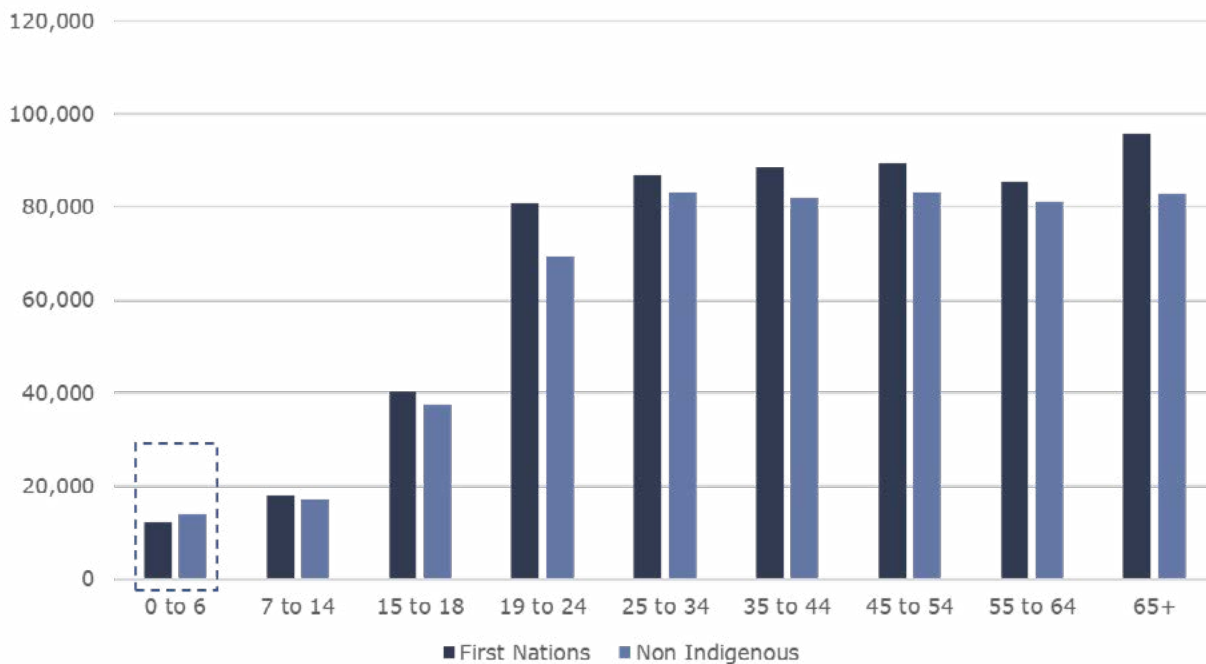


Figure 34. Average payment per participant in the NDIS, split by age and First Nations status (NDIS, 2021)

Of the 17 distinct primary disability types represented in the NDIS, Autism, Intellectual Disabilities, Psychosocial Disabilities and Developmental Delay account for over 68% of all participants (refer to Figure 35). First Nations NDIS participants have higher representation of Intellectual Disability and Developmental Delay than non-Indigenous participants, and lower representation of Autism but overall, these three account for 63% of the primary disabilities presented in First Nations people on the NDIS.

Figure 35, below shows that First Nations participants receive, on average, higher payments per person than non-Indigenous participants (particularly Spinal Cord Injury). However, this does not occur in the disability categories where a majority of First Nations participants are represented that is, for Autism, Intellectual Disability and Developmental delay, on average First Nations participants are receive lower payments on average than non-Indigenous participants.

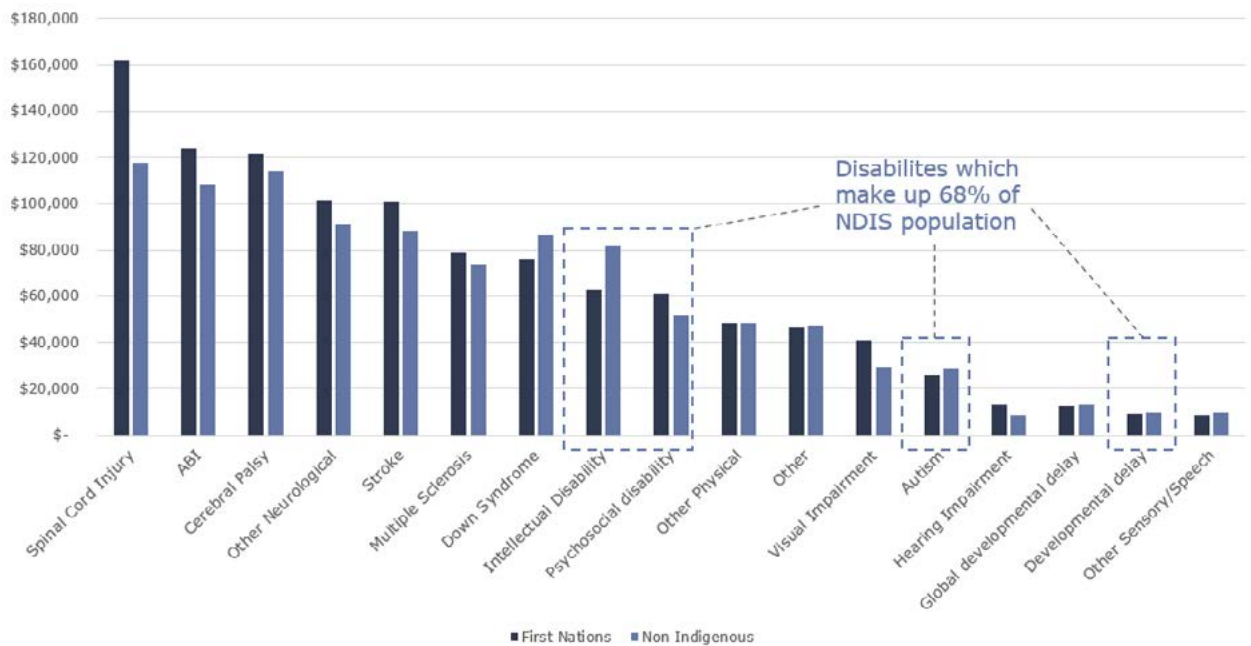


Figure 35. Average payment per participant in the NDIS in 2021, split by disability type and First Nations status (NDIS, 2021)

The combination of age and disability type provides further insight behind the lower average payment in ages 0-6 for First Nations participants in the NDIS, as seen below in Figure 36. The difference appears to be driven by different levels of need. In ages 0-6, there is a lower proportion of participants with Autism and a larger proportion of First Nations participants on the NDIS with Developmental Delay, when compared to non-Indigenous participants. This is significant as autism is associated with higher levels of support need compared to Developmental Delay.

In ages 7+, the difference in average payment is largely driven by a higher representation of intellectual disability and lower representation of developmental delay in the First Nations NDIS population compared to non-Indigenous NDIS participants (Developmental Delay is associated with lower levels of support need compared to Intellectual Disability). Refer to Figure 37, below.

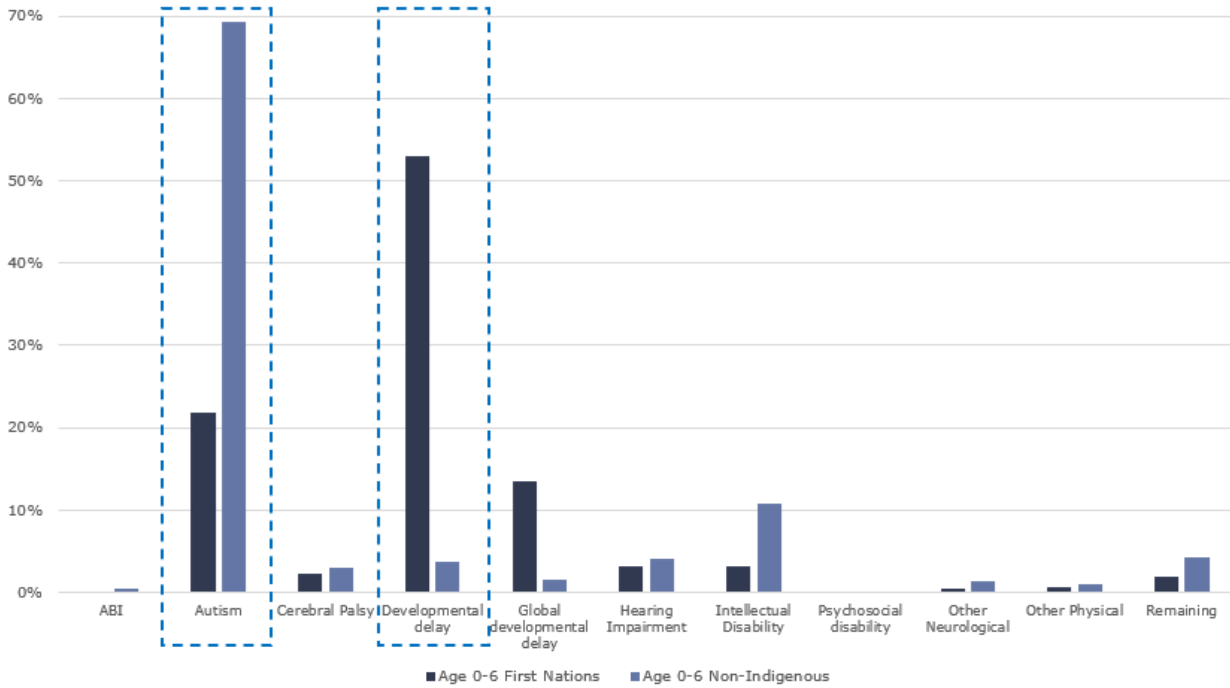


Figure 36. Proportion of participants in the NDIS, split by age group (0-6 years), disability type and First Nations status (NDIS, 2021)

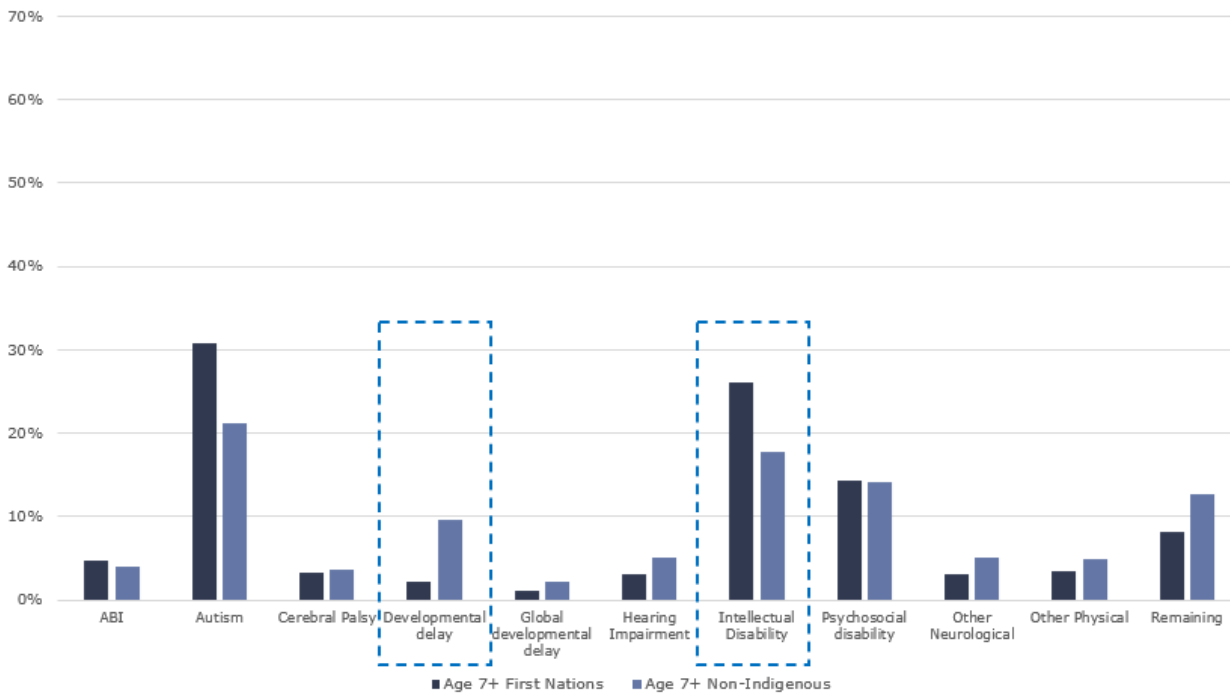


Figure 37. Proportion of participants in the NDIS in 2021, split by age group (7+ years), disability type and First Nations status (NDIS, 2021)

By region, we observed that First Nations NDIS participants receive higher average payments in remote communities and regional centres compared to non-Indigenous participants, as seen below. High payments in remote communities are attributed to a higher share of those disability types which are associated with a need for higher levels of support.

It should be noted that under the NDIS Pricing Arrangements and Price Limits services delivered in remote and very remote areas are subject to higher price limits than those delivered in metropolitan or regional areas. As a result, some of the increase in payments in remote areas reflects price effects, rather than increased levels of service provision.

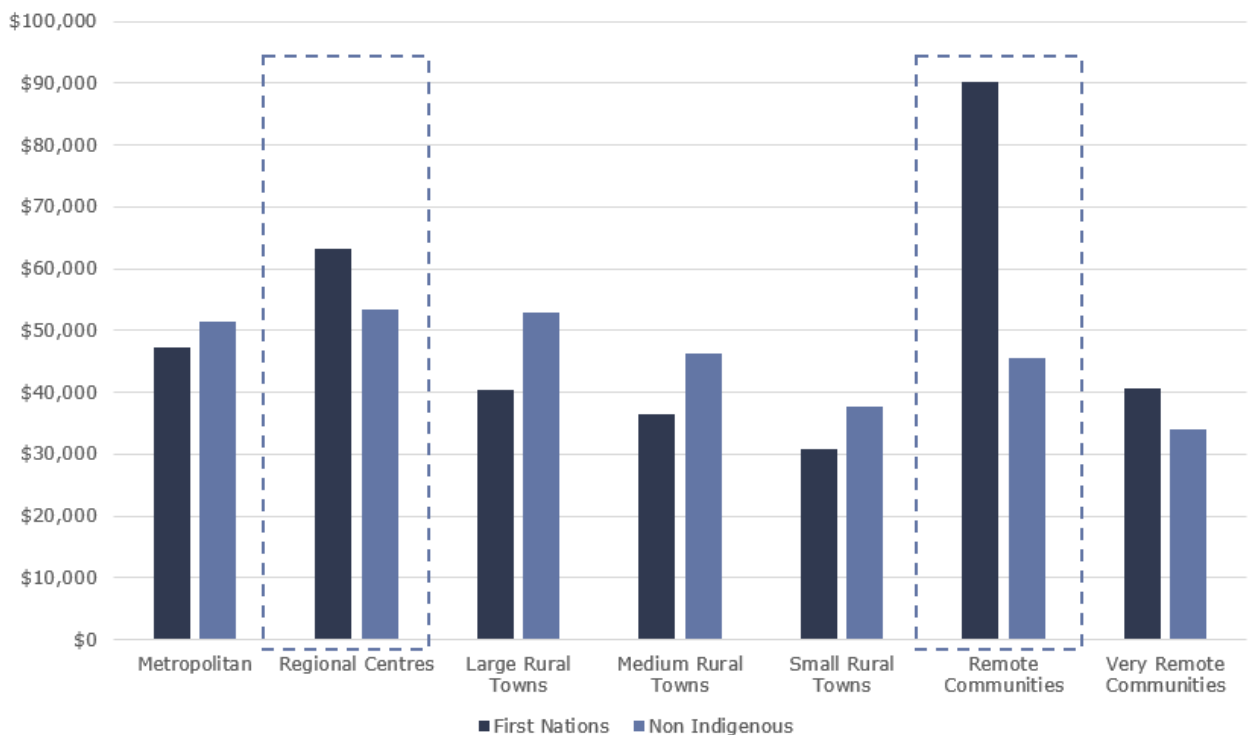


Figure 38. Average payment per participant in the NDIS in 2021, split by remoteness region and First Nations status (NDIS, 2021)

As seen in Figure 38 in New South Wales, Victoria, Queensland, Tasmania and ACT, the average payments for First Nations participants are lower than those of non-Indigenous participants. In South Australia and Western Australia, First Nations participants received higher payments on average, while in the Northern Territory First Nations participants receive payments on average 65% more than non-Indigenous participants, noting that NT represents less than 1% of the NDIS.

The higher average payments for First Nations participants in the Northern Territory can be explained by the following (as seen in previous graphs and Figure 39):

- First Nations participants represent around half of all Northern Territory NDIS participants
- The Northern Territory has a very high proportion of participants in Remote Communities

- First Nations participants in Remote Communities receive payments significantly more compared to non-Indigenous participants.

We are unsure which of these are causal relationships (i.e., First Nations people residing in the Northern Territory cost is more due to higher degree of remoteness, or average payments received in the Northern Territory generally being higher, which raises the average payments in Remote Communities).

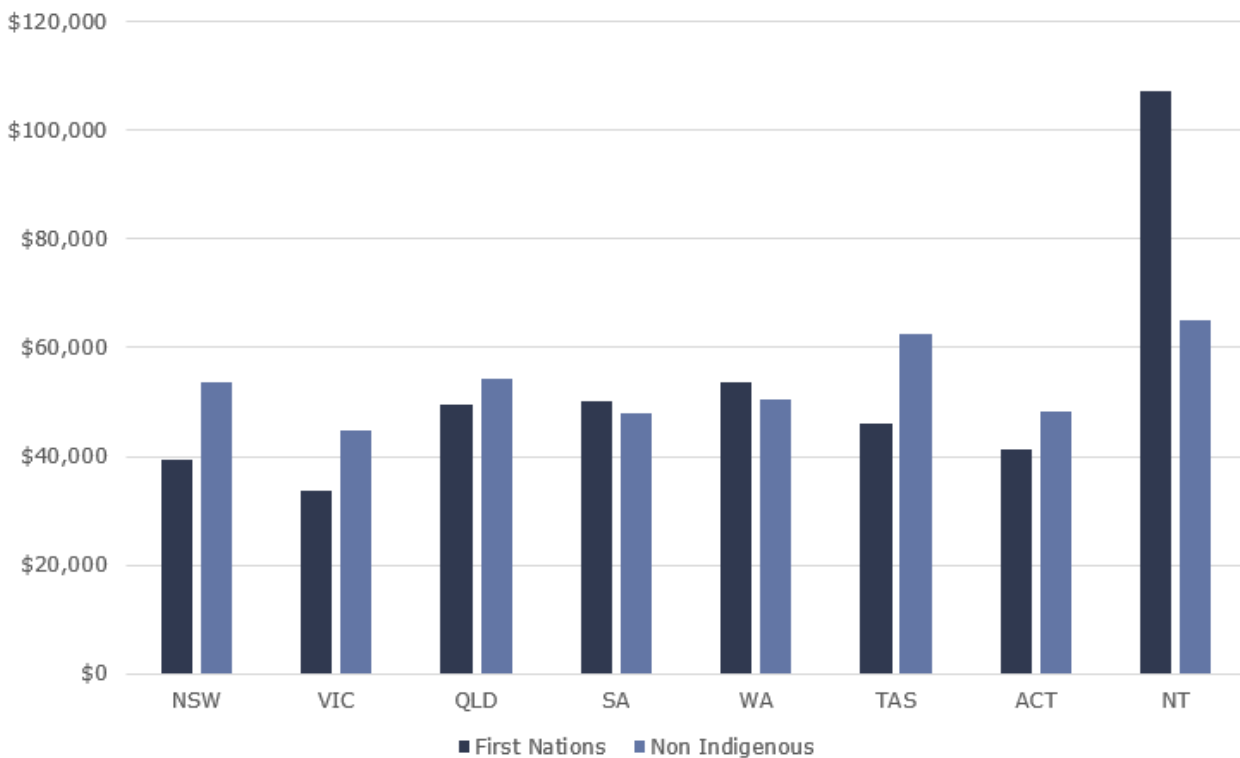


Figure 39. Average payment per participant in the NDIS in 2021, split by State and First Nations status (NDIS, 2021)

We have considered the disabilities which are most prevalent and with higher support needs (i.e., higher average payment) in the NDIS, when separately analysing the population in different locations⁴⁴ by disability, the key disabilities which fall into both categories include Intellectual Disability, Psychosocial disability, ABI, Cerebral Palsy, Other Neurological.

First Nations participants in the NDIS in remote communities and regional centres receive higher average payments compared to other regions.

The share of disabilities amongst participants in regional centres is consistent with those in metro and rural communities (see Figure 40 below). As observed for almost all disability types, the average payments in regional centres are higher than other regions. For example, the average payment for First Nations participants with Intellectual Disability in regional centres is 30% higher than for all First Nations participants with Intellectual Disability.

In remote communities, amongst First Nations NDIS participants, there is a higher share of conditions receiving higher support needs (particularly Intellectual Disability, Psychosocial Disability and ABI), as well as a lower share of Autism (which is a condition with relatively lower support needs) and is one of the reasons why those in remote regions receive higher average payments than those in less remote regions. This may be attributed to First Nations people with severe disabilities remaining in remote communities compared to non-Indigenous people who move into regional centres to access treatment.

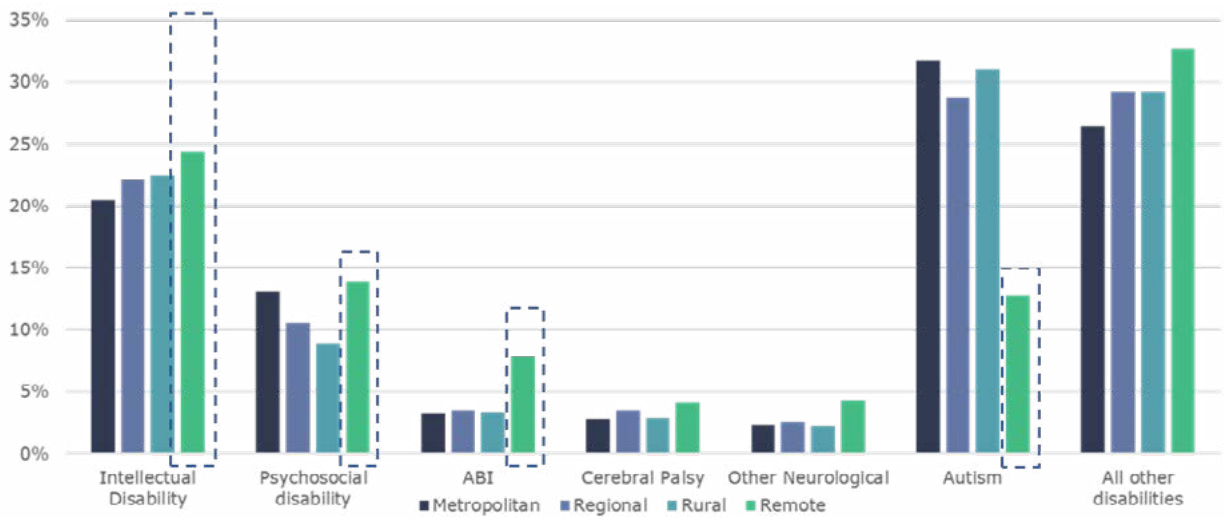


Figure 40. First Nations population in the NDIS in 2021, split key disability types and location (NDIS, 2021)

The share of people with low and medium function is similar across First Nations and non-indigenous NDIS participants but the share is highest for First Nations participants in Remote Communities. Refer to Figure 41, below.

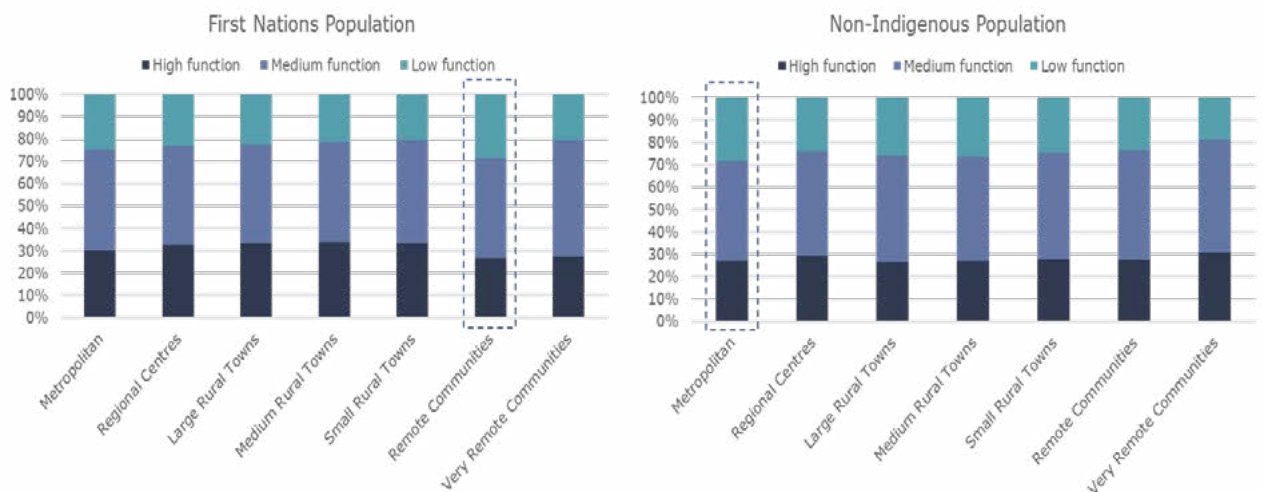


Figure 41. First Nations and non-Indigenous populations in the NDIS in 2021, split by location and severity (NDIS, 2021)

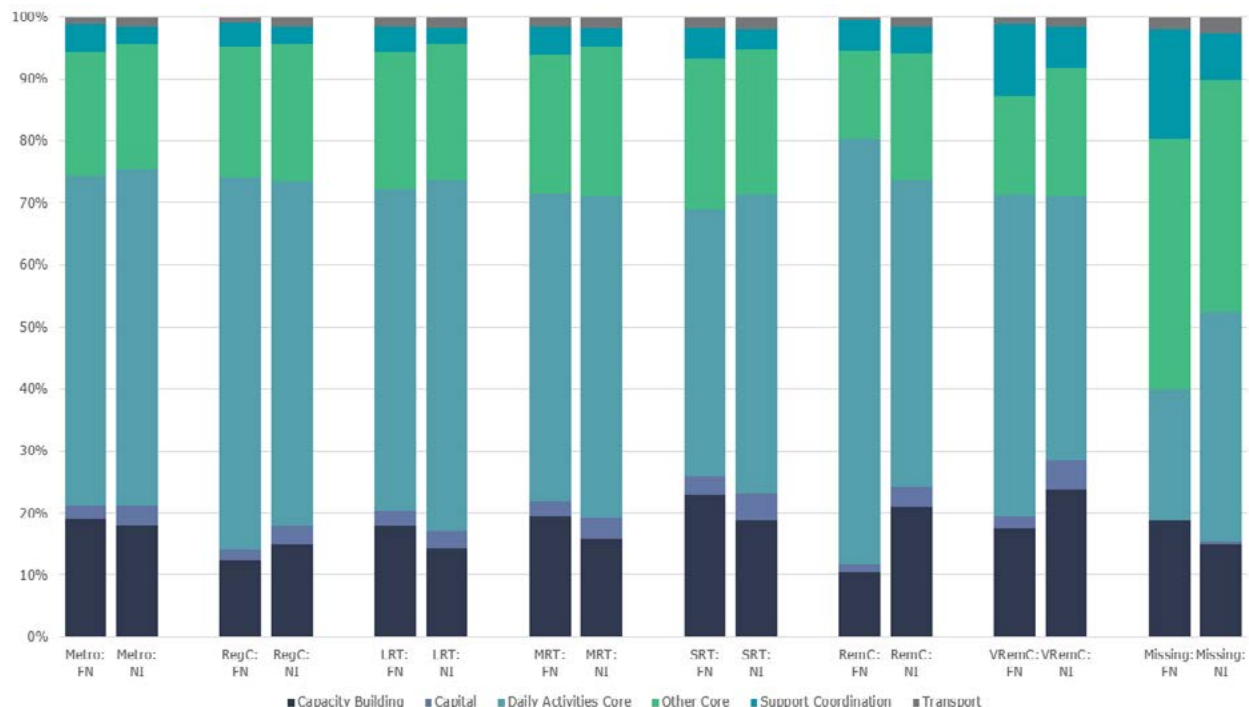
Analysis of participant payments by support type (based on disability support categories)

Figure 42, below, shows the share of payments by support classes in each region, separately for First Nations and non-indigenous NDIS participants. In general, and across all regions, Daily Activities Core accounts for the largest proportion of funding, with the effect being especially true for Regional Centres and Remote Communities. This is followed by Other Core which represent 20% to 24% of claims as remoteness increases from Metropolitan to Small Rural Towns, before decreasing back to 20% in Remote and Very Remote communities.

Transport is a small portion of payments, representing 1.6% of funding for those in Metropolitan regions, 2.1% in Small Rural Towns and 1.4% in Remote and Very Remote Communities.

Comparing First Nations and non-Indigenous participants, the share of payments received by First Nations people in Remote and very Remote Communities is higher for services described as Daily Activities Core and lower for services such as Capacity Building and Other Core.

Capacity Building for First Nations people are higher in Small, Medium and Large Rural Towns while in Remote and Very Remote the share is noticeably lower than for non-indigenous participants.



Note abbreviations for above: NI = Non-Indigenous, FN = First Nations, Metro = Metropolitan, Reg = Regional Centre, LRT = Large Rural Town, MRT = Medium Rural Town, SRT = Small Rural Town, RemC = Remote Community, VRemC = Very Remote Community.

Figure 42. Share of payments split by First Nations and non-Indigenous participant by Support Class and split by Remoteness level in 2021 (NDIS, 2021)

Daily Activities Core is the largest payments support class and has remained constant at 54% of all payments across time (see Figure 43, below). Further, the share of Daily Activities Core payments has consistently been higher for First Nations participants across all years, which is reflective of the comparatively greater proportions of First Nations people living in Regional Centres and Remote Communities.

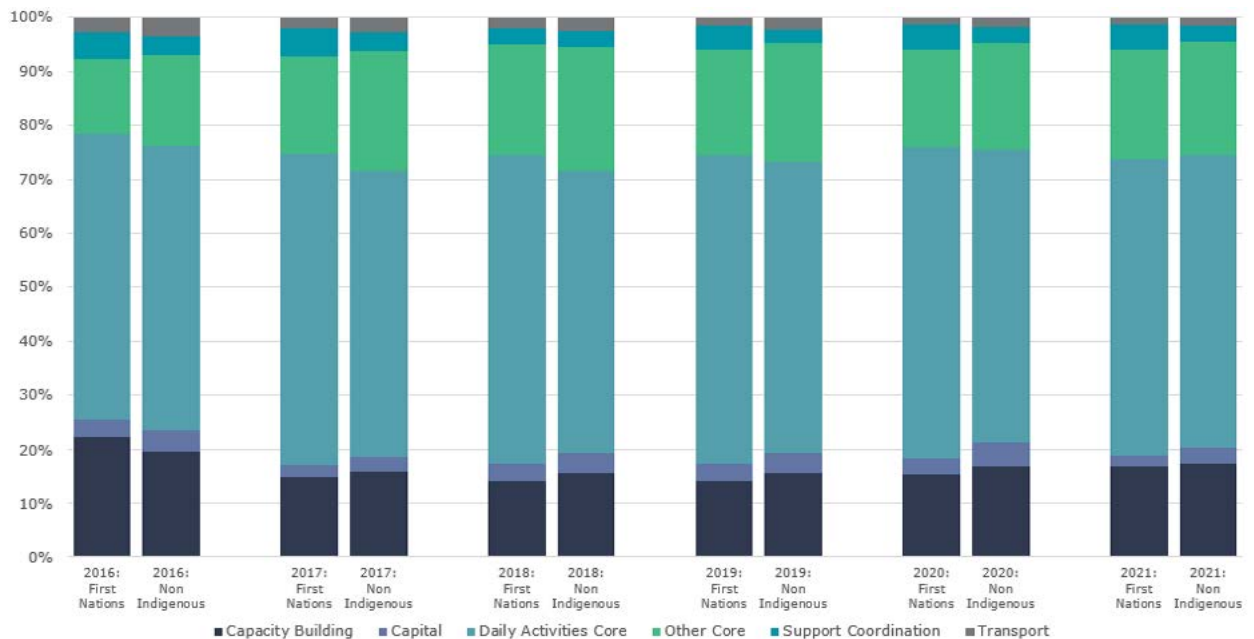


Figure 43. Share of payments by Support Class split by First Nations and non-Indigenous participant and Year (NDIS)

For both First Nations and non-Indigenous participants, the share of Transport and Support Coordination payments has decreased over the years (Figure 44, below). Transport accounted for 3.3% of payments received in 2016, but accounts for just 1.6% in 2021. Similarly, Support Coordination accounted for over 3.6% of payments in 2016, but accounts for 3.0% in 2021. The share of Support Coordination payments was at its lowest in 2019 and has since been increasing slightly from 2020 (although still lower than 2016 and 2017 levels).

For Transport, the share of payments for First Nations is consistently lower by around 0.5% compared to non-Indigenous participants. This has been true for all years the NDIS has been active. This data may suggest a lower willingness to travel for access to services when compared to non-Indigenous counterparts.

In contrast, the share of payments for Support Coordination for First Nations participants is greater than non-Indigenous participants, with the gap⁴⁵ ranging from 1.5% to 1.9% across the years.

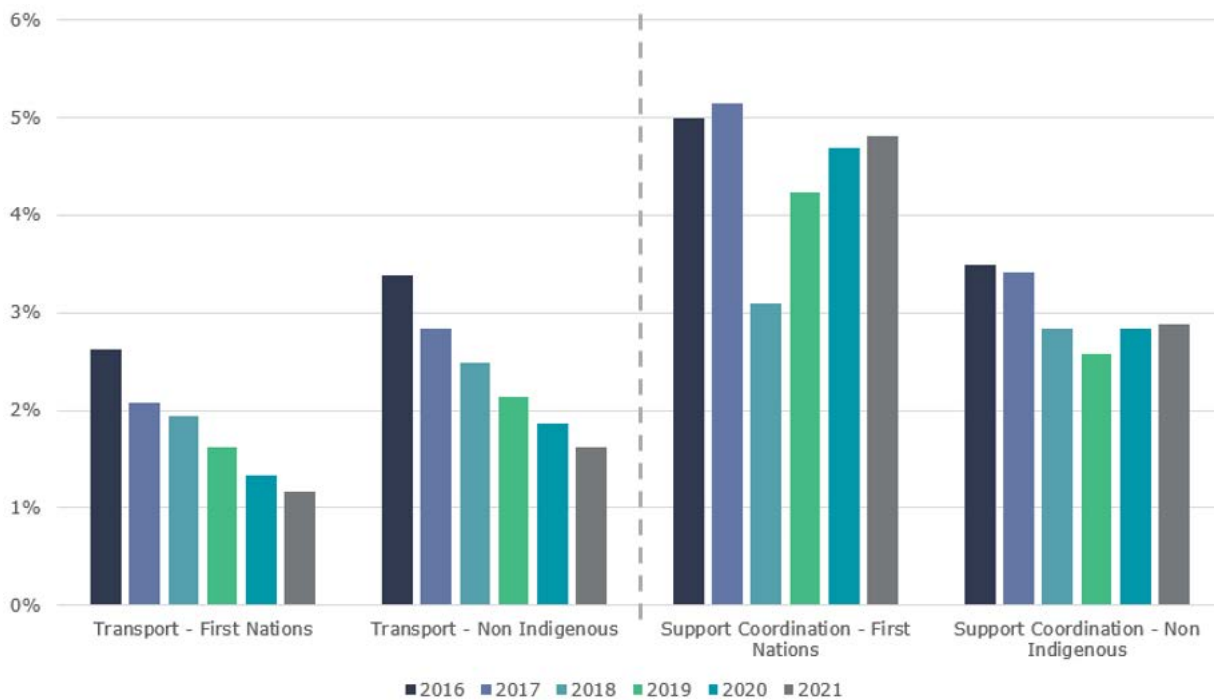


Figure 44. First Nations and non-Indigenous Transport and Support Coordination claims as a proportion of all claims across the years (NDIS)

Comparison of actual payments to committed supports

We compare the total payments to date for each financial year to the total committed support budget figure for each financial year. This is a proxy measure for utilisation noting however, that the figures that follow differ from those reported in the 2021-2022 Annual Financial Sustainability Report compiled by the NDIA (both shown in Table 3 Comparison of Committed Support budgets with Payments to date (NDIS) and Table 4, below).

Table 3. Comparison of Committed Support budgets with Payments to date (NDIS)

Comparison	FY16/17	FY17/18	FY18/19	FY19/20	FY20/21	Jun-Dec 2021
Budget	\$2,289,992,847	\$7,219,921,992	\$13,974,820,052	\$23,561,961,557	\$31,489,948,055	\$34,970,061,791
Payments to date	\$1,232,888,839	\$3,988,140,385	\$8,388,885,545	\$15,437,119,696	\$21,042,688,869	\$12,540,461,706
Proxy Utilisation metric	53.8%	55.2%	60.0%	65.5%	66.8%	35.9%

Table 4. Comparison of Budgets with Payments to date (NDIS, AFSR 2021-2022)

Comparison	FY17/18 and prior	FY18/19	FY19/20	FY20/21	FY21/22
Budget	\$12,591,000,000	\$14,577,000,000	\$24,433,000,000	\$32,345,000,000	\$36,030,000,000
Payments to date	\$8,790,000,000	\$10,378,000,000	\$17,313,000,000	\$23,523,000,000	\$28,206,000,000
Utilisation	69.8%	71.2%	70.9%	72.7%	78.3%

The payments to date figures reflected in the data sets are approximately 3% lower than the information shown in the AFSR. This is due to our methodology making no adjustments to the payment data for known differences including the annualisation of claims. When accounting for the effect of annualisation based on an impact analysis, the resulting ratio of paid to budgeted amounts (or proxy utilisation metric) shown in this report becomes between 0.5% and 3% lower than the utilisation values shown in the AFSR, depending on the financial year.

Differences include granularity in the availability of data (where we have quartered data and have no visibility on information such as decommissioned plans), application of the specific rules applied in the NDIS calculated utilisation figures such as annualisation of payments and the pro rata allocation of committed support costs by proportion of the plan falling within each financial year. We note however, that differences in committed support budget and payments data for FY17/18 and prior, seen in the AFSR and in data used in this report, are large and cannot be accounted for by the items identified above.

Figure 45 Comparison of actual payments to committed supports, split by First Nations Status (NDIS), below depicts the comparison for all participants at each financial year, split by their First Nation status.

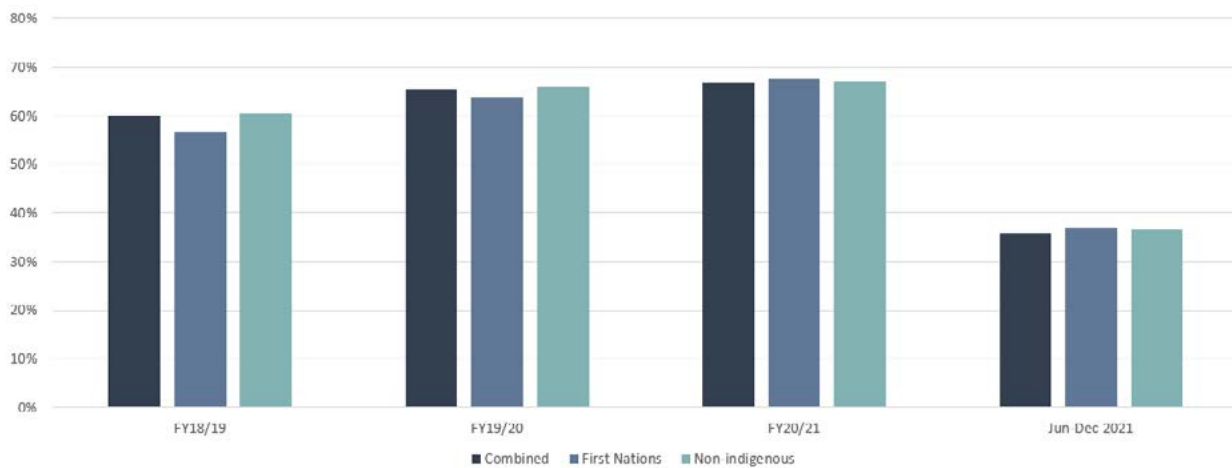


Figure 45. Comparison of actual payments to committed supports, split by First Nations Status (NDIS)

Participants with a First Nation background had a slightly lower ratio of actual payments to committed supports across all financial years, apart from FY20/21. In general, all participants saw increases in the ratio of actual payments to committed supports over time.

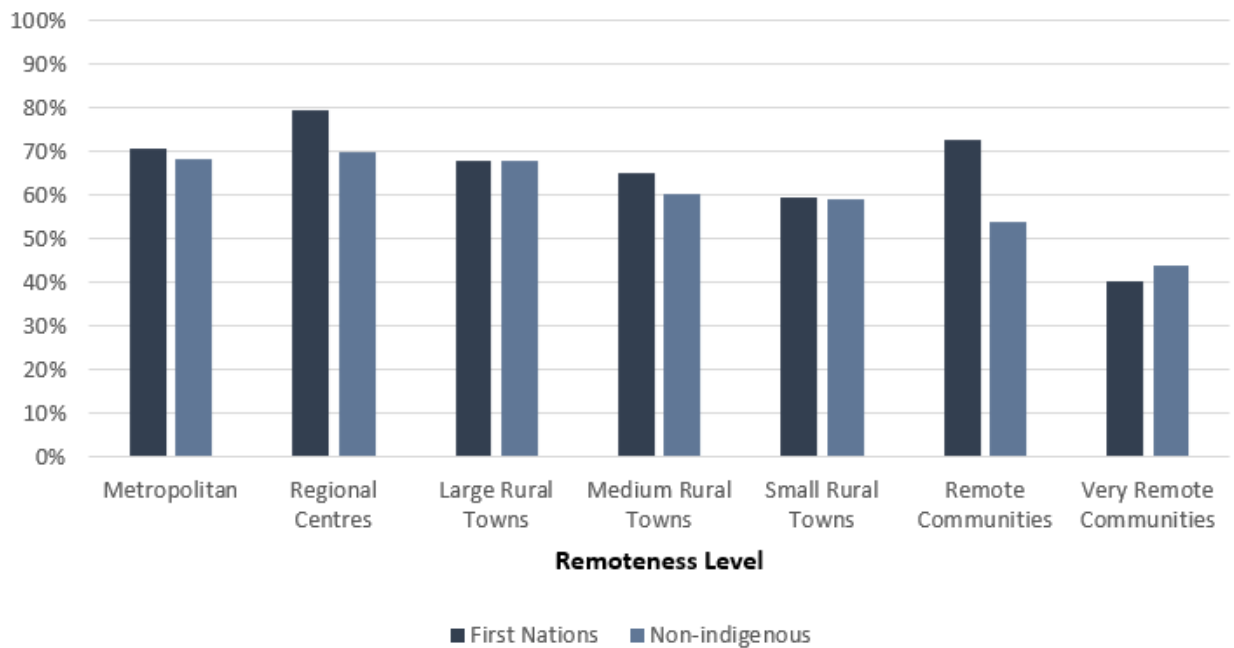


Figure 46. Comparison of actual payments to committed supports, Split by First Nations Status and Remoteness, FY20/21 (NDIS, 2021)

Regardless of First Nation Status, the ratio of actual payments to committed support is highest in Regional Centres and in general decreases by remoteness. See Figure 46, above. Notably, participants with a First Nations background have higher ratios ratio of actual payments to committed support compared to Non-First Nation participants across all financial years in Very Remote Communities.

Analysis of payments for services per participant in DES

DES offers a range of supports to participants for a limited period (e.g., the DES program caters for participation over a period of two years) and DES providers are remunerated through a combination of ongoing service fees and outcomes fees linked to milestones achieved by DES participants. Figure 47, below, we show results for all service fee types. We have no evidence of significant variation in the service fees which may moderate any potential variation in outcome payments (should variation exist). We have not considered outcome payments or outcomes separately as analysis of outcomes of the DES program or the NDIS are beyond the scope of this report, this may warrant further investigation to understand whether any specific trends for First Nations people with disability are masked by service fees in this overall view.

First Nations and non-Indigenous participants in DES have very similar average annual payments post the 2018 reforms⁴⁶. In the latest two years of data, there appears to be no material difference in average payments between First Nations and Non-Indigenous participants, as seen below in Figure 47.

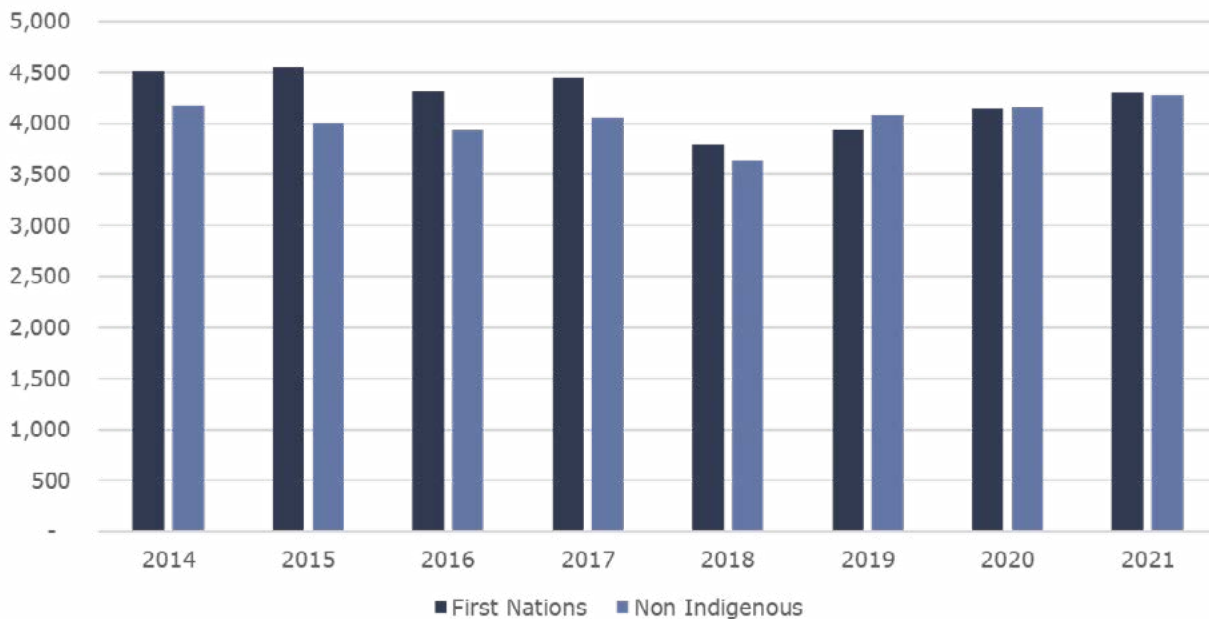


Figure 47. Average payment per participant in DES per calendar year, split by First Nations status (DES)

The difference in average payment between First Nations and non-Indigenous participants are negligible for the two most common disabilities on DES (psychiatric and physical). In comparing other demographic splits of cost, such as remoteness region and First Nations status, we have also observed relative consistency for average payment for DES participants (see Figure 48, below). We can conclude that funding is somewhat standardised across DES participants and does not demonstrate much consideration for First Nations status, disability type, or region.

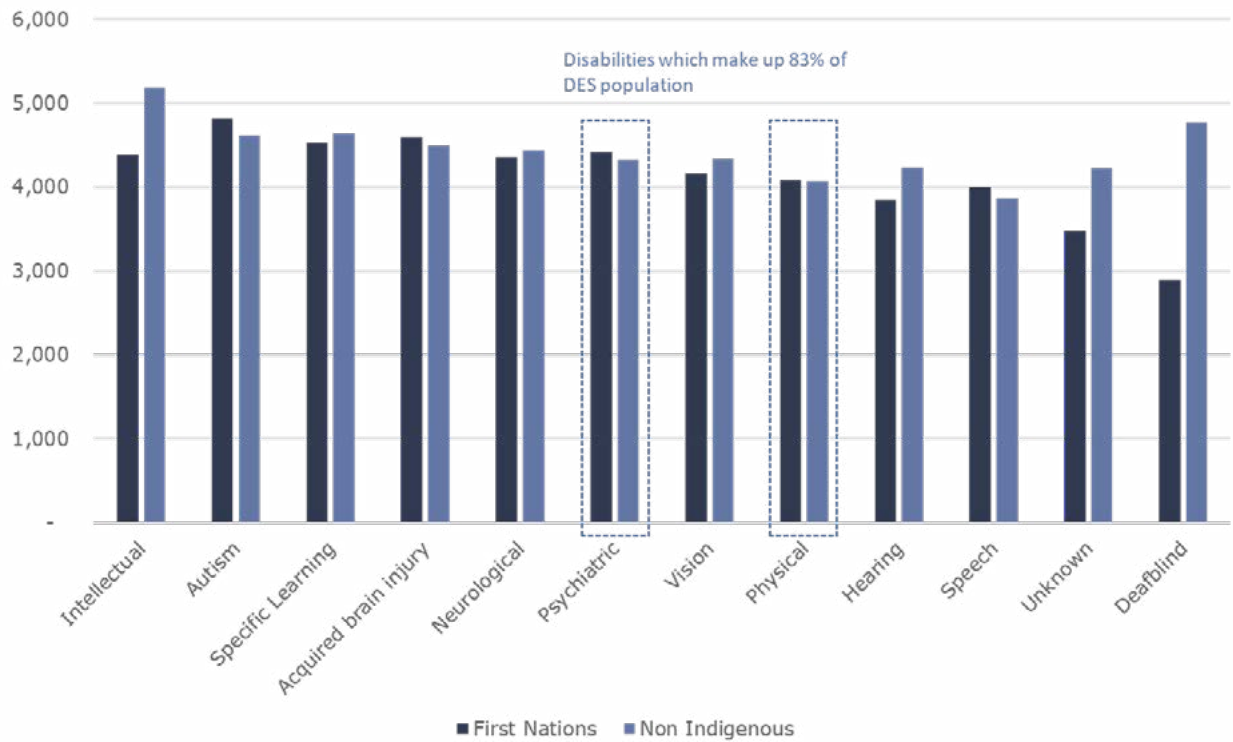


Figure 48. Average cost per participant in DES in 2021, split by disability type and First Nations status (DES, 2021)

Similarly, to the overall DES population, Figure 50 and Figure 50, below show that average payments between First Nations and Non-Indigenous participants are similar for both DMS and ESS. Since 2014, average payments for First Nations DMS participants have been less than 2% lower than Non-Indigenous DMS participants.

First Nations ESS participants on average received higher payments than Non-Indigenous ESS participants prior to the 2018 DES Reforms. After the reforms apart from 2018, we see similar trends to DMS participants, where First Nations participants receive slightly less on average. The greater average for First Nations ESS participants in 2018 is likely a reflection of continuing plans and services from prior to the reforms.

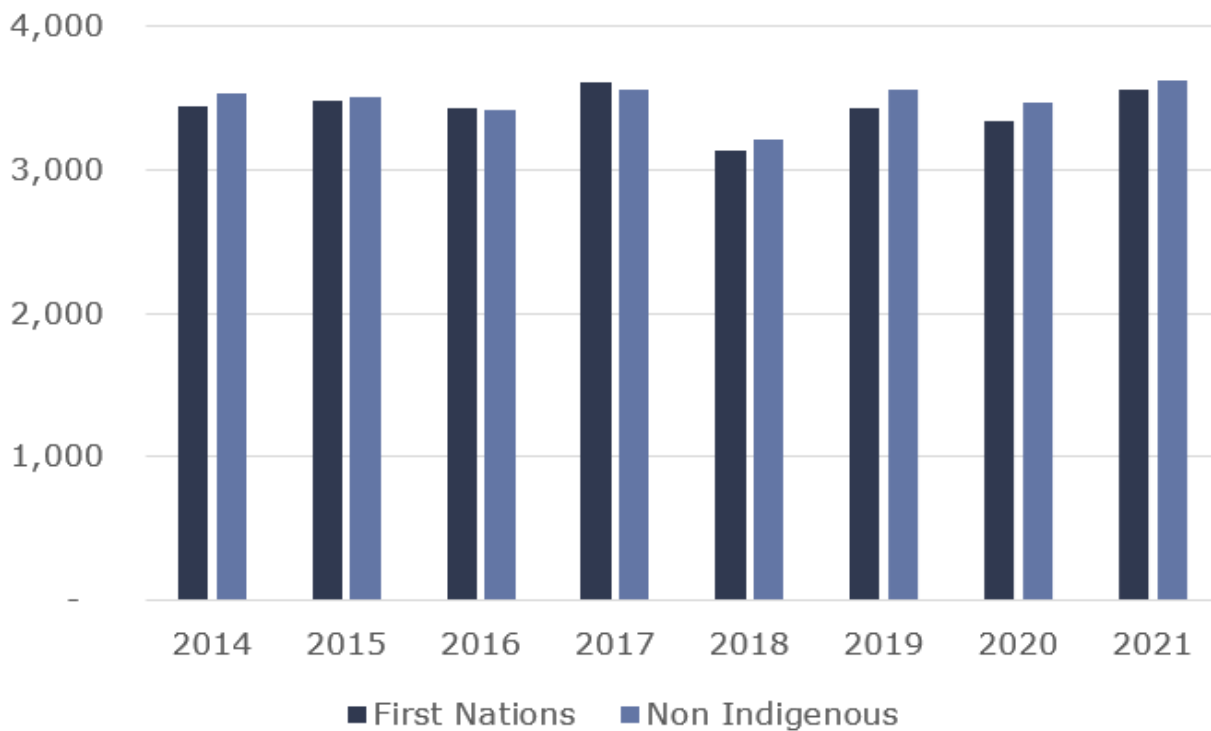


Figure 49. Average payment per participant for DMS in DES per calendar year, split by First Nations status (DES)

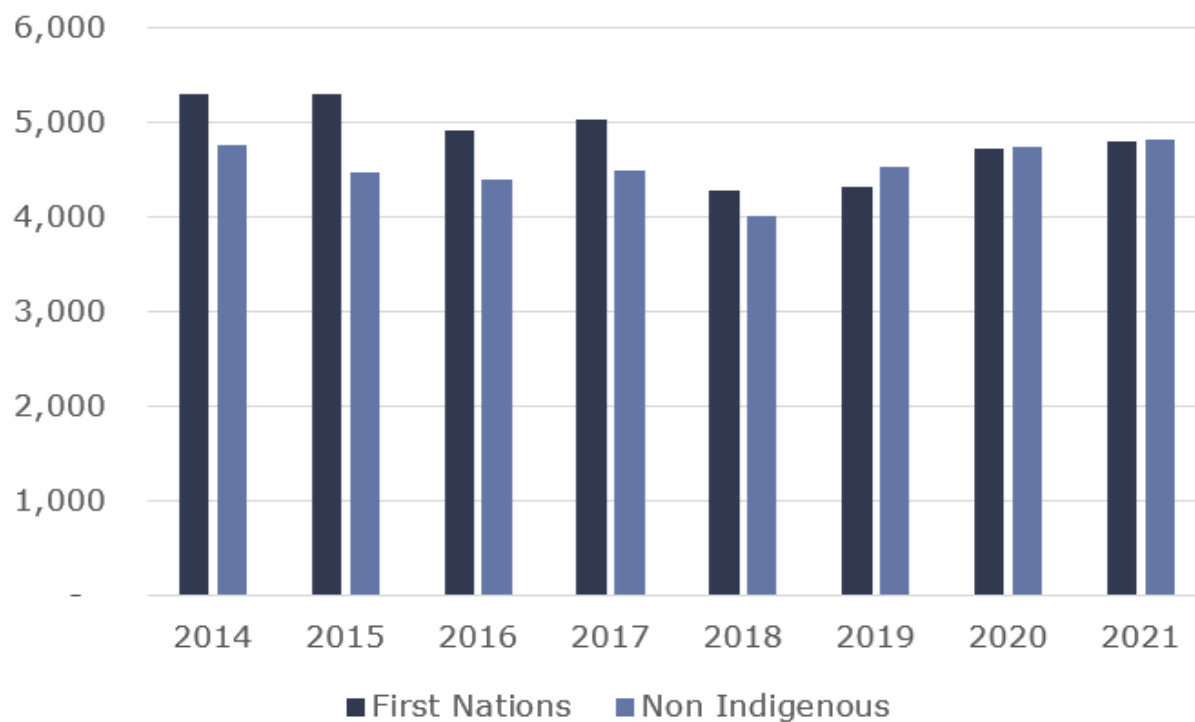


Figure 50. Average payment per participant for ESS in DES per calendar year, split by First Nations status (DES)

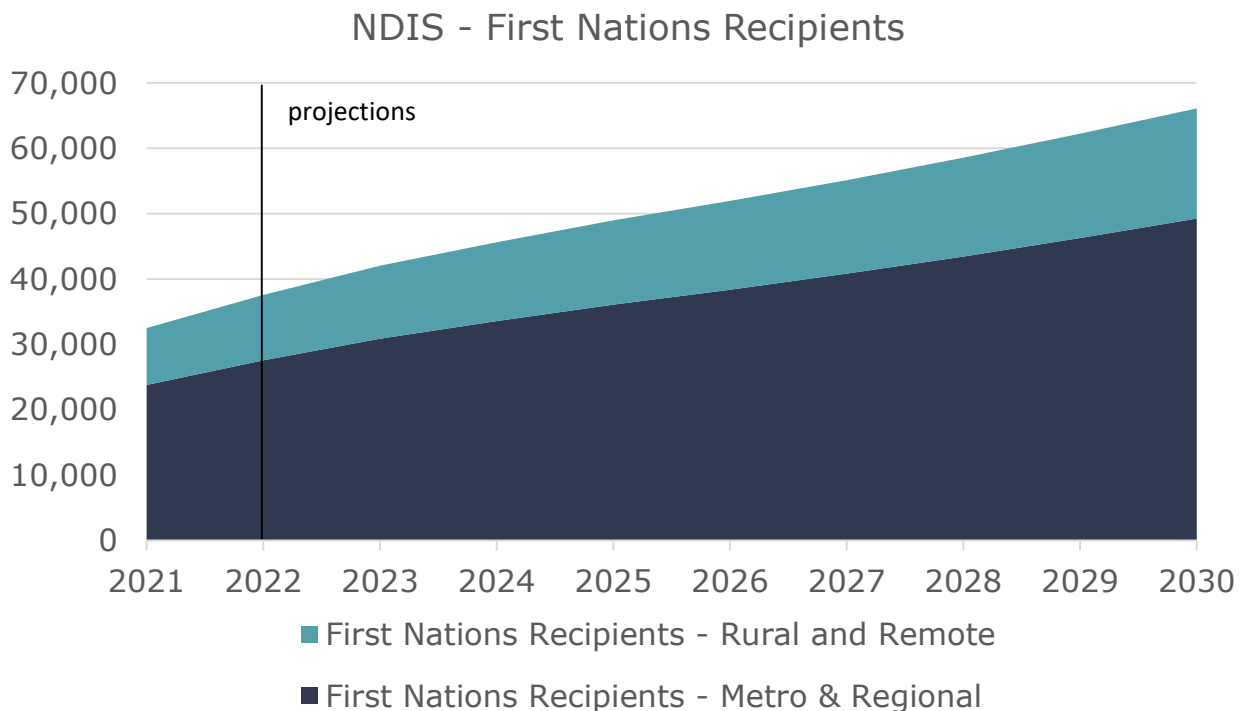
Future

What does this mean for the future?

Recommendations have been designed to improve the performance of the disability services sector in supporting the needs of and, generating better outcomes for, First Nations people with disability. The recommendations will improve the sector through workforce capability uplifts, secure and increased funding into the sector, providing First Nations people with disability a 'seat at the table' to design supports and implementing accountability, governance, quality, and assurance mechanisms to guide sector development.

Disability support will be among the fastest growing sectors of the Australian economy over the next decade. This is irrefutable for both First Nations people and non-Indigenous people with disability as the NDIS continues to grow and importance; the number of participants is growing rapidly. The scheme is expected to include a larger share of the population over the next decade. The NDIA projects that the scheme will grow from 2.1% of Australians aged 0-64 to 3.5% by 2030.⁴⁷

Based on current access to the NDIS and growth in total recipients projected by the NDIA we expect 32,000 additional First Nations people with disability to be receiving support through the NDIS by 2031 (Figure 51). This would see First Nations people grow from 6.9% of NDIS participants today to 7.7% in 2031.⁴⁸



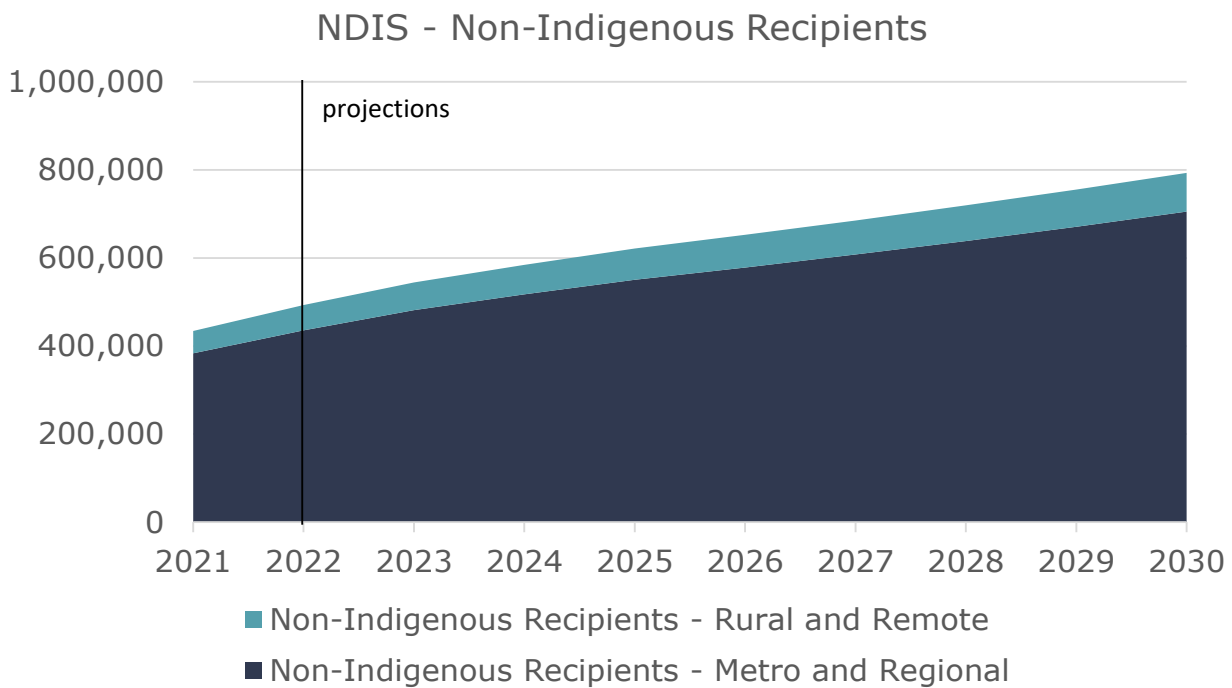


Figure 51. Projected NDIS participants by First Nations status and location (Deloitte, 2022)

There may also be greater access provided over time. Recent years have seen access to the scheme better matching the lived experience of First Nations people and there remains a need to close the gap in disability service provision in the future.

Costs too will be rising, as trends continue to alter both the mix of services and the cost of delivering those services over time.



Costs per recipient are expected to continue to climb over time due to:

1. Inflation in costs in the disability sector
2. Higher wages for disability care workers
3. Higher levels of care need on average within the NDIS
4. Higher levels of care provision over time consistent with the experience of the scheme to date.

In recent years average costs per participant have been rising rapidly, experiencing average growth of 17.8% per annum between 2017-18 and 2020-21. That trend has been stronger still for First Nations participants, for whom average costs grew at 20.4%.

3.3 Current and future supply of services

Overview

NDIS Providers

For the following analysis, a First Nations focused provider is defined as having received at least 21% of their NDIS payments from claims related to First Nations participants. Analysis of the share of payments received by provider and considering First Nations participants comprise 7% of the NDIS population, a cut-off that is three times this representation has been selected to define these providers.⁴⁹

Under this definition approximately 7% of all providers are classified as First Nations focused providers.

Changing landscape

The provider landscape has changed over recent years with provider consolidation reducing the total number of providers in the market. This is particularly evident in metro communities and more remote communities, where there has been historically fewer number of providers across the participant base, and it is continuing to decline.

First Nations-focused providers typically have a higher needs population based on key demographic and needs characteristics of their population. However, in the current state, First Nations-focused providers receive lower average payments for the participants they service as these services are supplemented by other providers.

From the analyses that follow, there is no evidence of a differentiated offering between First Nations focused and other providers, illustrated by a similar service mix. Additionally, First Nations providers appear to offer similar services to both their First Nations and non-Indigenous participants. This suggests there may be an opportunity to further tailor service offerings to the unique needs of First Nations participants.

Provider supply over time

Overall, the total number of providers servicing the NDIS fell by approximately 5% per annum over the period December 2019 to December 2021, as seen in Figure 52, Figure 53, Figure 54, Figure 55, below.

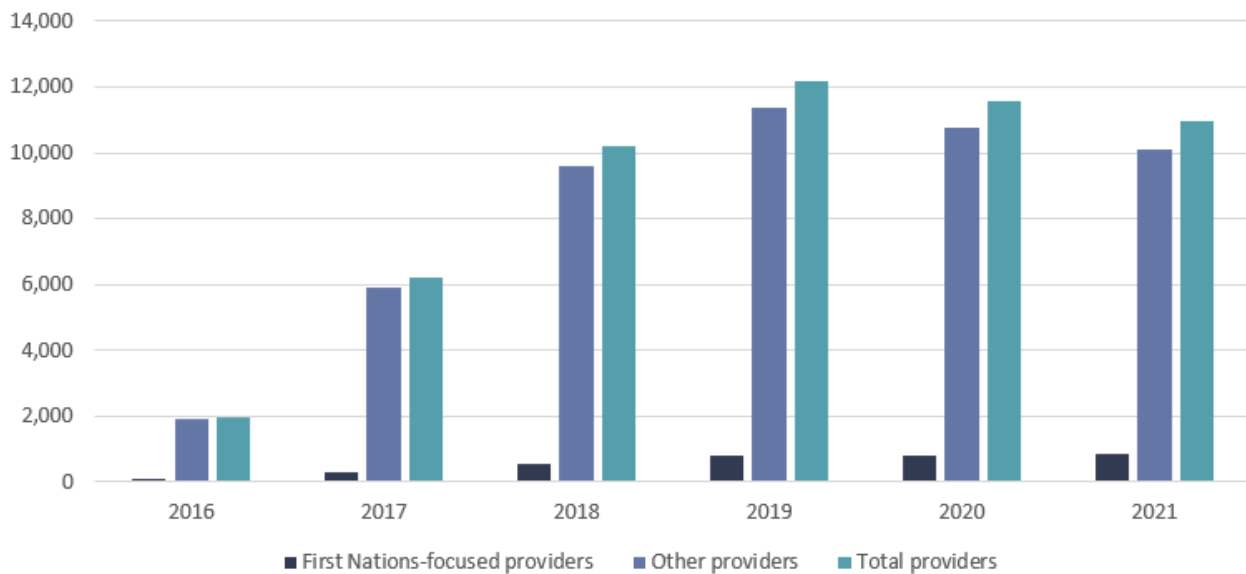


Figure 52. Number of providers servicing the NDIS over time (NDIS, 2016-2021)

As the following charts illustrate, there is a decline in the number of providers per participant they service over 2019 to 2021 across all provider types and locations. This is in line with the trend of rapid provider consolidation occurring in the NDIS.

Provider concentration has been greatest in major cities. It is also evident in more remote communities where First Nations-focused providers are larger in relative terms. There are also a significant number of other providers supporting participants in these remote communities as illustrated below.

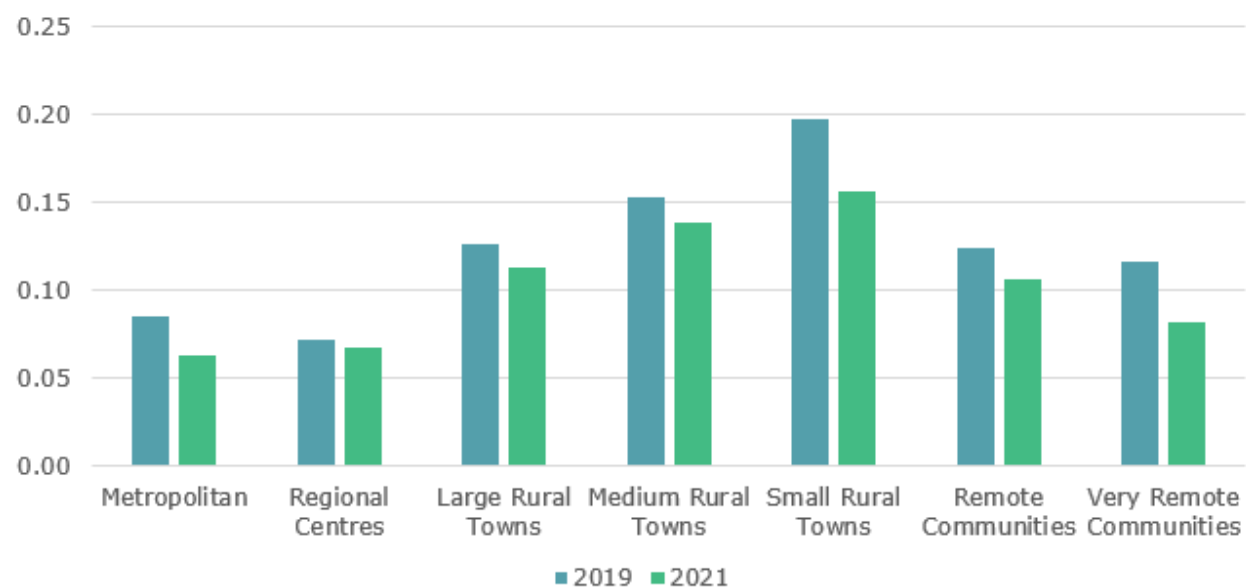


Figure 53. Number of First Nations-focused providers per participant they serviced in 2019 and 2021, by location (NDIS, 2021)

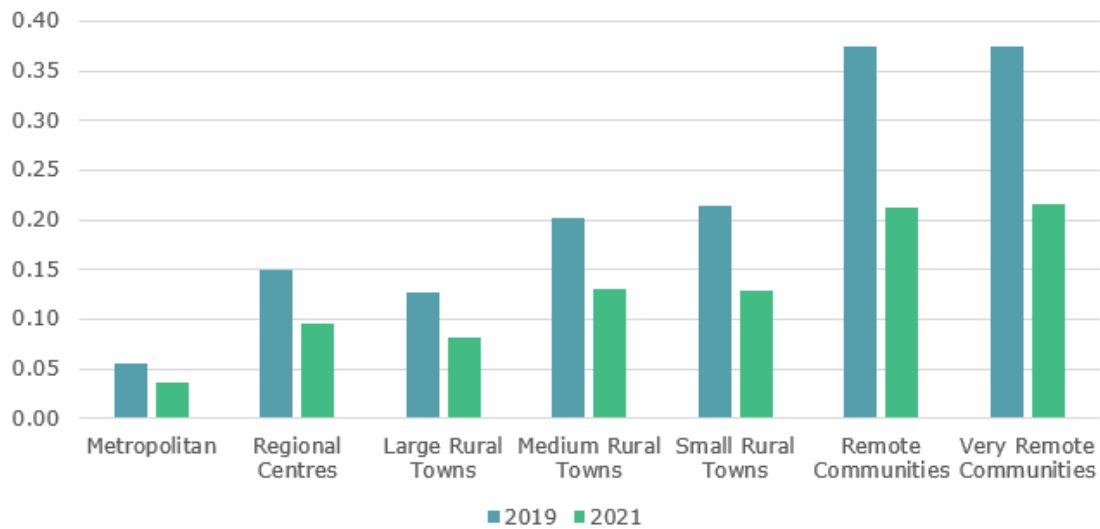


Figure 54. Number of Other providers per participant they serviced in 2019 and 2021, by location (NDIS, 2021)

Figure 55, below shows the proportion of payments (excluding those classified as “Paid to participant”) that is attributable to First Nations participants separately for First Nations-focused providers and other providers in 2021. On average, 6% of all payments through other providers were in respect of First Nations participants. This compares to 46% of payments through First Nations-focused providers that were in respect of First Nations participants. We note that these proportions are likely to change, based on our definitions of a First Nations-focused provider (see Appendix D for details on provider definition).

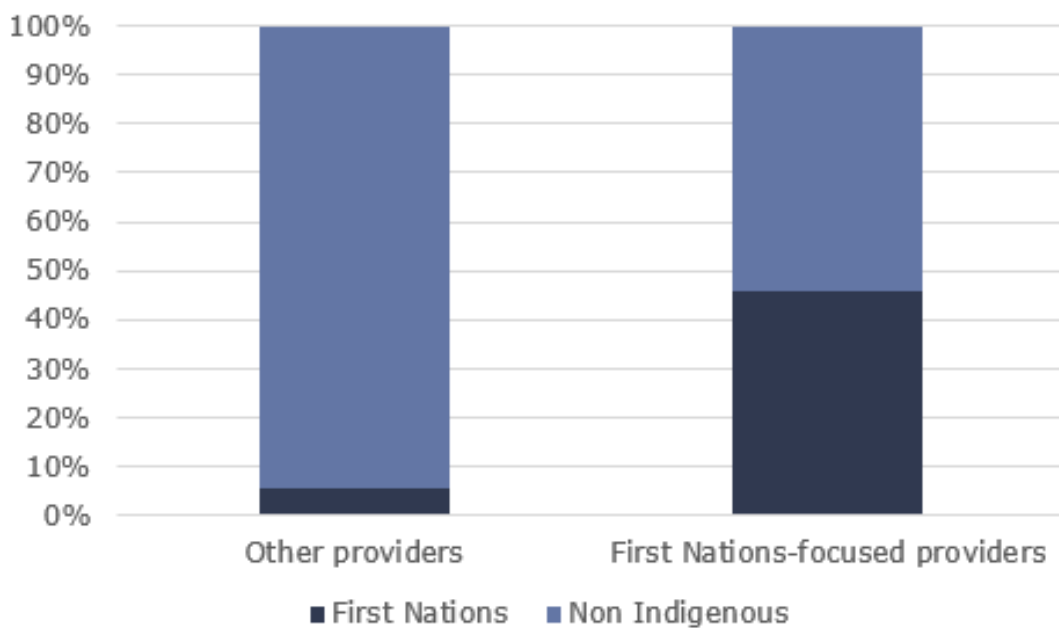


Figure 55. Proportion of funding between First Nations participants and non-Indigenous participants across provider type (NDIS, 2021)

Support categories offered by providers

We have analysed the service categories offered by First Nations-focused providers and other providers to attempt to identify differences in support offerings. This has been done by analysing payments by service category.

Provider services have been analysed by grouping granular NDIS support categories into the following broad categorisations: Other Core, Daily Activities Core, Capacity Building, Support Coordination, Transport and Capital.⁵⁰ Figure 56, below shows that between First Nations-focused and other providers, the mix of services differ slightly. First Nations-focused providers deliver a higher share related to Daily Core Activities while other providers have a higher share of funding related to Capacity Building, Capital, and Other Core Services.

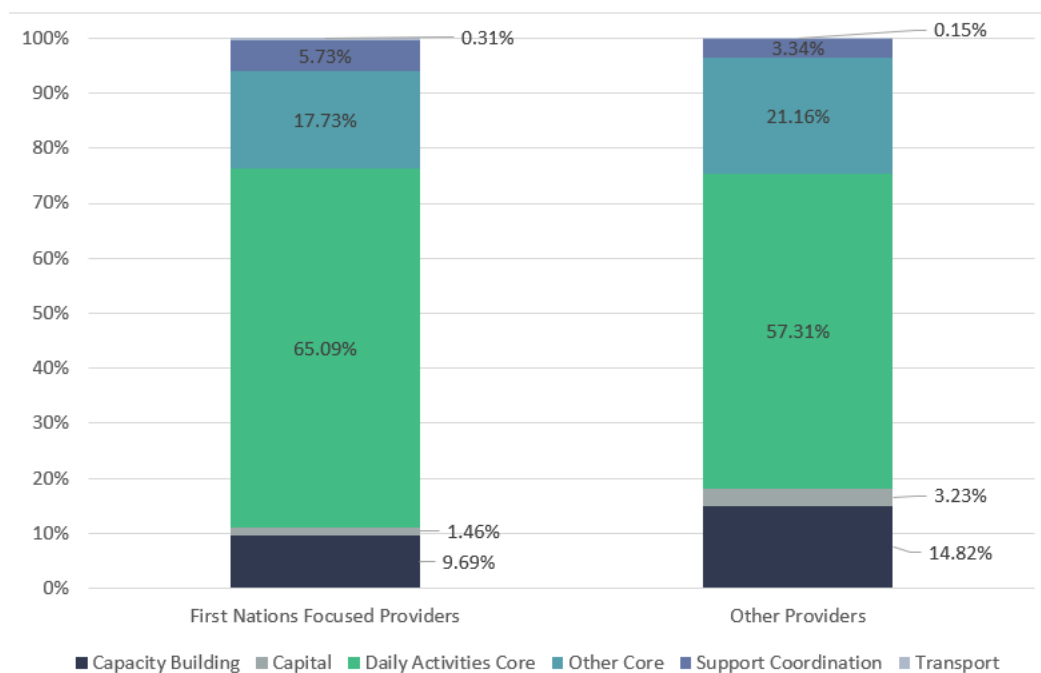


Figure 56. Distribution of payments by service categories and provider type (NDIS, 2021)

When looking within each provider type (Table 5, below), there is no clear difference in the services received between First Nations people and non-Indigenous people. There is no evidence of differentiated service offering between First Nations and non-Indigenous participants by First Nations-focused providers (as defined in this report).

Table 5. Distribution of payments by service categories by First Nations status for both provider types (NDIS, 2021)

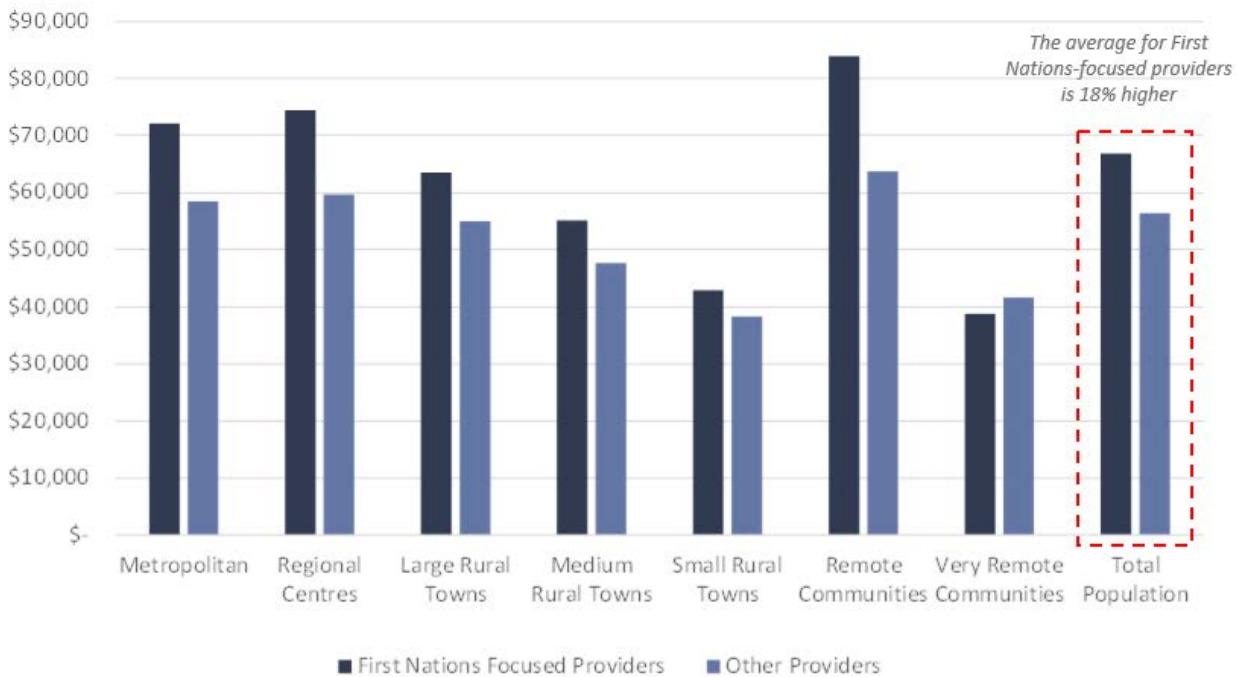
Service categories	First Nations-focused providers with First Nations participants	First Nations-focused providers with non-Indigenous participants	Other providers with First Nations participants	Other providers with non-Indigenous participants
Capacity building	8.7%	10.5%	18.1%	14.6%
Capital	1.3%	1.6%	2.4%	3.3%
Daily Activities Core	66.5%	63.9%	53.4%	57.5%
Other Core	16.5%	18.7%	21.2%	21.2%
Support Coordination	6.6%	5.0%	4.6%	3.3%
Transport	0.4%	0.3%	0.2%	0.2%

Standardised average payment per participant per provider type

This section analyses payments (excluding any claims paid directly to participants) paid to providers. This section also excludes any analyses of committed supports.

After adjusting payments to account for key demographic and needs factors of the participants that they serve, First Nations-focused providers would expect to receive 18% more per participant than other providers (see Figure 57, below). This trend of higher payments per participant for First Nations-focused providers is evident across most locations, except for very remote communities.

The characteristics used to standardise the payments are age, First Nations status, disability type, and level of function.



*The standardised average annual payment assumes that the services being offered by First Nations-focused providers and other providers are similar.

Figure 57. Standardised* average payment per participant and provider type in 2021, split by location (NDIS, 2021)

Higher expected average payments for First Nations-focused providers reflect the higher need profile of the population they service. As the following chart illustrates, there is a higher proportion of participants categorised as having a low level of function for First Nations providers compared to other providers i.e., 33% vs 30%, respectively (see Figure 58, below).

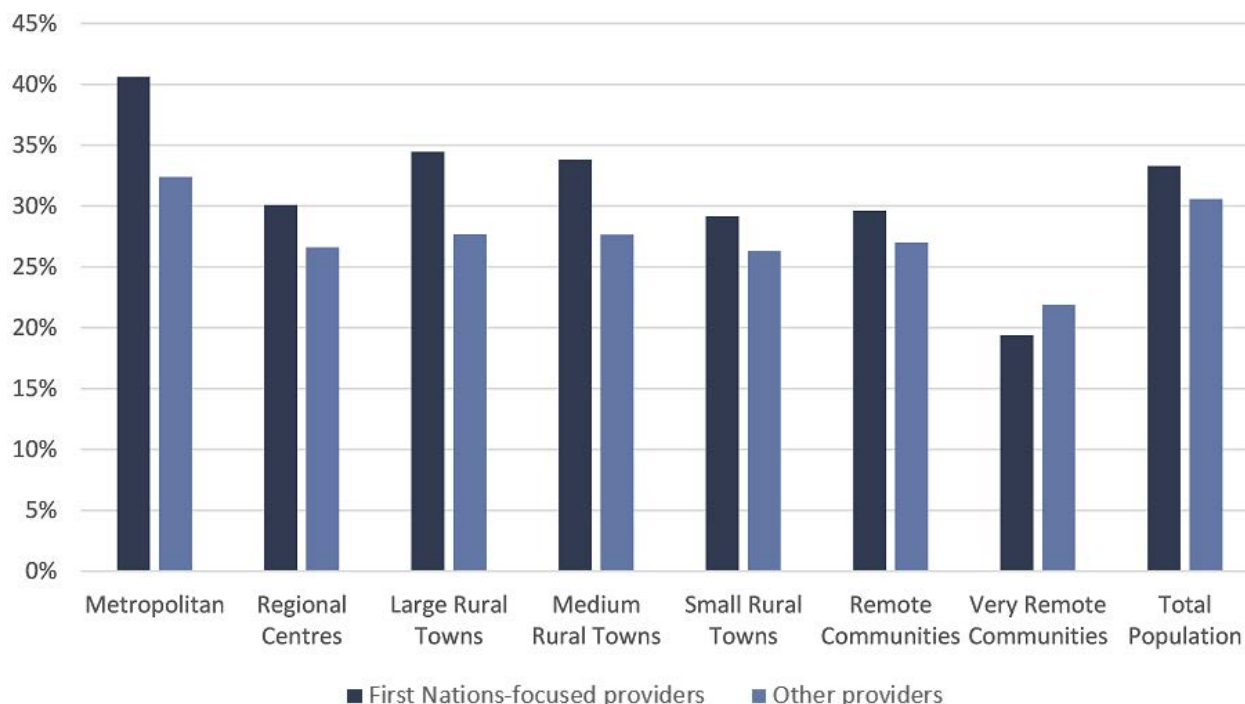


Figure 58. Share of population categorised as having a low level of function in 2021, split by provider type and location (NDIS, 2021)

Payments to First Nations-focused Providers and consideration by Primary Disability type

This section analyses the total payments (excluding payments to participants) to First Nations-focused providers and considers payments in the context of primary disability type.

- 3.6% of all NDIS provider payments (dollar amount) in 2021, went to a First Nations-focused provider.
- ABI, Stroke, Psychosocial, Other and Intellectual Disabilities are disability types where First Nations-focused providers received more than 3.6% of all payments for that disability type and may reflect the higher level of prevalence of these disabilities amongst First Nations people (see Figure 59, below). For example, nearly 6% of all ABI payments, went through a First Nations-focused provider.
- The four most common disability types in the NDIS are Autism, Intellectual Disability, Psychosocial Disability and Developmental Delay. Of the four, Autism is the only disability type that is more common in non-Indigenous participants than First Nations participants. This is reflected in the share of payments by disability of First Nations-focused Figure 59 providers. The share of Autism payments that went through First Nations-focused providers is 2.5%, lower than the 3.6% of all payments made to First Nations-focused providers.

- For Psychosocial Disabilities and Intellectual Disabilities, the share of payments that went through First Nations-focused providers reflects the higher prevalence of these disabilities among First Nations participants.
- Developmental Delay is much more common in First Nations participants but has 3.1% of payments to First Nations-focused providers, 0.5% lower than the 3.6% for all payments to First Nations-focused providers and may indicate that First Nations participants use other providers when receiving services related to Developmental Delay.

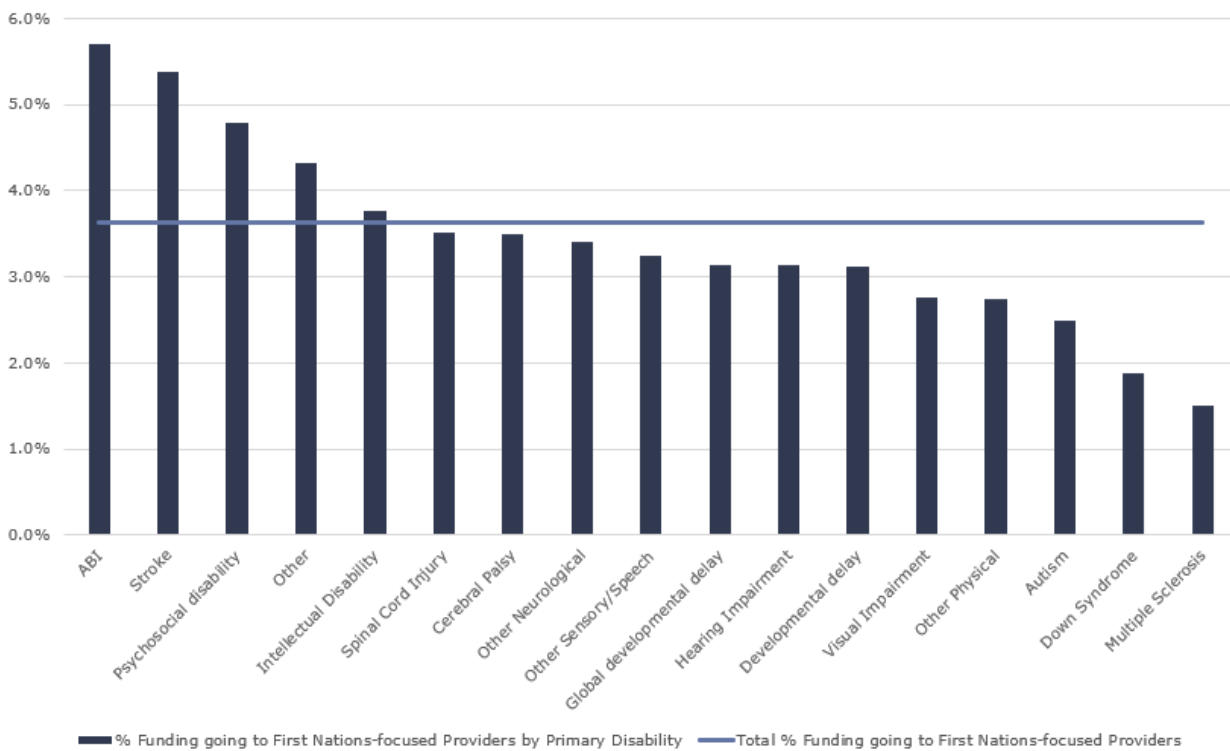
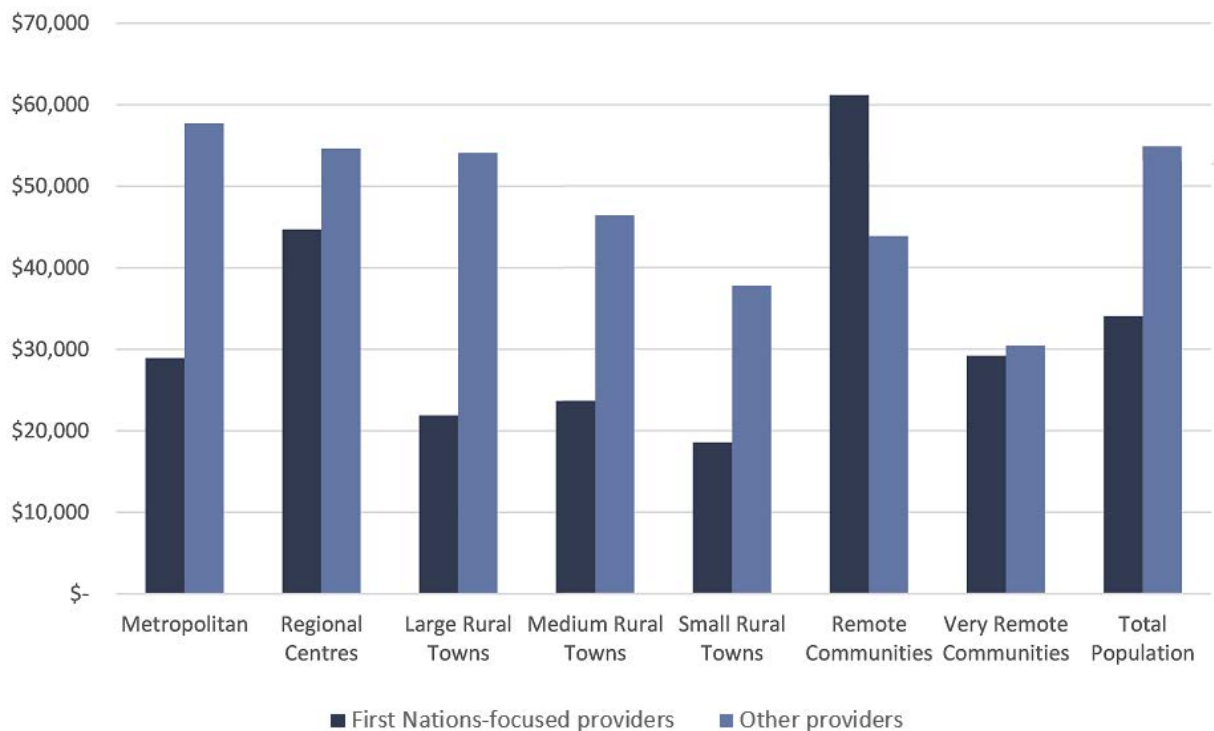


Figure 59. Average share of payments through First Nations-focused providers by Primary Disability (NDIS, 2021)

Current average payment received per participant per provider

Overall, First Nations-focused providers received significantly lower average payments (excluding amounts paid directly to participants) per participant serviced compared to other providers in 2021, as seen below in Figure



*Note, we have also analysed this trend by consideration of the median amount received per participant, to reduce the impact of outlier participant payments. The overall trend, and gaps between First Nations-focused providers and other providers does not materially change.

Figure 60. Average* payment received per participant per provider type in 2021, split by location (NDIS, 2021).

Across regions in 2021, of the participants who received any services through a First Nations-focused provider, less than a quarter received all their services from First Nations-focused providers. The remaining three quarters of participants who split their payments between both types of providers, around 70% were made through other providers. The low share of payments to First Nations-focused providers contributes to the observation that the average payment per participant by First Nations-focused providers is significantly lower than the average payment per participant by other providers. This trend is evident from Metropolitan regions to Small Rural towns. Other factors like competition between providers and the specific preference of participants may explain some of the gap in average payment, but not all. Further, should there be capacity and capability constraints among First Nations-focused providers, then a shortage of facility infrastructure or working staff can also drive payments to other providers, lowering the average annual payment per participant.

Analysis of the participant demographics (primary disability type, level of function and age profiles) show differences between First Nations-focused providers and other providers. First Nations-focused providers tend to service slightly younger participants, more participants with Intellectual disabilities and fewer Autism participants. These differences, however, are due to the different demographic composition of First Nations people, as opposed to actual differences in the Providers. As such, the types of people First Nations-focused providers service compared to other providers also does not explain the gap in average payment.

Further, we have analysed the payments that go directly to participants, and that are not paid via a provider (as analysed above). In Metropolitan regions, the average annual claim paid directly to the participant is extremely similar between First Nations and non-Indigenous people. This is also true in other regions, and across other characteristics. Refer to Figure 61.

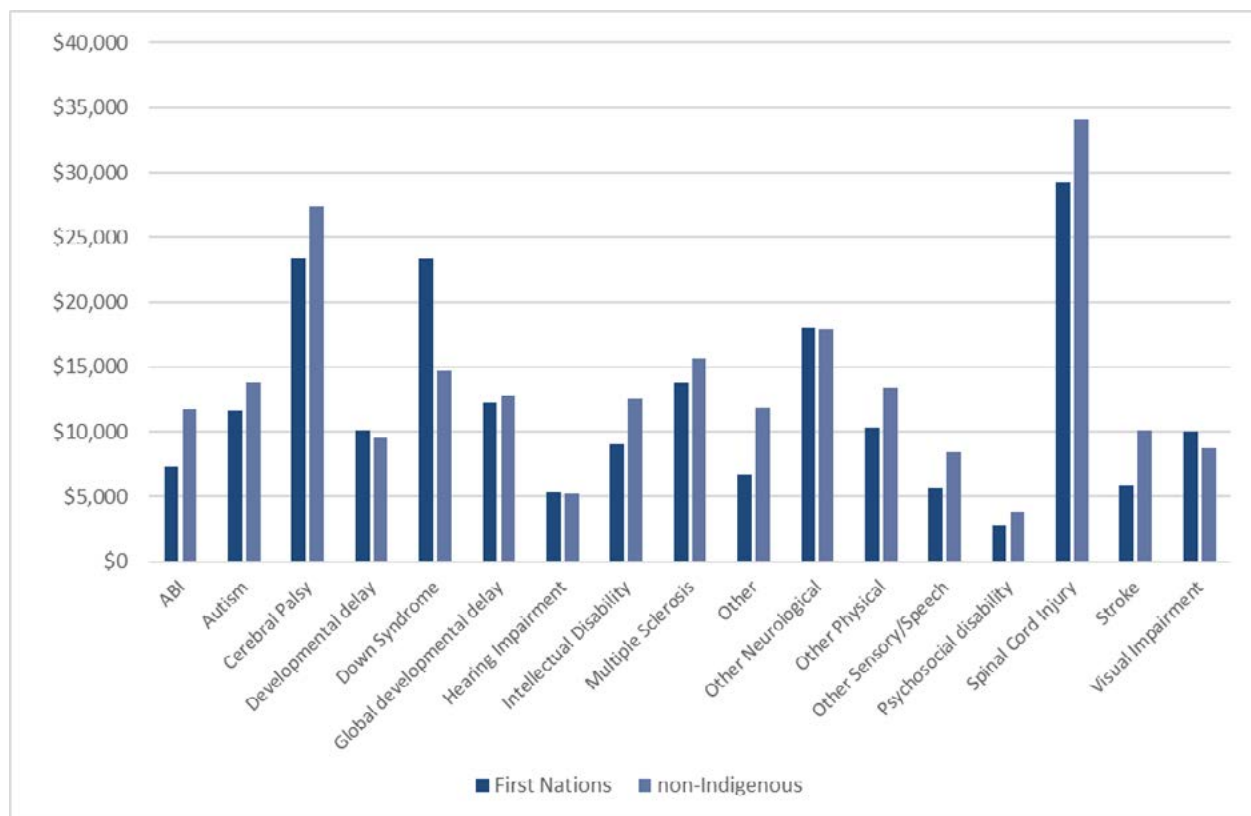


Figure 61. Average annual payments made directly to participants in Metropolitan regions, split by Primary Disability Type (NDIS, 2021)

The data does not provide sufficient information to completely reconcile the gap in average payment per participant using First Nations-focused providers and other providers in metropolitan areas, or to ascertain explicitly why participants serviced by First Nations-focused providers may tend to split their NDIS claim payments over multiple providers (some services with First Nations-focused, some with other providers).

Further research, beyond what is possible in the time and scope for this report is required to sufficiently address these residual questions. We have proposed recommendations that provide greater transparency and accuracy in provider data to allow better answers to questions such as these.

Future

Consolidation in the disability support sector will continue in coming years, but it is important to preserve the option of First Nations-focused providers to provide choice for First Nations people with a disability.

Feedback from our consultations indicates that we must incentivise more providers urgently. The priority must be for First Nations led and First Nations focused providers. However, even with successful interventions to grow First Nations led and focused providers, future service provision cannot come from these providers alone. Existing providers of quality services to First Nations people must also be empowered to invest, uplift, and grow to meet fast growing needs over time.

4 Workforce

4.1 Current

This NDIS National Workforce Plan: 2021-2025 highlights the extant workforce issues facing the NDIS. Although it does not explicitly highlight the challenges within the First Nations disability workforce, it provides an excellent summary of the current state.⁵¹

The First Nations disability workforce ('the workforce') is complex. Due to the reporting limitations in the disability sector, there is minimal data available to accurately qualify skills and capability gaps for servicing First Nations people with a disability at the individual or team level. Disability data is often aggregated with health support and aged care sector data, which does not accurately reflect the disability workforce.⁵²

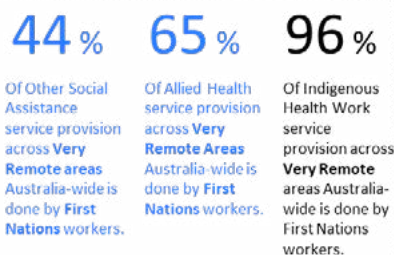
At time of writing, relevant 2021 Census data has not been released. It should be acknowledged that data analysis in this section uses 2016 Census data from the Australian Bureau of Statistics⁵³ to provide context and to highlight broad trends and patterns.

The First Nations disability workforce is defined as any worker who services First Nations people with disability, regardless of employer or cultural identity. However, it is also useful to consider the segmentation of the complete disability workforce in Australia who identify as First Nations, as in Figure 62, below. Due to inappropriate and unregulated cultural safety standards, First Nations workers often bear the 'cultural burden' of their workplace.

Breakdown of workforce

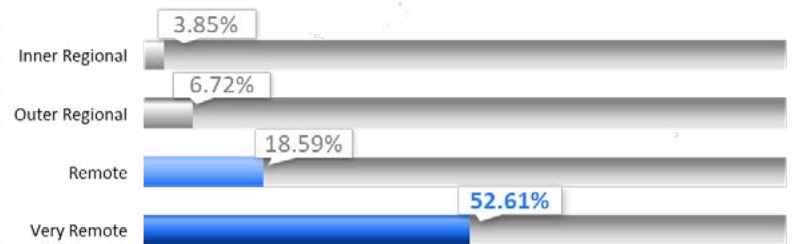
This breakdown looks at the occupations which service all people with disability

Across multiple occupations (with the exception of Indigenous health work), data shows that in metropolitan areas, First Nations people have a much lower chance of receiving care from a First Nations worker. This trend is reversed in remote and very remote areas where almost half the workforce is made up of First Nations people.



Regional vs. Remote

In Inner and Outer Regional Australia, First Nations representation is still quite low compared to Remote and Very Remote areas. The below looks at the share of workers in disability care industries.



Occupational share of First Nations workers in major cities Australia-wide



Figure 62. Breakdown of workforce which service First Nations people with disability (BAS, 2021)

What does this breakdown mean?

First Nations people are underrepresented in the care workforce nationally. Approximately 4.6% of the workforce (of aged and workers supporting those with disabilities, First Nations health workers, and welfare support workers) are First Nations people, compared to 7% of NDIS (forecast to rise to around 7.7% by 2032). This is an obvious gap in First Nations support available for First Nations people with disability.

A First Nations person with disability may not want a First Nations provider, but they do want a choice. In many areas, that choice simply isn't available.

When overlaid with consultation responses, low national numbers of First Nations people within disability related occupations contribute to culturally unsafe disability service provision. These gaps in cultural capability have occasionally been mitigated with the use of Community Connectors or Aboriginal Liaison Officers, and there is no mandated cultural safety benchmarking in the sector.

In regional and remote areas, most service provision is by First Nations people with the highest instances of representation being in occupations such as First Nations Health Work. From our demand projections, there is insufficient workforce in these areas to meet the expected increase in support required. The solution to this problem has traditionally been the use of outsourced or fly-in-fly-out workers. In areas such as Very Remote Northern Territory, where First Nations people make up around 75% of the population, cultural safety and competency is paramount to service provision but is not always achieved.

In addition to all of this, it must be recognised that many of the identified occupations share most of their capacity with the health and aged care sector, and therefore proportions of service provision to First Nations people with disability may not be accurately represented in the numbers.

These observations in the data present workforce challenges for disability service provision for First Nations people, which align with sentiments in the literature and in consultation:

- The disability sector needs more workers generally but particularly in remote and very remote areas
- First Nations people will benefit from greater representation in all care sector occupations; and
- Cultural competency must be embedded in service provision to ensure culturally safe support, both in major cities where First Nations representation is very low, and in remote and very remote areas where capacity is needed but may not come from First Nations workers.

Workforce capacity

Using an employee lifecycle lens to assess current workforce capacity, multiple barriers to employment in the First Nations disability care workforce are identified at each stage of the workforce journey (see Figure 63, below):

	Identified barriers to employment	Impact on workforce
Stages of the employee lifecycle	Attraction Insufficient knowledge of First Nations disability care careers The wider population is generally misinformed about the careers that exist across the disability sector. In addition to simply not knowing which jobs and careers exist, the population has a poor understanding of the variety of entry and exit points into disability care careers this is further exaggerated by the increasing role that microcredentials play in rapidly preparing people for a role in a range of jobs. For example, the <i>Entry to Care Skill Set</i> developed in 2020 is a 3-4 week nationally recognised microcredential that provides the skills and knowledge required to provide entry level support for basic client care for a range of roles and purposes required within the aged care and disability support sectors. Additionally, the general population is unaware of the increasing recognition of prior skills and experience by disability carer employers. Better recognition of existing capabilities, has long been seen as a quick win for addressing skills shortages, however perceptions of the transferability of skills by individuals can hinder employers' efforts. In addition, there is still a fear of discrimination within services which can deter First Nations people from seeking out careers in the sector.	Fewer people, particularly First Nations people, consider pursuing a career in disability care due to perceptions of the industry.
	Participation Contract lengths, inadequate funding and cultural safety Relatively short employment contracts combined with a lack of the premiums that contract work usually attracts, impact employers' ability to provide long-term job security to the workforce. This situation has also given rise to companies that collect and distribute payments to NDIS workers, therefore to increase certainty of payment, but for fees of 1.5% of the contractors' salaries. This disincentivises participation in the disability sector, and additionally constrains organisations from long-term workforce investment in the sector. In addition, First Nation Workers require culturally safe workplaces and culturally competent peers, both of which are not consistently found across the employment market.	Disability care workers experience lesser job security and poor cultural safety from their workplaces relative to other sectors.
	Development Systemic barriers to upskilling and training These affect access to education for further training and accreditation pathways, especially in remote and rural areas. Barriers include a lack of flexible and frequent training opportunities, lack of cultural safety, lack of support systems (particularly for those who have had to leave their community to access training), individual and community trauma, remoteness, poverty, digital exclusion and institutional discrimination. Additionally, nationally endorsed training products such as the <i>Certificate IV in Disability</i> are now outdated having been released in 2015 and lack sufficient coverage of First Nations specific skills and knowledge. This in turn has led to the development of a variety of state based accredited courses resulting in inconsistency amongst the skills (and skills gaps) that employers try to address through internal training and other mechanisms. Additionally, there are arduous processes to formally recognise prior learning and experience, disincentivising individuals from applying for credit for a learning pathway, further inhibiting access to the sector.	Disability care workers are not appropriately skilled, nor do they have access to upskilling pathways to deliver First Nations Disability Care.
	Retention Accumulation of challenges leading to burn out and fatigue Understaffed and underpaid workers are frequently experiencing burn out and fatigue. For First Nations workers, this fatigue can come from being a lone spokesperson for cultural engagement and the absence of culturally safe environments and professional networks. This then inhibits staff retention at an organisation level, but also encourages workers to leave the sector as a whole. Additionally, those who have had a poor worker experience are less likely to speak positively of, and advocate for a career in First Nations disability care, therefore compounding the issue by disincentivising other First Nations people who were considering a career in disability care, from doing so.	The disability care sector struggles to retain workers, and those who leave are not likely to positively advocate for a career in the sector.

Figure 63. Employee lifecycle and barriers (Deloitte, 2022)

Where are the workers coming from?

Australia's broader care workforce has transferrable skills that can be employed in disability care, health care and aged care. New workers in relevant occupations often come from related fields, meaning there is a 'tug of war' for skilled staff across programs and providers. Consequently, this source of workers alone often fails to deliver the required volume of workers required to meet the needs of Australians requiring support⁵⁴. However, these intra-care sector flows of workers can be positive for both workers and the provision of support, with workers building on their existing capabilities by applying their skills and knowledge in new environments, while also sharing best practice from other sub sectors. This will only be successful with cultural safety uplift.

Building a stronger workforce for the future will require strategies and incentives to attract new workers into the sector as well as capability building across the whole care sector. For example, the sector would benefit from critically analysing the underpinning skills required of support roles and identifying other job roles where these skills are in abundance to better understand how transferable skills can be leveraged to address attract workers and address workforce capacity.

Capabilities and Geography

Urban areas experience lower numbers of First Nations people working in areas such as Indigenous Health Work, Disability and Aged Care, and welfare support services, than compared to the general population. 2% of these occupation workforces across Major cities in Australia identify as Aboriginal, Torres Strait Islander or both.⁵⁵

In addition, cultural safety training is not compulsory for service providers, resulting in unsafe workplaces for both workers and those receiving support⁵⁶, and a lack of understanding of trauma within First Nations communities. Consequently, First Nations workers within non-Indigenous organisations frequently bear the burden of being the source of any cultural knowledge and a spokesperson for community engagements which results in fatigue and burn out.

Rural and remote areas are critically affected by the gap in these capabilities due to a general lack of services and reliance on temporary or 'fly in, fly out' services, many of which do not have relevant cultural training and do not build trusting relationships with the community that they briefly enter. Visits to remote communities can also be infrequent and sporadic. Consequently, a substantial portion of both formal and informal disability support in these regions come from family or community members who have not undertaken formalised training and may lack required skills and capabilities⁵⁷.

In Dr Scott Avery's *Culture is Inclusion*, informal supports are discussed as being at the unique intersection of remoteness and gender, acknowledging that women in remote communities frequently play caregiver roles but also frequently relocate to metropolitan areas when it is themselves who have a disability and do not benefit from the same support that they would usually give.⁵⁸

4.2 Future

The rapid growth predicted in the demand of increased access and the level of service provision will place immense pressure on service providers in coming years. Current inequities will be exaggerated for First Nations people with disability. There will be a need for new providers to take on a First Nations focus and for existing providers to grow their service offerings alongside the rapid growth in demand.

The aging population of First Nations people with disability will also alter patterns of service delivery and require different approaches among providers to meet the needs of individuals. While the prevalence of 'thin markets' is expected to decline overall, First Nations communities are expected to be disproportionately affected by the impact of these markets, especially in rural areas.⁵⁹

While this clearly highlights the needs for more and stronger First Nations led and focused providers, future service provision cannot come from First Nations-focused providers alone. Increasing the talent pipeline for the First Nations disability workforce will not solely address the increase in demand. That said, without successful efforts to grow the First Nations workforce at all, we will fall further behind in terms of the ratio of First Nations care workers to First Nations people with a disability.

The solution of rapidly injecting talent to support First Nations people with disability, where First Nations led options are exhausted is the uplift of non-Indigenous providers in culturally appropriate support through defining and mandating the required skills and capabilities of the workforce to meet this need.

Delivering rapid growth and cultural transformation in the sector at the same time is a huge challenge. Success cannot happen without the skilled workers needed to deliver quality support. Expanding the disability care workforce (both non-Indigenous and First Nations-focused providers) will be a critical part of securing future service provision.

The challenge is made greater by competition from other fast-growing care sectors in health and aged care who will also be looking to find new workers to meet growing demand over time. Priorities for growing the disability care workforce should focus on strategies and incentives to attract new workers into the sector from all sectors of the labour market, as well as capacity building across the whole care sector. If strategies only attract the existing healthcare workforce to move into the disability workforce, they have failed.

The identified gaps in the current capability and capacity of the sector must be contextualised by the projected demand and supply of the workforce.

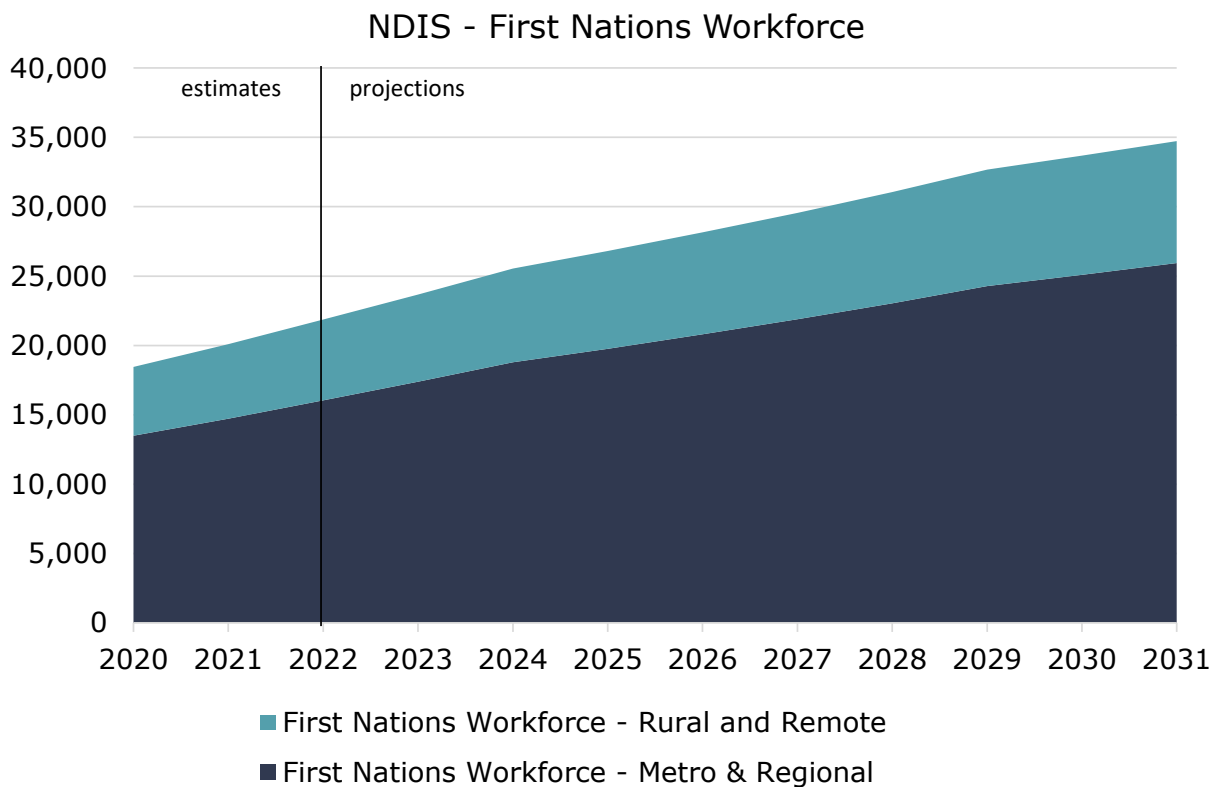
A note on data

It should be noted that our projections are based on current participation trends, which means that the undisclosed demand within First Nations communities is not included and cannot be appropriately planned for. Additionally, shared spending and creative means of NDIS package use, which has been reported in consultation, results in inaccurate representations of average spending and need. It is these extraneous variables that need to be more accurately captured in future data collection and demand mapping to be able to plan services appropriately.

Workforce Growth

The current disability workforce has 209,000 workers. Taking account of both the number of NDIS participants and increases in the level of support provided over time we project that the workforce required to service total demand will grow by 146,000 workers by 2032 and 344,000 workers by 2042.⁶⁰

While there is no data on the proportion of the workforce currently serving Indigenous participants, we have used First Nations people with disability participation to project demand for the workforce⁶¹. The total workforce requirement for the First Nations disability sector is 22,000 in 2022 and forecast to grow by 13,000 by 2031, and 28,000 by 2042 (see Figure 64, below).



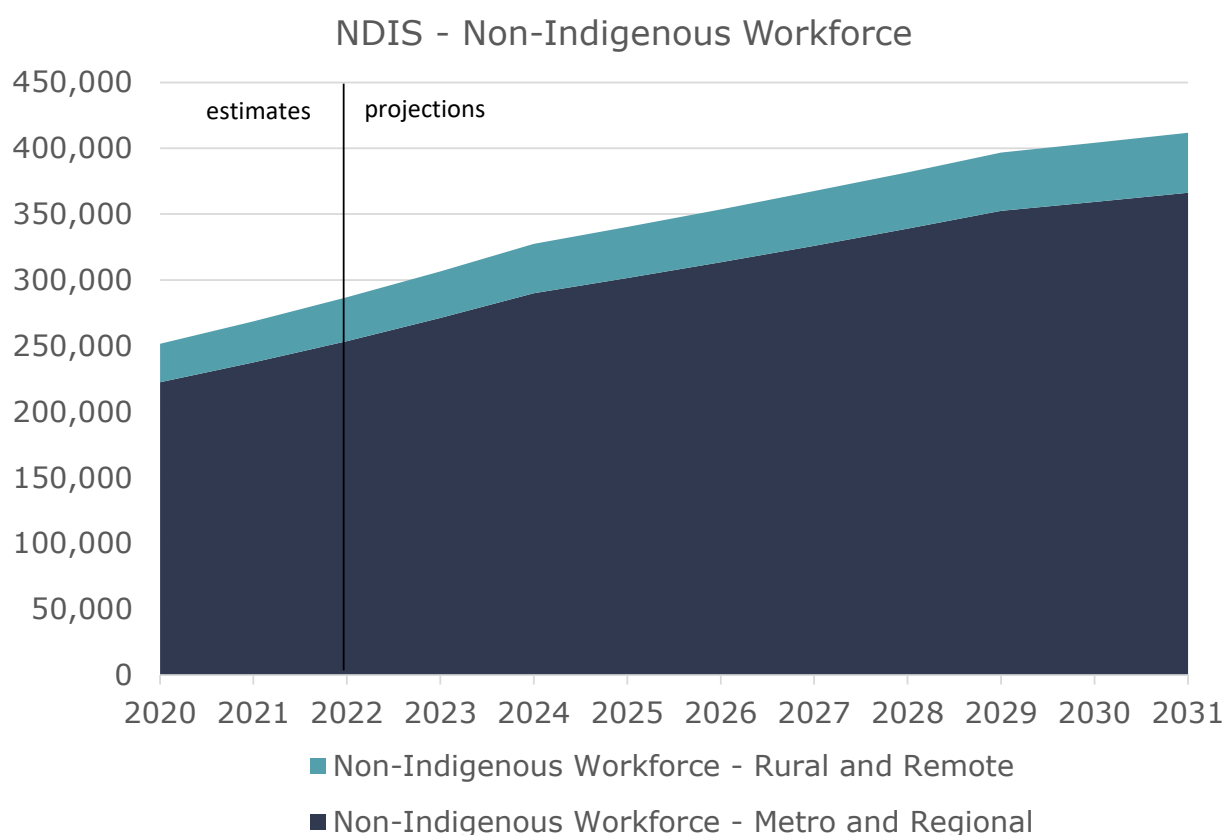


Figure 64. Projected growth of First Nations disability workforce (NDIS, 2022)

Those new workers will be needed to meet the needs of both new scheme participants and existing participants who are expected to receive higher levels of support on average in the future.

Based on the current composition of the workforce, 73% of new workers will need to be home-based support workers, 12% community based and 10% allied health nationally. 54% of these workers will be needed in cities and regional centres, 38% in rural towns and 8% in remote and very remote locations.

Workforce constraints are already a major challenge for providers and will be a key impediment to participants accessing services in the future.

Defining the future best-practice skills and capability needed for culturally safe service provision

We applied what we heard in consultations to the existing quantitative data available to identify the following capabilities (and associated skills) as essential and distinct in servicing First Nations people with a disability (see Figure 65, below).

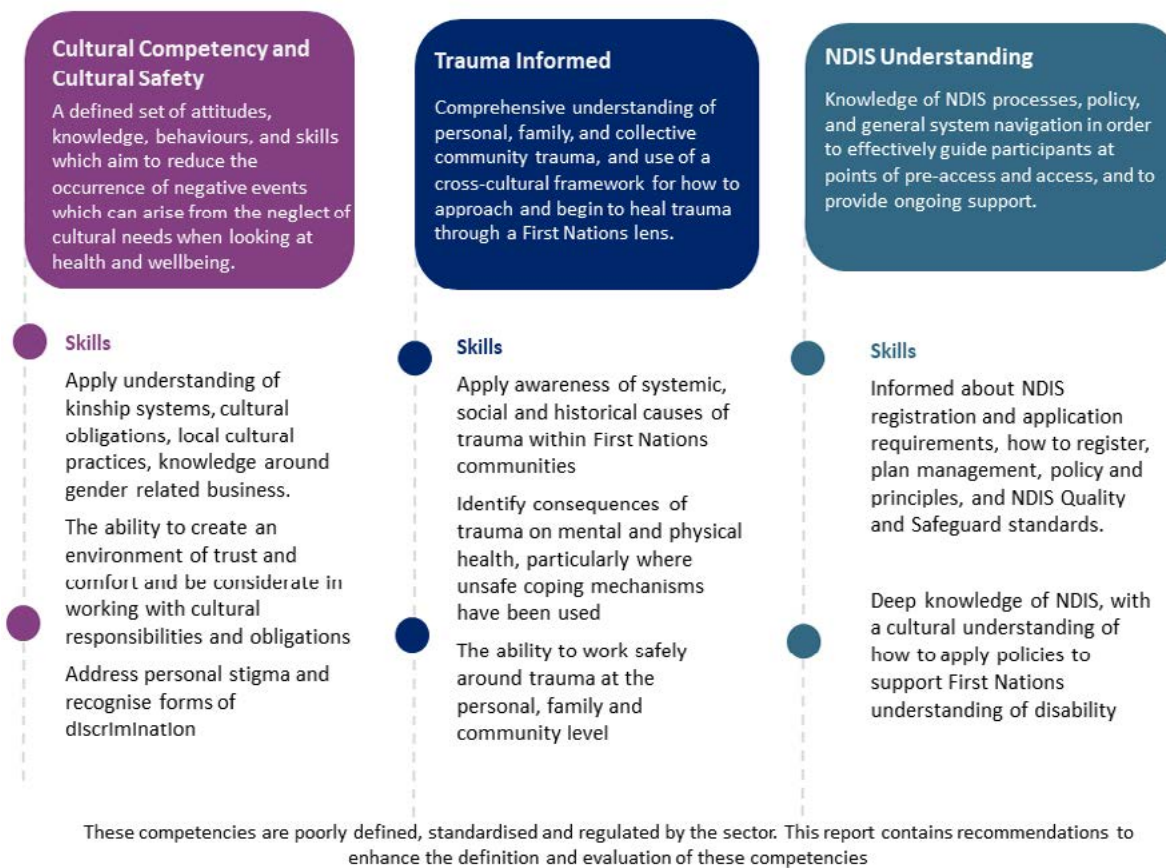


Figure 65. Essential capabilities of a worker providing services to First Nations people with disability (Deloitte, 2022)

An appropriate worker will be proficient in all three of these competencies. Currently these competencies are poorly defined, standardised delivered and regulated by the sector. This report contains recommendations to enhance the definition and evaluation of these competencies.

So how are we doing? Analysis of identified skills

During consultations we repeatedly heard evidence of consistent skills and capability gaps across Australia in metropolitan, regional, and remote areas. The Summary of Key Findings articulate these in detail, supported by empirical data. While some of these gaps are common across the whole disability sector, the unique needs of both the First Nations workforce and First Nations people with disability are often misunderstood or underrepresented.

‘Most allied health and service provision is done by non-First Nations people with little training or cultural awareness.’

- *Aboriginal Community Controlled Organisation*

First Nations Cultural Competency and Cultural Safety

Within non-Indigenous organisations, First Nations workers often bear the ‘cultural burden’ of representing and advocating for First Nation’s needs. This reflects the lack of culturally appropriate contextualisation, training, and compliance for non-Indigenous organisations. Additionally, ‘cultural safety’ and ‘trauma informed’ have become terms that are used by services but are not fully understood and applied. Further, as mentioned previously nationally endorsed training designed to prepare workers in disability care, is outdated and does not adequately address the required cultural competency for disability care workers.

It is important to note that across the entire training market, there is a strong demand for First Nations Cultural Competency training with over 100,000 subject enrolments annually in CHCDIV002 - Promote Aboriginal and/or Torres Strait Islander cultural safety. However, the learners undertaking this training are not pursuing jobs in the disability sector with only an average of 179 of those enrolments occurring as part of the Certificate IV in Disability (average between 2016 and 2020). Instead, these students are pursuing qualifications in areas such as community services, aged care, and allied health amongst others.⁶²

Trauma Informed Support

Non-Indigenous providers lack education around causes and consequences of personal, social, and systemic trauma, including trauma as a barrier for participation within First Nations communities. There is not enough understanding of systemic violence and the resulting trauma which has been passed intergenerationally through disruption of attachments and family dynamics, language, and cultural practices and sharing.⁶³ This is coupled with an absence of safe coping mechanisms and siloed knowledge within healthcare which does not address the interconnectedness of trauma with health, spiritual, cultural, emotional, and social wellbeing. There is inadequate education in safely supporting First Nations people with disability who may need to heal trauma alongside disability support.

NDIS Competency

Thin service markets, combined with a lack of cultural safety in non-Indigenous organisations, lead to the First Nations healthcare workforce (AMS/ACCHOs) providing support to First Nations people with disability. This results in degraded quality of disability services and increased pressure on First Nations healthcare services. We heard clearly in consultations that the disability workforce is not trained, equipped, resourced, or designed to support the unique intersectionality of disability and Indigeneity while simultaneously navigating the NDIS and its principles, policies, and protocols.

5 Recommendations

5.1 A series of recommendations, at a point in time

Based on the qualitative and quantitative data analysis, combined with extant empirical and grey literature, a series of options for service delivery reform are recommended.

All recommendations should be understood in the historical context and often fraught relationship between First Nations people and the nation more broadly. This is manifested in the ongoing entrenched and profound disadvantage faced by First Nations people that continues to this day. Furthermore, the crushing poverty that underpins many First Nations communities cannot be ignored, knowing full well how this exacerbates the already complex and challenging circumstances faced by First Nations people with disability.

Additionally, our recommendations must also be understood in the context of the current disability sector and be confirmed through a robust process of participatory decision making and ongoing consultation with community. It would be inappropriate to mandate future timeframes, budgets, and processes without doing so.

A single capstone recommendation has been designed that will create the foundations for the remainder of the recommendations. For the complete list of recommendations to be implemented, the capstone recommendation should be accepted. Consequently, it can also be considered the recommendation with the highest priority within the combined list.

Capstone recommendation

Recommendation one

An Intermediary Body should be appointed and endorsed to govern sector development, improvements in service delivery, quality assurance for the First Nations disability sector and establish a regional governance structure which hears and values the voices of First Nations people with disability.

The disability services sector is complex and difficult to navigate, culturally unsafe and support options are not standardised. First Nations people with disability are often forced to navigate the complex systems alone, many failing to do so and are consequently missing out on support.⁶⁴ During consultations, we heard that First Nations people with disability are reporting that services are of a below average quality, re-traumatising and culturally insensitive, and feel that they are unheard when they raise concerns. This was supported by our quantitative analysis, which showed First Nations people with disability are more likely to be denied access to the NDIS. Emphasising this further is the fact that services are not being provided to a consistent standard meaning that the quality-of-service delivery varies dramatically between regions.

In consultations, the sector highlighted uniformly the absence of a mechanism or body that provides voice, support, and governance to the sector; immediate establishment of a governance structure is essential. It is recommended that the Intermediary Body ('Intermediary') be established as a national body with a regional governance structure to ensure realisation of benefits can be achieved regardless of location. The Intermediary Body should be led by First Nations people to elevate and promote the voices of First Nations people and their communities.

This is likely to require a First Nations tailored recruitment program with mentoring and other established support systems, as required. Specific costings would depend on the eventual design which can only be determined with input from community.

The Intermediary Body

The Intermediary could perform several roles to facilitate the recognition and action of the voices of First Nations people with disability and First Nations disability sector development, including:

1. Identify and analyse current and projected demand for disability services to inform investment opportunities across regions
2. A formal agreement with Quality and Safeguards Commission (QS&C) to work in conjunction to conduct audit and research into standards of training and trauma informed support across providers
3. Write and implement First Nations disability policy that will improve service quality and standards
4. Assess and report on performance of the NDIS in its ability to adequately serve First Nations people with disability
5. Convene regional round-table discussions with First Nations people with disability to understand their lived-experience to use lived-experience to inform service delivery improvements
6. Document and monitor risks facing service delivery, workforce management and future investments
7. Receive and report views of First Nations communities and language groups to support their right to autonomy
8. In partnership with First Nations people with disability, identify priority outcomes and indicators based on what is important to First Nations people with disability and build these outcomes into commissioning and service delivery requirements
9. Development of an assessment criteria which is applied to all investment opportunities and is guided by First Nations principles and ways of working; and

10. Establish and coordinate a global Community of Practice with other nations (e.g., New Zealand, Canada).

Appendix B conducts a comparative analysis of three viable structural options for an Intermediary Body and concludes that Option Two is most suitable against a range of criteria designed with First Nations principles. Option Two is summarised in Figure 66, below.

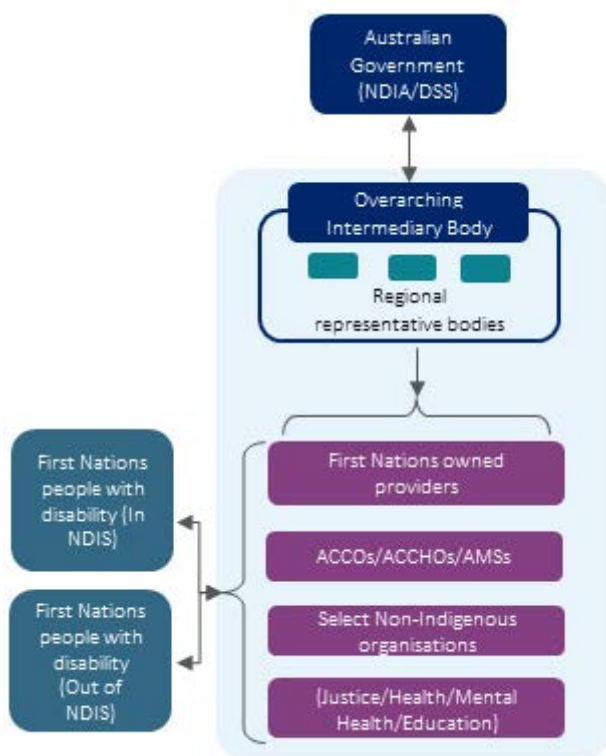


Figure 66. Proposed Structure of a First Nations Intermediary Body (Deloitte, 2022)

In this option, there are region specific representative bodies who oversee the operations of a single region and report to a National Intermediary Body which governs the entire sector. This presents a high level of coordination but also maintains a high level of representation of region-specific issues.

Costing the Intermediary

Any final costing analysis should only be completed with design input from all stakeholders. However, historically similar bodies provide an order of magnitude⁶⁵. Given the regional structure proposed, we estimate in the vicinity of \$150 million plus administered expenses. A full feasibility study should be conducted as a high priority to ascertain exact forecasts.

‘The Intermediary Body is not the hands, nor the wallet. It is the eyes, ears and voices of First Nations people with disability to Government.’

- *Deloitte*

Supporting recommendations - Service delivery reform

We heard:

- There is a need to decentralise the execution of service delivery across the states and Territories utilising regional governance approaches
- The sector highlighted the need to reconsider the use of guardianship by the public trustee and the unintended consequences it has for First Nations people with disability
- The interface between disability, the NDIS and other sectors is challenging to navigate and may be causing further trauma and harm to First Nations people with disability
- Case management support needs to be able to cross-cut sectors and provide holistic lifecycle support
- There is a desire for a culturally appropriate NDIS communications strategy to raise awareness, understanding of and most importantly access to the NDIS amongst First Nations people and communities
- The NDIS wasn't designed to consider a First Nations view on disability or a social model of disability; and
- In rural and remote contexts, the unavailability of services and culturally appropriate services undermines principles of choice and self-determination.

Recommendation two

The Intermediary should lead, in collaboration with First Nations people with disability and industry, a First Nations Disability Development Policy to increase and safeguard investment into the First Nations disability sector.

To address the quality and accessibility of First Nations disability service provision in Australia, a First Nations Disability Development Policy is required to increase and safeguard investment into the First Nations disability sector. First Nations Development Policies provide tangible community benefits when implemented appropriately; evidence of this includes both the State level Procurement Policies and the Commonwealth Indigenous Procurement Policy (benefits outlined in Figure 67).⁶⁶ Each has realised significant increases in tangible community benefits and a stronger First Nations workforce and economy.⁶⁷ Focused investment from the Federal Government and the NDIA, guided by specific and measurable targets and First Nations principles, would also be required to facilitate sector development and to prove that the disability sector could be a viable sector for organisations to operate within. Additional governance requirements would need to be outlined alongside the implementation of such a policy.



Figure 67. 2020-2021 Commonwealth Indigenous Procurement Outcomes (National Indigenous Australians Agency, 2022)

The implementation of a First Nations Disability Development Policy should specify specific investment targets that consider the urgent and priority needs of First Nations to ensure adequate consideration across communities based on factors such as: the current demand for disability support services in that region, the projected length of need for these services, a consideration of service demand comparatively to other regions and their existing ability to provide services before funding is received.⁶⁸

Recommendation three

The Intermediary should define and oversee a national Community Connector program to ensure uniform application, responsibility, and availability of the role in each community.

‘[First Nations] People in our rural areas generally must engage directly with the NDIS; LACs or Community Connectors are rare.’

- *Aboriginal Community Controlled Organisation*

‘The Community Connector role should be funded centrally and offered in every community uniformly.’

- *Peak Body*

Through community consultation it was made clear that there is a lack of capacity in the sector generally; community organisations are providing services outside the scope of their obligations and are not being paid to do so. One of the types of support they are providing, without specific funding, is assisting applicants to apply for support under the NDIS. Community organisations

are doing so because local First Nations people with disability require urgent and timely support and struggle to navigate complex disability systems including the NDIS. Without recognised and allocated support to do so, they are relying on already overwhelmed community organisations for guidance.

The terms Community Connector⁶⁹ and Local Area Connector⁷⁰ have no standard national definition, nor are they nationally resourced. The NDIS funded a Community Connector program to ensure better support Australians with disability from four specific population groups to access the NDIS,⁷¹ however this program ceased in 2021. In some areas, the term Community Connector is used by providers with no regulation.

By establishing a nationally funded, locally executed 'Community Connector' role, the administrative and funding burden is transferred away from the community level organisation. The Intermediary would take carriage of this program and fund those positions to be available in all regions, pro-rated by need. A cost-benefit should be conducted by NDIA to identify the priorities of roll-out for urban, regional, remote, and very remote areas. Training such as FPDN's Community Connector Training should be leveraged for standardisation of service quality.⁷²

The roles and responsibilities of the Community Connector:

1. Use information about an individual's needs to match them to the appropriate service providers
2. Support ACCOs to become registered. This role can be considered as an uplift of the existing 'caretaker' role and previous 'Community Connector' roles
3. Have delegated authority and the ability to input into scenarios where individuals are caught between two sectors
4. Assist communities and providers in writing grant and NDIS applications
5. Collect data on individual's needs in a region to map the current demand in an area to inform policy reform and support grant applications; and
6. Assist communities to coordinate the spending of pooled funds in a region (e.g., providing advice on cost effective, culturally safe, and high-quality contractors).

Recommendation four

Where the assessment is made that a thin market is unlikely to resolve itself under current market conditions, the NDIA should block fund Aboriginal Community Controlled Organisations or preferred providers for disability service delivery.

'A move back to block funding arrangements would mean we could better support people in our remote community with disability.'

- *Aboriginal Community Controlled Organisation.*

Ideally, through diverse and robust disability markets, First Nations people with disability can exercise choice and control under the NDIS; delivering on the goals of the scheme. Unfortunately, in some cases this is not possible without intervention. Very thin markets are unlikely to resolve naturally under the current market conditions.⁷³

The NDIS has moved away from the previous system of block funding (previously called the National Disability Agreement, the 'NDA') to a fee-for-service, insurance-based, market-based approach. It is based on the premise that people with disability each have different support needs and should be able to exercise choice about the supports they need. In 2011, the Productivity Commission recommended that Australia replace the existing system with a unified national scheme to fund long-term, high-quality support for all Australians who experience significant disability (the NDIS). It described the NDA as 'underfunded, unfair, fragmented, and inefficient', arguing that it gave people with a disability 'little choice and no certainty of access to appropriate support'.⁷⁴

While this approach was designed to facilitate individual choice and control for 'all Australians', it has failed to consider the benefits and suitability of a block funding approach in a First Nations context. During our community consultations, we heard that many of the NDIS payments available to First Nations people with disability are not being used appropriately or efficiently:

- Recipients are not aware of the services that are available to them
- People require a support service / infrastructure that exceeds the permitted spending limit; and
- People are spending money on duplicated services whereby coordination of services would allow recipients to realise economies of scale.

The NDIS is a social and economic lever which takes an individual approach, whereas First Nations social and economic understanding is family based and collective. In markets where choices are limited, the NDIS should provide tailored forms of support to cater for these differences. Service delivery must be flexible to include First Nations approaches to providing services, including group service provision, and sharing of disability infrastructure and community support networks.

Government 'block' funding provides grants to approved providers to deliver community service programs. This is best suited to a First Nations remote context, allowing disability service providers to invest in larger infrastructure projects and services which benefit larger groups of First Nations people with disability.

The need for a different approach for First Nations people was recognised by the Productivity Commission when it recommended the creation of the NDIS. It called for an indigenous strategy addressing both funding and community involvement:

.... barriers to service delivery suggest that the service delivery model underpinning the proposed NDIS may not, on its own, deliver adequate care and support to Indigenous people with a disability. While Indigenous Australians would have access to individual support packages on the same basis as non-Indigenous Australians, it may also be necessary to block fund some services to overcome the additional barriers that Indigenous Australians face.⁷⁵

In practice, service providers will be required to meet a range of conditions and funding will be linked to their client numbers and services delivered. This information will be monitored and reported by the NDIA.

A note on plan lengths

We endorse the NDIA's move to provide longer plan options. Providing secure long-term funding packages would provide organisations with greater capacity to anticipate demand for their services and allow them to prepare and respond appropriately. In regional and remote areas, this will encourage competitive and deeper markets because organisations can invest in their growth proactively rather than reactively. As the market becomes more competitive, services will expand further across regions, become more accessible and give individuals choice between several suitable service providers. In many markets longer plan options will bring some of the benefits of funding certainty while retaining choice and agency for First Nations people with disability.

Recommendation five

The Intermediary Body should investigate the use of guardianship orders by the Public Trustee and expose impacts and experiences of First Nations people with disability under guardianship.

A guardianship order is a legal document that gives a person (called a 'guardian') power to make decisions on behalf of another person about personal matters. This may include decisions about where an individual lives, health care and access to services.⁷⁶ A guardian is usually a close family member or friend, someone trusted to make decisions.⁷⁷ If there is no one suitable, the Public Trustee and Guardian is usually appointed as guardian.⁷⁸

According to the Australian Law Reform Commission,⁷⁹ guardianship and administration laws need to be reviewed to ensure, among other things, that guardianship and administration are:

1. Invoked only as a last resort and after considering the availability of support to assist people in decision-making
2. As confined in scope and duration as is reasonably possible
3. Subject to accessible mechanisms for review; and

4. Consistent with decision-making that respects the will, preferences, and rights of the individual.

‘[First Nations people under guardianship orders] Essential get locked into segregated settings whilst they’re under guardianship. They have no choice or control over where they live or what they do.’

- *Disability advocate*

During the community consultations, it was made clear that in some cases the conditions above are not being met and that First Nations people with disability, who are represented by a guardian, are receiving inadequate support because of inappropriate and culturally unsafe decision making on their behalf.

Often First Nations people with disability have less autonomy and self-determination under guardianship orders. The appointing of a third-party guardian is not suitable in a First Nations context due to existing trauma from historic separation of families and lack of autonomy and self-determination. To make matters worse, First Nations people with disability or their family do not have autonomy over choosing a guardian, in many cases this is being allocated to them. This also has meant that in many cases families are not being consulted for decision making when appropriate.⁸⁰

Guardianship orders are exacerbating the already inadequate and culturally unsafe standards of support being received by First Nations people with disability. Guardians are not required to complete cultural training and as such are not providing culturally safe services. This has meant that guardians are failing to contact and involve an individual’s family for decision making purposes and are not able to act in their best interest. The guardian lacks consideration for the individual they are caring for and are not acting with integrity; it has been seen that guardians are taking advantage of their positions of power over an individual in their support.

Greater sensitivity must be made to the cultural implications of a third-party guardian for an individual and/or community and the current system’s alignment to the values outlined in best practice principles of engaging with First Nations people, including -but not limited to the *UN Declaration on the Rights of Indigenous Peoples*.

A review of the use of guardianship orders by the public trustee must occur to expose and further understand the real-life impacts and experiences of First Nations people with disability under these orders, the insights from which would be used to provide a First Nations tailored form of representation.

Once the applicability of the guardianship order has been assessed, further investigation must occur into the improvement of services provided by a representative of an individual (the guardian or equivalent which is found to be most appropriate in a First Nations context). This would include increasing capacity to deliver support within communities and / or provision of training programs for family members to be qualified to perform the role of guardianship. They

would also be provided access to resources to aid in applying for support and performing decision making processes for an individual. Under the social model of care which assesses support requirements on a need's basis, a trusted guardian would be equipped with the necessary understanding of an individual's needs to make tailored decision-making surrounding support provisions.

Recommendation six

The NDIA should identify unfunded supply to, and undisclosed demand from, First Nations people with disability delivered outside of the NDIS and compensate providers who are bridging the gap.

There are currently four major reasons why disability support is being provided and not compensated for, including:

Service providers exceeding obligations

Service providers that provide support outside of the limited services that are covered by the NDIS funding provided to individuals. These service providers are meeting the unmet demand for services and sourcing the financial support from other places. These additional services provided are often not reported which makes it difficult for the NDIS to be held accountable for the service delivery gap.

Unsupported people

Individuals who are not registered under the NDIS who require support but are unable to provide compensation for these services. This is either due to failing to successfully complete the application process, or not ever attempting to apply for NDIS support or not knowing about the NDIS.

Unregistered service providers

Organisations who are not registered under the NDIS are providing support to First Nations people with disability because of a lack of other available resources. Additionally, there are several people who are providing disability support but are not registered under the NDIS and are therefore not being compensated for it.

Alternative funding sources

There are several other healthcare related financial support programs which are being redirected towards disability services.

Under a reformed NDIS, there should be significantly fewer disability services being provided which are unsupported by the NDIS. To further understand the extent of the required increases of funding, the NDIA should commission research and analysis into the proportion of disability services delivered outside of the NDIS, and therefore not funded under NDIS packages.

Information should be gathered surrounding:

- Number of hours of support provided
- Number of hours funded by the NDIS
- Identification of additional sources of funding
- The number of service providers who are actively providing services
- The region / location of services being provided
- The main barriers to accessing NDIS support (if any)
- The main barriers to becoming registered under the NDIS (if any).

To complete this process and gain accurate insights, a culturally safe and trauma informed community consultation program is required to be completed with a First Nations representative of each region, and an audit will be conducted for all providers of services. There are a series of complexities in accurately capturing undisclosed demand and this project should be phased and prioritised to ensure efficient use of research resources. The results of this process would inform initial funding increases by the NDIA, including distribution of resources. The Intermediary Body will represent the needs of First Nations community during this process.

It is important to highlight that it is very difficult to capture the full undisclosed demand- whether under-funded participants, or those who are not registered at all with the NDIS. Other recommendations in this report will provide scaffolding for First Nations people with disability to be more likely to apply for the scheme, but there will always be a data gap in this area.

Recommendation seven

The NDIA should facilitate cross-sector collaboration to address the unique and holistic needs of First Nations people with disability.

‘We hear of examples where First Nations people are forced to stay in hospital or other residential settings for extended periods of time due to the inability of different sectors and systems to communicate with the disability sector, and appropriately plan for transition arrangements back into the community.’

- *Disability advocacy service*

Many First Nations people with disability have multiple health care needs and require support from more than one service provider (most often in differing industries). Our community consultation highlighted that these individuals are receiving less support than those with a single healthcare need. This is reportedly happening because:

- Needs are holistic and interconnected
- Providers generally are funded for one aspect of support and do not have the capacity to consider holistic needs in their service delivery model
- Participants receive funding in their plans to access ‘reasonable and necessary’ services and supports to help pursue their goals.⁸¹ We also heard during consultations that goals are inappropriately made on behalf of First Nations people with disability and as such do not accurately represent their needs
- The current health care systems don’t support collaboration between sectors, sharing of knowledge and infrastructure or to provide services in parallel; and
- Non-Indigenous organisations view individuals with multiple areas of need as being ‘not their responsibility’.

During the community consultations, we also heard that organisations in health care services have the tendency to work only within the comfort zone of knowledge they have. The systems that support these organisations are designed to keep adding depth but only within their niche of support and aren’t designed to highlight synergies between multiple aspects of support.

‘It seems like there is no coordination or system and structure – everyone is operating in their own narrow band of health and disability – none of the bits are communicating well with each other.’

- *Aboriginal Community Controlled Organisation*

The NDIS needs to take a holistic approach to service delivery, and fund deliberate planning for First Nations people who fall within multiple categories of need. A holistic approach provides support that looks at the whole person, not just their disability support needs. The support should also consider their mental, physical, emotional, social, and spiritual wellbeing⁸². In the context of First Nations disability support provision, this includes enabling individuals receiving support to choose the provider of services depending on their needs and preferences of providers. This life-course approach is not unique to First Nations people with disability. This recommendation should extend to the intersectionality of all participants under the NDIS.

The Community Connectors will address and navigate complex system interfaces, most notably between Disability and Health, Justice, and Education, to ensure First Nations people with disability are not caught between sectors.

A note on poverty

We can't ignore the entrenched poverty that exists in remote and very remote communities, which contributes to the holistic needs of an individual with disability. In a life-course approach, we acknowledge that this colonial legacy continues to pervade contemporary contexts for First Nations people with disability. The NDIS is not responsible for this, but agencies must be aware of the important role the NDIS can play in contributing to improving circumstances through health and wellbeing.

When recommending a holistic case management approach, a supporting funding model must be available to First Nations people with disability to access these services in the long term. The NDIA should lead inter-sector development of collaborative funding models in cases of First Nations people who fall within multiple categories of need (e.g., disability and education). This multi-disciplinary model of support would better accommodate a pooled funding model as communities with multiple service requirements would easily and efficiently access support. During the community consultation process, it was made clear that the current NDIS does not have a funding model that is suitable for First Nations people with disability who have needs across multiple sectors.

Collaborative funding models would provide several benefits:

- Economies of scale are realised, whereby organisations can fund infrastructure that will provide greater return on a longer-term period
- Organisations save on transaction costs for infrastructure that is required by more than one organisation
- Cost benefit analysis is required for all investments meaning that benefits are maximised at each stage of the decision-making process
- Organisations will have a greater reach to provide support services to individuals across regions
- Avoids unnecessary duplication if investments
- Unifies service demands within communities which can be used to inform the Intermediary Body for further investment
- Collective identification and management of risk
- Increased accountability of quality and timeliness of service provision across the health care system/
- Unification of system and increased communication would relieve some of the pressures on service providers who are understaffed and unable to meet current demands
- Increased transparency for resource allocation across communities⁸³

- Services are provided in the most ‘convenient’ way possible (e.g., coordinating physical therapy and disability support services in the same region); and
- Funding infrastructure that benefits First Nations people with disability on several fronts (e.g., park ramp access facilities for aged care residents who are also First Nations people with disability in a wheelchair) park ramp.

A collaborative funding model would allow funds to be distributed depending on community needs and demand. The collaborative funding model would build capacity of providers to deliver services across sectors and would create tangible benefits for the region in ways that each community wants. It is important to ensure this has tightly controlled scope and parameters to avoid abuse of the model.

Through diverse and robust disability markets, First Nations people with disability can exercise choice and control under the NDIS; delivering on many of the goals of the scheme. Without this analysis, the NDIS will continue to face thin market issues, which are only likely to be exacerbated as in many cases these thin markets are unlikely to resolve naturally under the current market conditions.⁸⁴

Recommendation eight

The Intermediary should establish a global Community of Practice, most notably with Māori organisations from New Zealand and First Nations organisations from Canada to share learnings and accelerate sector development.

If Australia’s disability services sector is to be world class, it must consider the existing progress made by our First Nations brothers and sisters globally. We need to know what worked and what didn’t, in doing so we have an opportunity to ambitiously position Australia as a leading example of best-practice First Nations disability support. The Community of Practice is an important step to ensuring we are leveraging global lessons learnt.

In practice this would require regular meetings between the Intermediary Body and representatives of each international First Nations partner. Learnings would be shared and, with permission, documented to build a durable database of First Nations designed solutions. This database will inspire innovative policy design in Australia and increase the evidence base for First Nations designed solutions for First Nations recipients of support across several sectors.

New Zealand

Some Māori provider organisations offer services for Māori and non-Māori disabled people using a kaupapa Māori approach⁸⁵. As New Zealand’s Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and

disability sector to achieve the best health outcomes for Māori. The Ministry of Health is also working with the wider health and social sectors to develop a Māori Health Action Plan that enables a more concerted and collective approach to implementing He Korowai Oranga. The Action Plan is set to be an important tool prompting collaboration to address health inequities, while delivering high-quality and effective services that support Māori aspirations for health and wellbeing.

Canada

The Assembly of First Nations (AFN) has been gathering the views of First Nations persons with disabilities (FNPWD), First Nations governments and others on distinct First Nations accessibility / disability legislation. The Government of Canada led an engagement with Canadians in 2016-2018 to develop the Accessible Canada Act.⁸⁶ In parallel, the AFN engaged with FNPWD and First Nations governments, among others on AFN mandated work in building distinct First Nations accessibility legislation. The AFN has undertaken several activities to engage FNPWD and First Nations governments to inform distinct First Nations accessibility legislation, including several surveys, workshops on cross-cutting issues, and key informant interviews. On-going engagement with First Nations includes discussions on the following themes: employment, procurement, service delivery, transport, the built environment, information, communications and / or themes identified by First Nations.⁸⁷

Supporting recommendations - Community level capacity building

We heard:

- First Nations Community Controlled (ACCOs) and Health Organisations (ACCHOs) frequently deliver disability services with inadequate funding and resourcing
- Partnerships and shared service delivery arrangements between First Nations and non-Indigenous organisations are often transactional and usually favour the non-Indigenous organisation; whereby First Nations organisations are used as a ‘foot in the door’
- In regional and remote areas, disability services are often delivered by Allied health providers who aren’t disability specialists due to thin markets in disability service delivery. These services are often inadequate and at times culturally inappropriate
- The sector stressed that First Nations people with disability have a right to remain on Country and have access to the essential services they require.

Recommendation nine

The NDIS Workforce Plan 2021-2025 should be revised to include the unique strategies required for the acceleration and growth of a First Nations disability workforce.

Under the NDIS there is a significant lack of both diversity within the workforce and the provision of culturally safe services. When First Nations people with disability are unwilling to access NDIS support, they source support from family, community, and unfunded First Nations-focused providers. The lack of diversity or culturally safe disability support services has directly contributed to the overwhelming of the community-controlled disability sector.

The current NDIS workforce plan recognises the importance of diverse backgrounds and experiences in the workforce to support choice and control for participants, particularly for First Nations people. It is acknowledged in the plan that there are unique challenges for First Nations workforce growth and the community-controlled sector, but these challenges are not elaborated on in detail, nor is the impact projected by the plan.⁸⁸

Commitments must be strengthened to support the workforce, both First Nations and non-Indigenous people who work in the First Nations disability sector. A First Nations disability workforce strategy, with deliberate goals for growth, would include both increase the number of First Nations people, and culturally competent non-Indigenous people within the First Nations disability sector⁸⁹. To do so, the renewed NDIS workforce plan must address systemic barriers to workforce participation such as education, location, digital exclusion, discrimination, and lack of cultural safety. The community-controlled sector and First Nations academics have researched extensively in this area.⁹⁰

Revision of workforce strategies should also look at the supports needed for First Nations people with disability to successfully participate in the disability workforce. Existing workforce plans do not appropriately address the intersection between disability and Indigeneity, or the barriers that accompany this intersection. Such barriers include instances of ableism, racism, accessibility issues, and services or organisations who, at times, inappropriately speak on behalf of First Nations people with disability.⁹¹

The expected benefits of goals for growth of a First Nations disability workforce strategy would include:

- Increased representation within the sector
- More culturally safe service provision
- Career pathways that suit the unique needs of First Nations people and breakdown systemic educational and employment barriers
- Increased financial capacity building of regional and remote communities, encouraging employment on country, for community.

Recommendation ten

The Australian Government, in collaboration with the Intermediary Body, should implement strategies to increase the First Nations disability workforce by 13,000 workers by 2031 to meet forecast demand.

Currently, the workforce moves between sectors and workers are being pulled back and forth between areas such as aged care and health. The challenge is made greater by competition from other fast-growing care sectors in health and aged care who will also be looking to find new workers to meet growing demand over time. Priorities for growing the disability support workforce should focus on strategies and incentives to attract new workers into the sector from all sectors of the labour market (including both the previously mentioned sectors, and other industries in which transferable skills can be applied in the disability sector), as well as capacity building across the whole support sector.

Attraction relates to both attraction of First Nations people to the disability sector, and non-Indigenous people to First Nations disability work. Both approaches are needed to create capacity and capability uplift in the sector.

Organisations such as the National Aboriginal Community Controlled Health Organisation (NACCHO) have outlined information campaigns and engagement strategies for use in a First Nations context which should be explored for adaptation to potential disability workers on a national and local level.⁹² Previously funded projects have developed allied health workforces in remote communities where there has been critical need and interest in creating a locally based, culturally safe health care workforce,⁹³ indicating the potential success that these programs can have. These initiatives further validate past recommendations made to fund the community-controlled sector to lead the development of the disability services workforces.⁹⁴ Many of these healthcare workers participate in both the health and disability sectors, especially where thin markets exist.

Recommendation eleven

The Intermediary Body, in partnership with the Aboriginal Community Controlled Organisations, should establish a First Nations disability workers hub which is nationally managed but regionally implemented. It will facilitate support groups, networking, and mentoring programs among First Nations disability workers both within Aboriginal Community Controlled Organisations and within non-Indigenous organisations.

High workloads, understaffing and unpaid work tasks have resulted in disability workers frequently experiencing burn out and fatigue.⁹⁵ There needs to be mechanisms in place which aim to combat burn out through mentorship programs, stress management and peer support which is culturally safe.⁹⁶ This is particularly important for very remote areas, where 59% of the disability workforce identifies as First Nations people.⁹⁷

Culturally safe networks are equally crucial for First Nations workers within non-Indigenous organisations. These individuals have frequently reported burn out and isolation from being a community spokesperson or bank for cultural knowledge and may not have other First Nations colleagues within the organisation for support.⁹⁸ Many Aboriginal Community Controlled Organisations and First Nations led programs have mechanisms which allow First Nations people with disability to come together and connect. Similar programs for the workforce would be an effective tool for coping with workplace burnout and fatigue and should be utilised on a national level as a part of best practice for worker wellbeing.

Recommendation twelve

The NDIA, in partnership with the Intermediary Body and Aboriginal Community Controlled Organisations, should design and develop guidance on best practice formal partnerships and engagement between First Nations and non-Indigenous providers and create an identifier for those businesses who meet the guidelines.

During the community consultations, it was made clear that relationships between First Nations-focused providers and non-Indigenous providers are not based on net benefits, are unregulated and most often favour non-Indigenous providers. All partnerships that are entered into between First Nations organisations and non-Indigenous organisations should be guided by international best practice principles, frameworks, and standards.

Like the Prime Minister's Veteran Employer Program⁹⁹ or Supply Nation business registry, First Nations 'friendly' non-Indigenous providers that meet the best practice guidelines should be eligible for a status that denotes them as such- with an option to link to funding and procurement opportunities.

First Nations specific best practices to guide partnerships include:

- Engaging in good faith negotiations to obtain and maintain free, prior, and informed consent
- Respectfully engaging with First Nations organisations to reach ethical, mutually beneficial agreements, ways of working and values-based partnerships
- Recognise and incorporate Indigenous knowledge and ways of working during internal operations and service provision
- Support First Nations organisations over the long-term through reasonable benefit-sharing provisions
- Set transparent targets and KPIs with accountability mechanisms
- Openly disclose the risks, approaches, policies, and governance relating to the First Nations organisations and Indigenous peoples more broadly

- Build ongoing engagement and co-design activities between organisations regarding policies and risk management frameworks
- Mandated cultural training for all non-Indigenous organisations who are entering into arrangements with First Nations organisations
- Provide transparent and usable dispute resolution and grievance mechanisms for First Nations people.

Recommendation thirteen

The NDIA should, in partnership with First Nations communities, academics and professionals, define and regulate the attitudes, skills and behaviours which encompass a culturally safe, competent, and trauma-informed approach to First Nations health and disability. This agreed standard should be upheld by all registered providers and used as a guideline for providers outside of the NDIS.

These definitions should be enforced by the NDIS Quality and Safeguards Commission, through levers proposed in other recommendations in this report.

Culturally safe and competent approach

There is an urgent need for services and providers to be appropriately informed and trained in what it means to create and maintain a culturally safe space, and how to engage and flexibly work with First Nations communities. Additionally, in the development of culturally safe spaces there should be education around power imbalances, stigma, and discrimination which aims to inform workers on how to recognise different power dynamics and identify their own biases in any situation, as well as that which may arise in system processes.

It was echoed in consultations with organisations that the terms ‘cultural safety’ and ‘cultural competency’ need to be clearly defined so that use of these terms by organisations accurately describe the services being delivered. There should be a standardised and regulated definition of cultural safety and cultural competency which is comprehensive in its capability requirements. Several models of cultural safety have been discussed in literature over the last two decades which should be further explored when defining the standards necessary across the Disability Sector¹⁰⁰. These definitions should be informed by, and integrate, the NDIS Quality and Safeguards Commission’s “Identity Capabilities” within their 2021 Capability Framework¹⁰¹ to contribute to an explicitly stated standard for cultural safety. Additionally, these definitions should be formally integrated into the requirements of nationally endorsed training, thereby embedding consistent understanding of key concepts across both disability support and related sectors.

There have been several models discussed in the literature review which should be further explored when defining the necessary standards for cultural competency and cultural safety across the Disability Sector.¹⁰² These should also be leveraged to inform a regulated standard for cultural safety.

In defining the attitudes, skills and behaviours which encompass First Nations cultural competency and cultural safety, it is imperative to recognise that each community has unique cultural needs. By taking a singular approach to cultural competency, the NDIS would be further isolating First Nations communities. Importantly, it must be recognised that culturally safe environments are as important for workers as they are for participants.

Any expectations or requirements of cultural competency definitions (or subsequent training) should be flexible in their approach but ultimately achieve the same goal; providing culturally safe services to First Nations peoples on their terms, guided by First Nations representatives, and regularly reassessed for appropriateness.

Trauma-informed approach

Cultural safety cannot be fully achieved without trauma-informed understanding and approaches. Through consultation, it was acknowledged that 'trauma informed' is a term that is frequently misused and needs a defined standard for organisations in the sector to meet. Though there is trauma that may exist within the disability sector generally, there should be standardised education around approaches to trauma which is experienced specifically by First Nations communities, and which is associated with historically related social and systemic violence. It should be recognised that cultural safety cannot be fully achieved without trauma informed approaches embedded within service provision.¹⁰³

The NDIA should, in partnership, define and regulate the attitudes, skills and behaviours which encompass a trauma informed approach to First Nations health and disability. This agreed standard should be upheld by all registered providers and used as a guideline for providers outside of the NDIS.

A trauma informed approach to First Nations health and disability would create a disability service sector that is culturally sensitive. This would be achieved through compulsory education programs for all service providers around systemic, social, and historical causes of trauma within First Nations communities. Educational programs would be a regulated standard which is expected to be upheld by all registered providers and used as a guideline for providers outside of the NDIS. These standards would be designed alongside First Nations communities. Existing First Nations led trauma healing programs operate currently around the country,¹⁰⁴ and these should be explored when looking at models for approaches to trauma in community.¹⁰⁵

Examples of considerations made for a First Nations trauma approach to disability services should include:

- Establishing language surrounding disability which is appropriate in a First Nations context and avoids using harmful labels
- Creating structures for First Nations people with disability to articulate their aspirations of empowerment, self-determination, inclusion and belonging and how this contrasts with their current circumstances

- Establishment of data sovereignty practices for service providers who are secondary custodians to testimonies of violence who have an ethical responsibility to respect the personal dignity of the person affected, whilst maintaining integrity to the ‘truth-telling’ that they have been trusted with
- Consideration of attachment disruption, physical and behavioural manifestations of trauma and healing cycles of intergenerational trauma across individual family and collective levels.

Recommendation fourteen

The NDIA should form partnerships with ACCOs and regional tertiary institutions to offer flexible course options for disability support accreditations which form pathways to becoming a registered NDIS provider- including those already providing unfunded and unqualified support.

Our literature review and qualitative data highlights pressure points impacting First Nations students from completing their training in the disability sector.¹⁰⁶ It was made clear during the community consultations that First Nations people have varying degrees of access to public facilities, technology, and affordable transport options. In addition, many potential students are already providing unfunded and unqualified disability support to family and community members limiting the time available to commit to study.

A key focus in achieving workforce growth is providing opportunities for people in the community who are unofficially acting in the role of a support coordinator or support worker, to become accredited and paid for their work. This will immediately ‘increase’ participation, by highlighting the current unpaid workforce.

For First Nations people with disability, additional considerations to assist in overcoming systemic and accessibility barriers to educational spaces and workplaces is essential for meaningful workforce participation. Systemic barriers¹⁰⁷ include ableism, racism, issues with accessibility, and services or organisations who, at times, inappropriately speaking on behalf of First Nations people with disability.¹⁰⁸

Qualification pathways have been piloted by several Community Controlled Organisations in recent years who have partnered with schools and tertiary institutions to introduce possible education and career pathways in disability, health, and other related areas.¹⁰⁹ These pathways can be used in both First Nations and non-Indigenous contexts to increase pipelines for workforce capacity in disability. Existing pathways and organisations should be considered when examining the possibility for leveraging programs which have cultivated meaningful relationships with service providers and tertiary institutions around the country, as these pipelines need to ensure connection to relevant industry jobs which have the potential for skill and career development.¹¹⁰

Crucial to these opportunities are flexible learning options which include access to online courses, so individuals do not have to relocate to obtain a qualification- this is especially important for those living in rural, remote, and very remote locations.

Fundamental to accreditation, flexible training and up-skilling opportunities is the funding and infrastructure to support individuals in rural, remote, and very remote areas. Additionally, rapid digital literacy courses are necessary to ensure people in remote communities can confidently undertake online courses and communicate virtually. Local Aboriginal Land Councils or ACCOs may be appropriate hosts for study spaces equipped with the necessary technology for remote learning. Inter-sector learning hubs can assist remote course participation across multiple areas in an environment that is culturally safe. Utilisation of these existing structures was highlighted repeatedly by organisations in consultation and has been seen consistently in the literature as a sustainable source for disability workforce growth.¹¹¹

It is important to recognise that those who do choose to leave community for education or accreditation opportunities (where local facilitation is not possible) also need to be supported at the institutions they attend. Networks with other First Nations students, mentors and workers within the industry is an essential element which needs to be considered to avoid feelings of isolation and to ensure culturally safe support.

Recommendation fifteen

The NDIA should block fund Aboriginal Community Controlled Organisations to deliver educational programs which aim to inform First Nations communities about careers in the disability sector, including possible pathways, accreditation options and career entry points.

There should be an active effort in cultivating interest in the sector from First Nations people, to grow capacity and enhance cultural safety of the sector. Culturally safe First Nations designed educational programs should be delivered by the community-controlled sector. Each program should specify types of roles available for employment, how to apply for them, and the benefits of growing the First Nations disability workforce. This includes information about advisory bodies, advocacy bodies, engagement officers, support coordinators, support workers and Community Connectors. Targeted recruitment may focus on groups such as school leavers, older workers, or contract/transitional workers.¹¹²

Part of this work should also include efforts to address negative associations around the NDIS and to convey the benefit of having First Nations people embedded in the process.

Recommendation sixteen

The Intermediary, in partnership with the NDIA and industry should design and deploy a professional and capability development program to support community organisations with the skills to manage increased inflows of capital from the First Nations Disability Economic Development Policy.

In parallel to the establishment of a First Nations Disability Development Policy, professional development support must be available to service providers to sustainably manage the expected influx of capital and to be able to grow their organisations sustainably. The development program will ensure that all First Nations organisations who are beneficiaries of the First Nations Disability Economic Development Policy are able to achieve sustainability, maturity, and their aspirations.

This could be designed and delivered in many forms; the Intermediary body being responsible for design and delivery, or a mixed model of delivery whereby service providers partner with an educational institution who offer similar existing services.

Like Supply Nation supported First Nations business procurement,¹¹³ the First Nations Disability sector requires a dedicated capability uplift program¹¹⁴. While this may be coordinated by the Intermediary, it must be adequately funded and supported to ensure that Indigenous owned and managed providers can maximise the investment into the sector.

A capability development program that would adequately support service providers to manage larger inflows of capital, would need to provide training to providers. Some examples of training outcomes may include:

- Development and implementation of a First Nations tailored workforce plan
- Establishment of governance mechanisms to oversee the use of funds attained
- Establishment of transparency controls to document all investment of funds and associated value creation to guide future decision-making processes
- Identification of investment opportunities and assessment of their ability to provide tangible benefits to First Nations communities.¹¹⁵

Supporting recommendations | Implementation of culturally safe services

We heard:

- Non-Indigenous providers are more likely to deliver culturally inappropriate services to First Nations people with disability, and are less culturally informed about individual and community needs
- The ongoing legacy of historical and systemic trauma is compounding for First Nations people with Disability and manifests differently in the sector
- There are deep concerns over the lack of representation of the voice of First Nations people with disability in the sector
- First Nations people with disability often feel invisible in the system
- There is a need across the sector to support First Nations people to identify disability in the community
- First Nations People with deafness do not identify as disabled but must fit regulatory definitions to access services- which often misunderstand their cultural and physical needs.

Recommendation seventeen

The Community Connector should deliver NDIA assessments in person, in a culturally safe way in community, especially in regional, remote, and very remote areas.

The current NDIS has been designed based on a Western view; with three dimensions of disability:¹¹⁶



1. Impairment in a person's body structure or function, or mental functioning; examples of impairments include loss of a limb, loss of vision or memory loss
2. Activity limitation, such as difficulty seeing, hearing, walking, or problem solving
3. Participation restrictions in normal daily activities, such as working, engaging in social and recreational activities, and obtaining health care and preventive services.

Whilst some First Nations languages have words for specific impairments, there is no known word for disability in any First Nations language. First Nations people with 'impairments' are not separated from the rest of the community for their differences. They are treated and cared for no differently from the other members of their cultural group; some general features of the First Nations perception of disability are described below.¹¹⁷



- Independence may not be seen as a major issue in some indigenous communities
- Disability may be viewed as a family or community problem rather than a personal one
- Indigenous people with disability are generally not excluded from their communities
- Some disabilities may be seen as 'payback' for a past wrongdoing, or as something special
- Some people with severe disabilities may be seen as the responsibility of welfare.

The NDIA has attempted to identify, evaluate, and select the most appropriate tools for independent assessments, however the current diagnostic tools used have been designed based on non-Indigenous understanding of disability. Currently, an individual meets the NDIS disability requirements if they have evidence of all the following:¹¹⁸



1. The disability is caused by an impairment,
2. The disability is likely to be permanent, and;
3. The permanent impairment suitably reduces the functional capacity of an individual to undertake one or more of the following activities: moving around, communicating, socialising, learning, or undertaking self-care or self-management tasks

To receive supports, the individual must prove that they are an Australian citizen, permanent resident, or Protected Special Category Visa holder and live in Australia. This is accompanied by several questions pertaining to their 'treating professional's information', 'evidence of disability', 'disability requirements', 'early intervention requirements', and 'evidence of functional capacity'.

The NDIS application process is not suitable for First Nations people for several reasons, including:

- The documents are in English, and while can be translated to other languages, these often don't include First Nations languages
- They use harmful labelling that may be problematic for some First Nations people (see Recommendation nineteen)
- Individuals are asked to provide evidence for their disability, which is not a term that is used in a First Nations context and individuals likely don't identify with. This can be a distressing process for some individuals. Additionally, many individuals do not have a previous history of working with health professionals and therefore access to existing bodies of documentation. To provide such evidence, individuals are required to undergo additional processes, which ultimately delays the time in which it takes to start receiving support; and
- Within the current application process there is currently no recognition or opportunity to understand unique cultural needs of the First Nations individual. The extent to which they can communicate these needs is by ticking a box to indicate that they are of First Nation origin.

The misalignment between the colonial definition of disability and the First Nations approach to disability is a barrier for all First Nations people trying to access support under the NDIS. To remove this barrier, in a culturally appropriate way, the Community Connector must conduct the NDIS assessment in person, when requested by the participant. The Community Connector will frame the assessment as a 'need for support' rather than a disability whereby an individual's specific needs are identified, and treatment is provided accordingly. This removes exposure to the harmful labelling within the NDIS application. The burden of navigating complex systems is then the responsibility of the Community Connector, if requested, rather than putting the burden on the individual with disability.

As their responsibilities as Community Connector go beyond assessments, as such they will have existing safe and reliable relationships with their local First Nations Communities. By providing First Nations people with access to this service on Country, the assessment process would be more culturally safe, be delivered in the appropriate local language and would acknowledge the First Nations approach to disability. This would also facilitate assessments occurring in the context of the community and acute needs arising from isolation/remoteness can be properly understood.

Providing services on a needs-basis avoids harmful labelling and includes those that do not identify as disabled but do require support (e.g., people with deafness do not identify as disabled however they do require support). The Community Connector will translate this information into NDIS assessment applications to avoid any risks of First Nations NDIS candidates not meeting colonial diagnostic criteria.

FPDN have developed resources that use the traditional method of art and storytelling to assist First Nations people with disability to identify areas of their life that they need assistance with; The Our Way Planning Resource.¹¹⁹ This resource should be leveraged to identify the needs and appropriate service providers for First Nations people with disability under the NDIS. While the NDIA has attempted to identify, evaluate, and select the most appropriate tools for independent assessments,¹²⁰ the system remains to be colonial; it is the responsibility of the Community Connector to bridge this gap on the ground- but they must be supported by adequate funding, resources, and policy.

Recommendation eighteen

The NDIA should, as a condition of commissioning and procurement for the provision of services to First Nations people with disability, mandate cultural safety training for all non-Indigenous disability service providers.

NDIS service providers are working closely with First Nations people in several contexts: within their organisations, working alongside other organisations and / or providing services to First Nations people with disability. Non-Indigenous providers must be equipped with the knowledge and resources to establish and maintain a culturally safe workplace and delivery options. In addition, this training may form part of a pre-requisite for receiving funding or other status.

The NDIS Quality and Safeguards' Capability Framework¹²¹ provides an in-depth guide to the attitudes, skills, behaviours, and knowledge that should accompany support for First Nations people, but this is not practically implemented in many organisations.

Cultural competency training must:

1. Be face to face where possible
2. Nationally aligned, but locally designed and delivered
3. Create a workforce that values diversity and differences and is self-aware of the impacts of their actions to their patients
4. Break down communication barriers within organisations which increases efficiencies and employee satisfaction at work
5. Break down communication barriers between individuals with disability and their service providers to create an environment where First Nations people's feel comfortable to raise concerns and opinions safely; supporting autonomy and self-determination
6. Foster mutual trust between co-workers, service providers and individuals.

When considering cultural competency training, it is important to note the perception of a unified 'Indigenous culture' is harmful and perpetuated in some extant cultural awareness training models. A false sense of cultural knowledge may create incorrect biases about the people being cared for. Training should be region specific and focus on cultural safety rather than awareness – focusing on the power relations that shape disability support relationships. Cultural safety training explicitly works to effect systemic change by exposing and confronting the discourses and assumptions that are used by the dominant disability structures and systems and leads to better training outcomes.¹²²

There are existing providers of cultural competence training (both national and regional) that should be leveraged to provide this service. It should also be noted that a cultural competence training program delivered by First Nations people with disability would further ensure the cultural competence training is relevant, honest, and targeted. FPDN is the current national best practice option for defining a national and regional approach to cultural training, however regulation of this training should be overseen by the NDIS Quality and Safeguards Commission.

Cultural training cannot make a meaningful contribution to the health of Indigenous Australians while it remains situated within the models that produce the very chasm it intends to bridge. By shifting the focus of training away from trying to teach about 'Indigenous culture', toward examining processes of power imbalance and identify, a cultural safety model appears to be out best option for delivering Indigenous cultural training that will produce lasting change among health staff and systems.

- *Downing, Kowal and Paradies, 2011*

Supporting recommendations - Reporting and accountability

We heard:

- Insufficient accountability and ownership across the sector are resulting in First Nations people falling through the gaps between complex sector interfaces
- There is no national framework guiding quality and assurance and cultural safety; nor is their enforced quality and safety standards embedded in service delivery requirements. There is no benchmark for cultural accountability and cultural training across the disability sector
- The sector spoke to the lack of First Nations representation and input into the NDIS Quality and Safeguards Commission to support and advocate for First Nations people with disability
- Current mandatory reporting is time consuming and places further resourcing pressure on First Nations service delivery organisations
- Limited and unregulated quality and safety standards across non-Indigenous disability service providers present challenges First Nations people with disability and the level of care they're provided
- First Nations people's NDIS plans are underutilised due to thin markets or unavailability of culturally appropriate services
- NDIS reporting requirements place compounding pressure on Aboriginal Community Controlled Organisations.

Recommendation nineteen

The NDIS Quality and Safeguards Commission should appoint a First Nations Disability Commissioner (mandated identified position).

To improve the Quality and Safeguards Commission's ability to appropriately handle First Nations complaints and issues, wherever possible it is important to employ, work with, and seek guidance and advice from First Nations people. A First Nations Commissioner would understand the importance of culture, country, history, community, and family to First Nations people across Australia. A First Nations Commissioner would increase innovation, engagement, and cultural sensitivity within the NDIA, and ensure tangible benefits for all First Nations people with disability are at the forefront of all NDIA decision making processes.

The role of the First Nations Commissioner would be to regulate NDIS providers, provide national consistency from a First Nations perspective, promote safety and quality service, resolve problems, and identify areas for improvement in a First Nations context within the NDIS. The First Nations Commissioner would revise the NDIS Quality and Safeguarding Framework¹²³ to include First Nations specific was of working, service delivery, cultural competence requirements and First Nations specific financial mechanisms. They would also play a key liaison role with the Intermediary to oversee decision making processes, policy reform, quality assurance and transparency measures.

Recommendation twenty

Federal and jurisdictional governments should invest in a First Nations Community Controlled Disability Research and Data Agenda, as outlined by First Peoples Disability Network.

It is acknowledged by practitioners and academics that extant research and data infrastructure and frameworks do not accurately nor adequately capture First Nations people's experience and perspectives with disability.¹²⁴ Our community consultations ratified that this reporting gap translates to underfunding of services, misunderstanding of needs and available support and contributes to racial inequity in the disability sector.

FPDN have previously outlined the framework for a culturally inclusive First Nations Disability Data Strategy, including a Culture is Inclusion Research Agenda¹²⁵. This will not only address the local needs of providers and their participants, but also provide an accurate local and national data story to assist in meaningful sector reform. Collecting accurate and timely data will lead to more holistic strengthening of related reforms including Closing the Gap and Australia's Disability Strategy Data improvement plan.

It is important to ensure that an increase in quality data collection does not translate to an increased reporting burden for already stretched First Nations-focused providers. Additionally, the data must not create a perception of additional surveillance and distort data sovereignty principles and rights. Uplifting existing digital data will assist in this.

Recommendation twenty-one

In the next revision of the Commonwealth Implementation Plan for the Closing the Gap Target, outcomes should explicitly include First Nations people with disability.

The first Commonwealth Closing the Gap Implementation Plan sets a foundation for the Commonwealth's efforts in achieving the targets in the National Agreement over the coming decade. The Plan provides an overview of the Commonwealth's existing actions that contribute to Closing the Gap as well as new investment and areas of future work.¹²⁶ It does not, however, specify any targets relating to First Nations people with disability. There are several outcomes and targets¹²⁷ that may impact First Nations people with disability, but none of these outcomes and targets include First Nations people explicitly. Instead, the National Agreement includes the commitment that, 'where available and appropriate, data against targets and outcomes will be disaggregated by disability, gender, and age to understand whether actions being taken are addressing the needs of these groups.'¹²⁸

There are several actions being taken to ensure that investments under each of the socio-economic targets are inclusive, accessible, equitable for First Nations people with disability, and meet Closing the Gap targets.¹²⁹ These should be explicitly included and monitored in the Commonwealth Implementation Plan.¹³⁰ The plan holds significant weight and will ensure measured, tangible, and lasting change for the disability services sector.

Recommendation twenty-two

The First Nations NDIS Quality and Safeguards Commissioner, in partnership, should design a National Quality Assurance and Cultural Framework to guide sector development and to clearly define quality and safety standards.

The NDIS has potential to produce major benefits for people with disability, their families, and the broader community. A NDIS Quality and Safeguarding Framework is needed to ensure that capability is built in the new market-based system, the rights of people with disability are upheld, and the benefits of the NDIS are realised. In addition to advancing the rights of people with disability, a National Quality and Safeguarding Framework is required to support choice and control in the NDIS by empowering individuals and driving quality improvement. Choice and control also mean that participants can make decisions about the level of risk they are prepared to take and have the tools and information they require to make informed judgements about the quality and suitability of providers.

Implementation will require a consistent national approach to quality and safeguarding. It would be the responsibility of the Commissioner, alongside the Intermediary (and in partnership with the Q&SC), to establish and govern accountability mechanisms of service providers and their staff in relation to their First Nations tailored service delivery model.

'We need to build a quality assurance framework that is led by First Nations people with disability. We need to ensure as the [First Nations disability] sector expands, we need to ensure quality of services remains and people aren't exposed to harm.'

- First Nations Academic

6 Implementation Roadmap

To ensure momentum is maintained a phased approach (Figure 68, below) breaks down the twenty-three recommendations into three manageable themes; pre-establishment of the Intermediary Body, establishing of the Intermediary Body, and Intermediary Body is established.

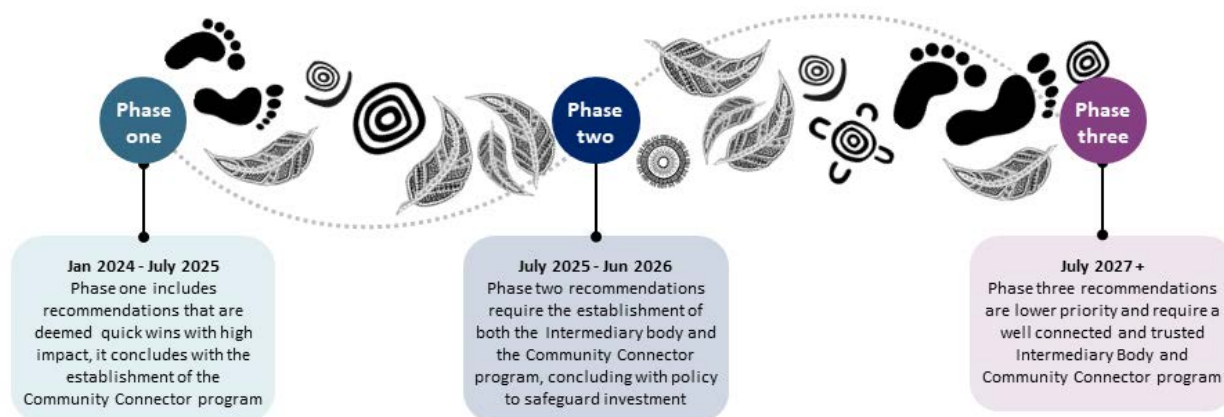


Figure 68. Phases of the Implementation Roadmap (Deloitte, 2022)

Figure 69, below expands on these phases further, identifying the key owner and cost of each recommendation. Appendix C provides more detail of each implementation phase.

At this stage the costs associated with each recommendation are uncertain. Detailed policy design work is required before precise costings are possible. There are also likely to be synergies and efficiencies associated with implementing a package of measures together, rather than separately.

Here we indicate the annual cost of each recommendation as either low (less than \$40 million), medium (between \$40 million and \$100 million) or high (greater than \$100 million), where these ranges represent our assessment of costs in real terms measured based on 2022-23 prices.

All costs would be in addition to funding under current arrangements

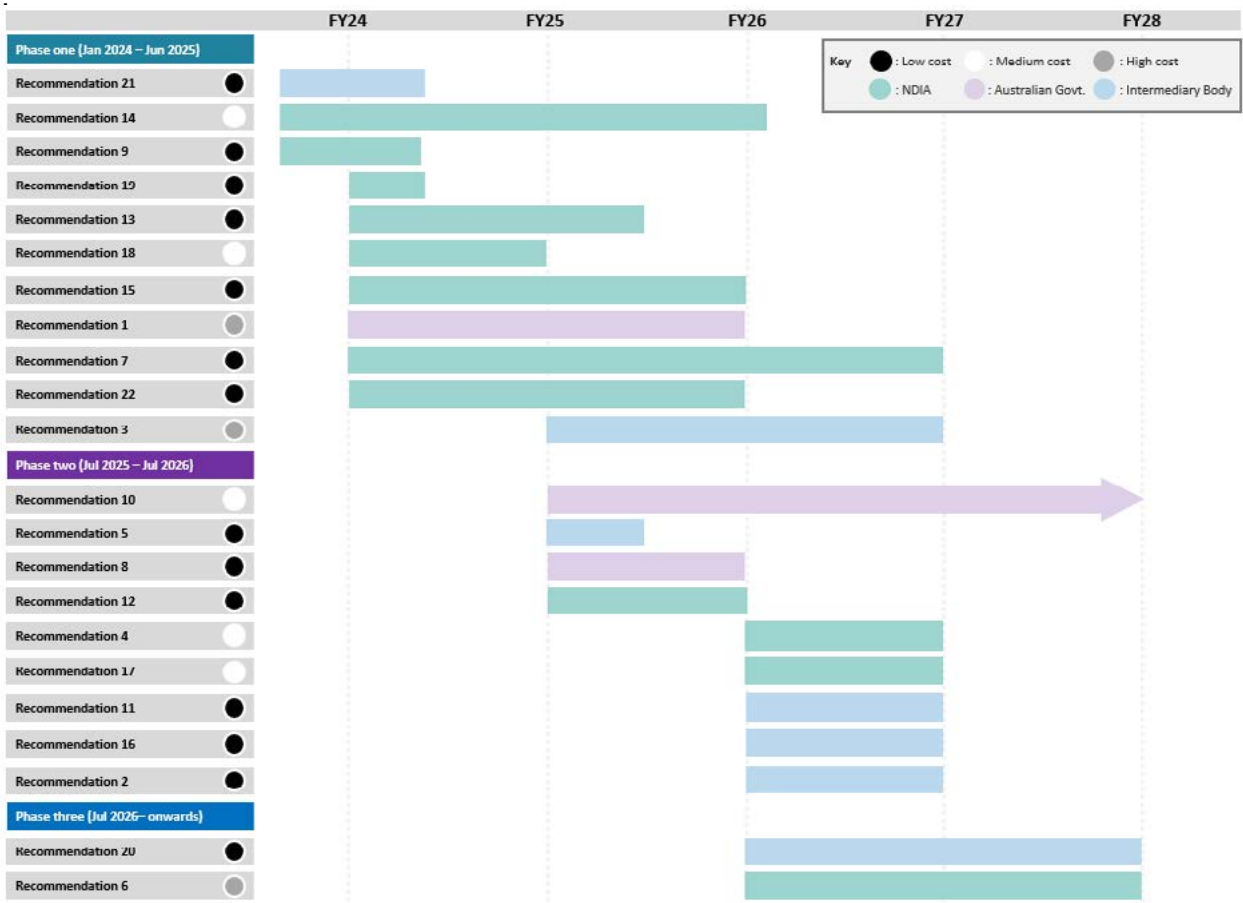


Figure 69. Implementation roadmap for recommendations (Deloitte, 2022)

7 Conclusion

Australia's current lack of availability, accessibility, and the effectiveness of culturally appropriate services for First Nations people with disability is a **time sensitive national crisis**.

Building on the existing findings from 'what we heard' during consultations within the First Nations disability sector and the data analysis of current and future state of demand for services, workforce and supply Deloitte has evidenced an existing overwhelmed disability services sector. This sector is unable to provide services with the qualifications, quality and cultural safety standards in the numbers and locations required. This is compounding with every year that the NDIS and the Australian Government fail to listen to the voices that are speaking against this system.

Deloitte has proposed several options for reform, each is of critical importance for the Disability Royal Commission. The recommendations have defined responsibilities and mechanisms at sector interfaces to cultivate holistic services and models of support. Sector reform has been designed to see decentralised execution of service delivery across states and territories, while enhancing regional governance to empower decisions to be made by local people through a centralised voice.

Various recommendations have been specifically designed to recognise and empower ACCOs and ACCHOs for the crucial role they play both in disability and across community wellbeing more broadly. Where the disability services sector is being upheld by the unrecognised contribution of ACCOs and ACCHOs, the recommendations will address the root cause of this - thin markets. Through the implementation of Deloitte's recommendations, the sector will develop more competitive markets which are upheld by a diverse and appropriately trained workforce.

The recommendations address First Nations people with disability's long-standing ambition to fulfil self-determination and agency over their lives and their affairs by creating easy access to appropriate resources and providing them a 'seat at the table' in all stages of their support.

The recommendations facilitate alignment between the current NDIS funding mechanisms and the nature of support for First Nations people with disability in their communities require. Cross sector collaboration is crucial to providing not only services that address the full suite of needs of each individual but consider a First Nations way of care giving.

7.1 What's next?

We call on the Australian Government and the NDIA to action all the recommendations that are outlined within this report as outlined in the implementation timeline.

The abovementioned recommendations create the concrete foundations for disability service sector reform; a great opportunity exists to change the lives of all First Nations people with disability across the whole of Australia. The NDIS is uniquely positioned to provides an important mechanism to facilitate this reform. The focus of efforts moving forward will require leveraging all available mechanisms to build capacity and capability across the First Nations disability sector.

8 Reliances and Limitations

This report is subject to important reliances and limitations which are set out below.

This report is prepared solely and confidentially for the use of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability only, under the contract between Deloitte and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Without the context of this relationship, our report may be misinterpreted by other parties. We accept no duty of care to any other person or entity. Our report should not be disclosed to any other party nor quoted, referred to or cited in any material without prior discussion with us.

In carrying out our modelling and analyses, we sourced data directly from the National Disability Insurance Agency and the Department of Social Services and sourced publicly available information. We have relied on the accuracy and completeness of this data in arriving at the results of our analyses. While we have conducted reasonableness checks regarding the accuracy of the information, we have not independently verified it. We are reliant on the accuracy and completeness of information provided by both agencies. If for any reason, there is any material error or omission in the information provided or obtained, then this may materially impact our conclusions.

A request was made for the disability services National Minimum Dataset from the Australian Institute of Health and Welfare, but this data could not be provided in time to be included in our analysis.

Our observations in this report on disability services refer only to those services under the NDIS or as part of the DES program we have not analysed other programs or sources of disability support.

Deloitte's analysis using the NDIS and DES datasets provided to us for this project is limited in time and scope. We have undertaken the following limited reasonableness checks:

- High level comparisons against published statistics
- checks on summaries of data fields against our expectations
- checks on missing values.

We have not and it should not be construed that we have completed a quality assurance process of data provided.

It is not possible to quantify future population; participation rates and costs changes for the disabled population with certainty. The estimation of changes in the industry is inherently imprecise, particularly in view of limited data availability and performing a projection over a period using a limited model of the industry. Although we have prepared estimates in conformity with what we believe to be the likely future experience, there is the potential for the experience to vary considerably from our estimates. Deviations are normal and to be expected. While due

care has been taken in preparation of this analysis, Deloitte therefore accepts no responsibility for any action which may be taken based on these results.

The purpose of this report is outlined in the Introduction of this Report. It is not intended for any other purpose. The report should be considered. Deloitte is available to answer any queries, and the reader should seek such advice before drawing conclusions on any issue in doubt.

8.1 Data sources and key assumptions

The Disability Royal Commission obtained administrative data from the NDIA for NDIS data and DSS for the DES program for the period 1 January 2016 to 31 December 2021. This included actual claims data and participant demographics for both programs. For the NDIS, committed support data at the participant level was also supplied.

Data from the Disability Services National Minimum Dataset was not provided in time to be included in our analysis.

Further, Deloitte Access Economics produced First Nations and non-Indigenous population and disability estimates for corresponding periods under varying characteristic groups, using publicly available information from the ABS and existing modelling.

Data reasonableness

We have compared general population statistics and trends in the programs to publicly available statistics and found that they are broadly consistent and conclude that any differences would not materially change or impact the analysis. Similarly, we have performed reasonableness checks on the data where possible and found no issues of note. Our analysis is entirely reliant on the accuracy and completeness of data obtained by the Disability Royal Commission.

The datasets received from the NDIS covered quarterly periods between December 2016 to December 2021. The DSS provided quarterly DES data between March 2014 and December 2021. As we have received data on a Quarterly basis, participants in both programs who enter and exit between reporting dates are not considered. As these participants are limited in number, we expect they would have an immaterial impact on our analyses and findings.

Treatment of payments

The average payments produced in this report have been calculated as the sum of total payments in the year, divided by total participants in the year. This does not account for cases where participants do not remain on NDIS or DES programs for a full year due to data limitations. As such, we have noted average payments differ from the NDIS scheme actuary report (“PB NDIS Annual Financial Sustainability Report 2021-2022”) due to different methodology in calculating the average payment as well as small differences in total dollars

in the data when compared to the NDIS scheme actuary report. Differences include no annualisation of payments, differences in the application of NDIS membership for inclusion in the calculation and the metric reflected on a calendar year basis as opposed to a financial year basis.

Further, our analysis has been completed on a payment received basis as opposed to a basis that also makes allowance for payments yet to be received for services already received. As a result, it may be impacted by a lag between service received and payment; for example, in instances where providers conduct administrative duties at quarter/half year end. However, we do not expect this to be material in the context of our key findings and recommendations. In some circumstances, our reported claims may deviate from other sources due to this difference in definition.

In the analyses of providers, amounts paid directly to the participant is excluded. This differs from everywhere else in the report where payments to both providers and participants are used.

Average payments are used as the primary metric for analyses of demand in this report, though it should be noted that this measure reflects the services supplied under the NDIS and DES, and not the level of service demanded by people with a disability (which cannot be directly observed in the data).

Ratio of payment to committed supports

We have considered measures that reflect actual payments in a period relative to committed support plans. The metric we calculate is not directly comparable to utilisation metrics derived by the NDIA. These differences are highlighted below.

The NDIA calculations involve committed support costs being allocated according to the proportion of plan duration within each financial year, with adjustments for plan indexation. Furthermore, the NDIA confirmed that plan costs are not spread out evenly throughout a plan. The NDIA utilisation metric looks at a six-month period which ends three months before the calculation date. This means that for 31 March 2022 data, the data from 1 July 2021 to 31 December 2021 is used. Again, the committed support for the exposure period is determined by taking an allocation of funding for the plan where the effective dates overlap the exposure period on a pro-rata basis. Participants and their payment/plan data are only included in the NDIS utilisation rate metric definition if they had at least one year of experience in the scheme before the exposure period.

As the data provided to us did not contain the specific information required to index plans, a pro rata method of allocating the committed support budgets to financial years by the proportion of plan duration within said year was not applied. Furthermore, due to data availability restrictions on participant scheme entrance dates and duration within the scheme, no exclusion was applied to specifically remove “immature” participants from calculations if they had valid numbers for claims paid and the FYXXYYCommittedSupportsBdgt variable.

The budget was provided directly by the NDIA, through the 'FYXXYYCommittedSupportsBdgt' variable. The total payments made for each financial year is determined by summing the Total payments for each calendar year quarter, and then assigning each sum to its appropriate financial year. To calculations, it was assumed that each payment in a particular period was relevant for that period alone, and no pro rata allocation was applied to split payments over multiple periods. The payments for each financial year were then divided by the budget for each financial year to give proxy utilisation.

Participants with missing First Nation status or MMM remoteness were excluded from calculations.

Treatment of demographic variables

We note that there may be data collection issues, with the challenges surrounding the First Nations indicator being of particular concern. Given the self-reported nature of the participant's Indigenous status, our First Nations populations is likely to be under-reported compared to the true figure, as some First Nations people choose not to identify out of perceived threats of discrimination. Although we have attempted to address this issue by backdating any First Nations indicators (i.e., a Person who reports that they identify as First Nations for the first time in 2020 is assumed to identify as a First Nations person in 2018), our analyses on total population and participation rates are still likely to be understated.

Further we assume the participant's demographics remain static over that period and reflect the demographics recorded at the start of the period of analysis. Around 5% of the participants change demographics such as disability and locality and 10% change an age band.

Participation rates

To compare overall disability service participation, we have estimated the number of people with each combination of demographic characteristics for each year between 2016 and 2030. This projection is predominantly informed by the ABS Estimates and Projections, Aboriginal and Torres Strait Islander Australians for First Nations populations, the ABS Survey of Disability Ageing and Carers for population wide disability data and our own internal Deloitte resources for other demographics.

First Nations-focused Providers

Due to privacy considerations, the Disability Royal Commission to the extent possible, sought only de-identified Provider ID data, meaning it was not possible to identify the providers which are either First Nations led, or First Nations focused. To address this, we define First Nations-focused provider as a provider who has received at least 21% of their NDIS payments from claims related to First Nations participants. Given that First Nations participants comprise 7% of the NDIS population, a cut-off that is three times this representation has been selected to define these providers.

Results of quantitative analysis

The quantitative analysis, modelling, forecasts, and findings in the Analysis section reflect estimates derived from data which represents only a sample of the First Nations population. Like all estimates, they have inherent uncertainty. Specific notable sources of uncertainty in the analysis outlined in this report include:

1. Under-reporting of self-identified First Nations status
2. Limited sub-segment of disability sector
3. Population estimates
4. Disability prevalence
5. Statistical sources.

Our actuarial team specialise in the derivation of insights in the context of high levels of uncertainty. Quantitative analysis has been undertaken consistent with PG 1 of the Actuaries Institute by qualified actuaries experienced in analysis of the disability sector and Government and Public sector policy analysis.

Transition services

The impact of First Nations peoples experience pre- and post-transition to the NDIS was therefore not included in this analysis. Due to technical limitations, the NDIA was unable to supply NDIS data over the pre- and post-NDIS transitional period. Equally, Australian Institute of Health and Welfare (AIHW) data could not be obtained within the time limit required by the Disability Royal Commission.

We acknowledge that, as a result, this data is unable to accurately portray the complete view, although it does provide useful and critical insights into issues of accessibility and availability for First Nations people. This may mean that the projections of current and future forecasted demand underestimates or overestimates the actual demand, however, for the first time it has been possible to quantitatively model the impact of the 'gap' in accessibility and availability for First Nations people in disability services.

Appendix A: Summary of consultations

Our consultation findings have been organised into the Royal Commission's Cultural Framework, all of which are underpinned by the *Convention on the Rights of Persons with Disabilities (CRPD)* and *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)* principles.

1. Community Level Capacity Building

1.1 We heard

Aboriginal Community Controlled Organisations (ACCOs) and Aboriginal Community Controlled Health Organisations (ACCHOs) frequently deliver disability services with inadequate funding and resourcing.

- ACCOs have become the default culturally accountable disability service, as they do not turn people away, which further stretches their capacity in an already under resourced sector.
- The lack of availability of culturally appropriate mainstream disability services places further pressure on First Nations service providers.
- Community Connector Roles are not overseen with centralised coordination at a federal, state, or regional level. This is compounded by unregulated and unstandardised funding and Community Connector positions, leading to inconsistencies in benchmarked support expectations.
- ACCOs generally encourage First Nations people with disability to become registered under the NDIS, which is a lengthy and time-consuming process, which ACCOs often provide support to the individual which they aren't recognised or supported to for.

'We can't walk away from our community, but those [mainstream] NGOs can.'
- *Aboriginal Community Controlled Organisations*

'There's a real sense of resilience amongst ACCOs and ACCHOs - that is their strength, their responsibility to community.'
- *Aboriginal Community Controlled Organisation*

'There is a cultural obligation to do what you can, which means people are doing everything that they can, even if they don't have time or funding.'
- *Aboriginal Medical Service*

'There are so many flaws in the current system and it's the ACCHOs who have to pick up the slack.'
- *Aboriginal Community Controlled Health Organisation.*

1.2 We heard

Partnerships and shared service delivery arrangements between First Nations and non-First Nations organisations are often transactional and usually favour the non-First Nations organisation; whereby First Nations organisations are used as a ‘foot in the door’.

- Partnerships between mainstream disability organisations and community-based First Nations organisations are transactional and do not support community-based First Nations organisations to upskill their capacity and capability to ensure long term success or sustainability.
- Many First Nations led organisations are hesitant to partner with a mainstream organisation without a sustainable and ethical partnership.
- Organisations may receive additional funding to support First Nations people, but do not always have a duty to report adequately; in one instance, funding was provided without requiring any evidence of First Nations clients they were supporting.
- Remote First Nations disability service providers often need to create their own Registered Training Organisation (RTO) to train their workforce to minimum standards. This places intense strain on service delivery due to pre-existing capacity and workforce constraints.

‘In one instance, a profit-share for a tender response was proposed between two organisations, but the First Nations organisation cancelled the agreement as there was no shared understanding of why an ACCHO was the best organisation to deliver the requested service.’

- Aboriginal Community Controlled Organisation

1.3 We heard

In regional and remote areas, disability services are often delivered by Allied health providers who aren’t disability specialists due to thin markets in disability service delivery. These services are often inadequate and at times culturally inappropriate.

- The reliance on fly-in-fly-out disability services, allied health and specialist health care in remote communities is unsustainable for both participants and organisations and is failing to adequately provide First Nations people with appropriate levels of disability care.
- The inadequate number of specialists in regions adds another complexity for participants attempting to meet requirements in becoming registered under the NDIS. Many of the specialist assessments needed for the application process are not available or financially inaccessible.

'First Nations women (many with their own disability) often assume a support worker role they are not qualified or remunerated for. This exacerbates gender inequity and causes further harm to the community.'

- *Aboriginal Community Controlled Organisation*

'Our funding has just been cut and our clients are now expected to communicate with a mainstream organisation in the city via phone box [remote location].'

- *Aboriginal Community Controlled Organisation*

1.4 We heard

The sector stressed that First Nations people with disability have a right to remain on Country and have access to the essential services they require.

- The sector highlighted numerous examples where First Nations people are required to leave Country to access the essential services they require. This is at odds with a First Nations worldview whereby connection to Country is paramount and with the State's responsibility to provide accessible services to all citizens, including in regional areas.

'[First Nations] people should be able to remain on country.'

- *Aboriginal Community Controlled Organisation*

1.5 We heard – First Nations disability workforce

The First Nations disability workforce is ill-defined, unsupported, and not equipped to support and grow First Nations workers in the disability sector.

- Stakeholders identified the opportunity to establish regional networks of First Nations disability workers to encourage sharing of best practice training, operations, approaches to care and facilitate staff sharing arrangements when organisations need surge capacity or a specialist skill which isn't available locally.
- It was stressed that gender balance is of high importance for services provided to First Nations people but is not always present or achievable due to inadequate funding and workforce shortages.
- Minor criminal offences often inhibit First Nations people from becoming employed with State and Federal governments and under the NDIS.
- The short-term funding arrangements under the NDIS do not provide certainty to the sector around future workforce needs.

'In our discussions [with the disability sector] most issues went back to workforce and the need to invest in building a stronger one.'

- *Disability advocacy service*

'One year funding models for workforce development are inadequate.'

- *Aboriginal Community Controlled Organisation*

'Organisations need flexible funding to be able to develop and then work with the workforce, the workforce is struggling.'

- *Aboriginal Community Controlled Organisation*

1.6 We heard – First Nations disability workforce

The workforce supports provided by other sectors are an exemplar of what could be implemented in disability service delivery.

- Attracting workforce to rural and remote areas is difficult without incentives or the appropriate resources and infrastructure to support them.
- There are existing financial, and housing supports provided by other sectors (e.g., Department of Education (WA) which are sometimes leveraged informally to support the transient workforce. Stakeholders highlighted housing, relocation allowances, professional development, and concessions for working in regional and remote areas as important factors to consider when attracting disability workers to regional and remote areas.

1.7 We heard – First Nations disability workforce

Retention of staff is challenging, and the disability workforce, often being multidisciplinary, requires diverse and extensive expertise.

- ACCOs and ACCHOs are constantly stretched thin due to an obligation to provide culturally safe, holistic care to First Nations people with disability, both inside and outside of the NDIS.
- ACCOs and ACCHOs do not receive enough funding to support the workforce growth and retention they require to meet the demand they face.
- Under the NDIS, 12–18-month plans do not provide long term job security for disability workers and deters First Nations people from pursuing a career in disability service delivery.
- Staff in ACCOs and ACCHOs regularly experience burn out due to the intensity of work, shortage of staff, and lack of support systems and networks. Burn out is particularly common for First Nations staff within mainstream organisations who become overworked due to the organisation's heavy reliance on them for cultural knowledge.

-
- Geographical and technological barriers to education create difficulties for community members to upskill or enter the disability sector while remaining on Country. There is hesitation for First Nations people who want to upskill or access training but do not want to leave their community uncared for.

‘Member services are struggling with workforce and workforce retention.’

- *Peak body*

1.8 We heard – First Nations disability workforce

First Nations people with disability often receive essential yet unpaid care from family members or the broader community who may not be able to become accredited under the current NDIS arrangements.

- The sector highlighted that First Nations people with disability are often cared for by their families and communities when there are systemic barriers and gaps in service delivery.
- Aunties, mothers, and grandmothers fill the gaps that exist in service delivery for participants. This contributes to a gender inequality in unpaid care. This imbalance also affects women and men with disability differently through the care and support they receive.
- First Nations families who care for those with disability are an untapped resource for the disability sector and its workforce. The opportunity exists to formalise and reward their support and use this as a foundation to support other individuals and families.
- As First Nations families have historically been providing significant proportions of essential yet unpaid care, the true cost to deliver services to First Nations peoples with disability has been disguised.

‘First Nations] People in rural areas are getting care from family or other people who don’t qualify for NDIS accreditation due to lack of credentials or formal qualifications.’

- *Aboriginal Community Controlled Organisation*

‘Provide people who are already caring for First Nations people with disability with qualifications and payment for the work they’re already doing.’

- *Aboriginal Medical Service*

2. Implementation of culturally safe services

2.1 We heard

Mainstream service providers are delivering services to First Nations people with disability that are culturally inappropriate and are less culturally informed about individual and community needs.

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- Non-first Nations service providers are not informed about First Nations cultural ways of being and doing that are crucial to community and individual health and wellbeing.
 - Locally relevant cultural training is not a formal, regulated requirement for working with First Nations people with disability and is often ineffective when it is implemented, particularly when given in short online modules.
 - First Nations people with disability will refuse care if they do not feel understood, safe, or as though services are culturally responsive.

'There is no real choice for specialists or culturally appropriate mainstream services [in a regional and remote setting].'

- *Aboriginal Medical Service*

'One thing that must be said is: The NDIS is an innovative way of supporting people, one thing that is generally missing is the real innovativeness of choice of service delivery.'

- *Aboriginal Medical Service*

'People want blueprints for how things should be done better when First Nations people already have blueprints that are thousands of years old.'

- *Aboriginal disability advocacy service*

2.2 We heard

The ongoing legacy of historical and systemic trauma is compounded by current inappropriate care for First Nations people with Disability and manifests differently in the sector.

- First Nations people deal with untreated and unrecognised trauma which impacts mental and physical health outcomes. This is exacerbated by the current lack of resourcing, services, and support.
- The lack of acknowledgement of trauma within government and many mainstream services has often led to re-traumatisation, violence, and neglect of First Nations people with disability.
- A fear and mistrust of government still exists within community and heavily influences motivations to seek help and engagement with the NDIS.

'Parents are not coping because they're scared to ring for help with their kids because they're scared that they'll be taken away'.

- *Aboriginal Community Controlled Organisation*

2.3 We heard

There are deep concerns over the lack of representation of the voice of First Nations people with disability in the sector.

- Stakeholders highlighted the crucial role that FPDN play in advocating for First Nations people with disability; noting that FPDN are a small organisation and are stretched thinly.
- It was broadly noted across the sector there is no mechanism for the voices of First Nations people with disability to be heard from a collective perspective.
- The sector acknowledged the opportunity to position the voices of First Nations people with disability centrally, and use lived experience as a key input into sector design and service delivery.

‘Such an important voice is that of First Nations people with disability.’
- *Disability advocacy service*

2.4 We heard

First Nations people with disability often feel invisible within the NDIA, government forums and boards, and the community sector.

- Stakeholders highlighted that First Nations people with disability often feel as though they are invisible to the system – a system that is large, complex, and overwhelmingly non-First Nations led and resourced.
- These sentiments hold true when considering the qualitative and quantitative data that is captured regarding First Nations disability service delivery both inside and outside the NDIS and across broader Government data collection and analysis. The type of data collected does not align to the culturally important measure of success to First Nations people with disability.
- The lack of qualitative and quantitative data across all service systems enables systemic neglect and hinders accountability in the sector – this extends to the invisibility in National frameworks.

‘There aren’t any opportunities [for First Nations people with disability] to tell their stories.’
- *Disability advocacy service*

‘Vulnerability is something that people are manoeuvred into, then put into situations where their agency is stripped from them.’
- *First Nations academic*

2.5 We heard

There is a need across the sector to support First Nations people to define disability in the community.

- The sector noted uniformly that our ACCOs and ACCHOs are best placed to support individuals and families to assist in identifying disability.
- The sector highlighted that our communities' views on wellbeing differ from that of non-First Nations views. First Nations views on wellbeing and psychosocial wellbeing have been developed over thousands of years, and cultural systems have been developed to support First Nations people and communities.
- Consideration into the identification and assessment of disability in the community should be delivered in the context of cultural gender roles to allow for a deeper understanding of the psychosocial needs of an individual.

2.6 We heard

First Nations People with deafness do not identify as disabled but must fit regulatory definitions to access services - which often misunderstand their cultural and physical needs.

- First Nations people living with partial or complete deafness do not necessarily identify as disabled, but rather as having unique linguistic needs. While they must fit a definition of disability to access support services, there is a sense of discomfort with this identification in the community.
- There is a lack of cultural safety for First Nations people with deafness when they are serviced by mainstream providers (including interpreters). Additionally, there are an inadequate number of services and interpreters to support this intersection- especially in regional and remote communities. This often leads to First Nations people with deafness leaving their community to relocate and access urban services. This will affect their sense of cultural identity.
- There is a lack of understanding amongst the deaf First Nations community about the requirements for accessing services they need.

'When we come together, we come together as deaf people. We don't see ourselves as disabled. The only barrier for us is communication.'

- *First Nations deafness advocacy service*

2.7 We heard - NDIS

Where the NDIS plans of First Nations people with disability are culturally inappropriate and misrepresentative, this causes feelings of isolation.

- The complexity of the NDIS application process (including language and cultural barriers) is contributing to First Nations people discarding applications, while also creating additional burden for family members and unpaid carers.
- Numerous barriers surrounding poverty and digital exclusion are further affecting pre-access, access, and compliance to the NDIS for First Nations peoples.
- The drafting of NDIS plans without full participant understanding has led to plans which are inappropriate, leading to lack of satisfaction, engagement, control, and choice.

‘You really must ‘disable yourself’ to get help, to prove how disabled you are.’
- *First Nations academic*

2.8 We heard - NDIS

Western models of care and disability service delivery do not consider First Nations culture and First Nations historical, cultural, and social circumstances.

- Western medical systems and approaches inherently disregard First Nations’ known ways for achieving wellbeing, reportedly due to entrenched racism and discrimination.
- Complexities of intersectionality are not addressed by Government and non-First Nations services, resulting in the neglect of First Nations people with disability who have multi-layered societal and individual problems on top of their disability.
- There is a disconnect between Government and community, this is compounded by a misunderstanding of culture and differences in communications styles. There is no consistency and commitment to engage with community in a way that is culturally appropriate.

2.9 We heard - NDIS

There is no mechanism under the NDIS for First Nations organisations to refer and apply for support on behalf of a First Nations person with disability with consent.

- Community organisations often highlighted there is no mechanism that allows for referrals into the NDIS and First Nations people with disability often need to act on their own behalf, which is preferable when the individual has the capacity to do so. However, when the individual does not have the capacity to do so, stakeholders highlighted the need for formal funding, structural support for the individual and that Aboriginal Community Controlled Organisations are best placed to provide that service.

3. Reporting and Accountability

3.1 We heard

Insufficient accountability and ownership across the sector is resulting in First Nations people with Disability having to manage complex sector interfaces.

- The absence of identifiable roles and responsibilities within the disability sector is failing to protect and account for those First Nations people that are at the intersection of multiple sectors (which will not take responsibility for them).
- There is demand from the sector to have flexible funding available to support interdisciplinary approaches to case management across sectors.

‘We hear of examples where First Nations people are forced to stay in hospital or other residential settings for extended periods of time due to the inability of different sectors and systems to communicate with the disability sector, and appropriately plan for transition arrangements back into the community.’

- *Disability advocacy service*

3.2 We heard

There is no national framework guiding quality and assurance and cultural safety; nor is their enforced quality and safety standards embedded in service delivery requirements.

- The absence of any compulsory cultural training and quality assurance, throughout the disability sector, continues to expose First Nations people to unsafe care, further decreasing their likelihood to engage with the system.
- Any sector design work must place a premium on the voices of and the experiences of First Nations people with disability.
- Outcomes and performance indicators must be aligned to what’s important to First Nations people with disability rather than a State or Commonwealth reporting requirement.
- There are no NDIS defined cultural competence training for non-First Nations NDIS registered service providers.
- The NDIS has an opportunity to drive improvements in quality and safety of First Nations disability service delivery by embedding quality and safety standards in the professional obligations of NDIS service providers.
- There is demand in the sector for quality and assurance mechanisms that ensure cultural safety and prevent First Nations people from being placed in vulnerable situations.

'We need to build a quality assurance framework that is led by First Nations people with disability. We need to ensure as the [First Nations disability] sector expands, we need to ensure quality of services remains and people aren't exposed to harm.'

- *First Nations academic*

3.3 We heard – NDIS

The sector spoke to the lack of First Nations representation and input into the NDIS Quality and Safeguards Commission to support and advocate for First Nations people with disability.

- There is a need for improved representation of First Nations people in the NDIA, government forums, boards, and the community sector- particularly across senior positions who can influence and action reform.
- There were multiple requests to establish a First Nations Commissioner in the NDIS Quality and Safeguards Commission to ensure First Nations matters are understood and assessed both through a service delivery lens but also from a cultural lens.

'The overwhelming evidence and advice are that people want and need First Nations people embedded in the process.'

- *First Nations academic*

3.4 We heard – NDIS

Current mandatory reporting is time consuming and places further resourcing pressure on First Nations service delivery organisations.

- There was a consensus that reporting responsibilities have become the burden of Aboriginal Community-Controlled Organisations.
- There are currently no funded roles in Local Community Organisations to report on real time service demand resulting in less funding and misrepresentation of demand.
- There is no feedback loop, especially in remote communities, to allow a reporting and accountability mechanism.
- There is a lack of qualitative and quantitative data to inform sustainable choices and funding recommendations.

'Reporting duties can take a staff member away from their role for two weeks at a time, this is time taken away from providing care and resources we simply do not have.'

- *Aboriginal Community Controlled Organisation*

3.5 We heard – NDIS

There is no benchmark for cultural accountability and cultural training across the disability sector.

- The sector doesn't provide opportunity for open and honest conversations around the intersection of racism and ableism, and the very real consequences of neglect for First Nations people in this intersection.
- There is a lack of embedded historical, social, and cultural education within services and sectors.
- The absence of the abovementioned manifests in poor service delivery and poor outcomes for First Nations people with disability attempting to access mainstream services.

'Most allied health and service provision is done by non-First Nations people with little training or cultural awareness.'

- *Aboriginal Community Controlled Organisation*

3.6 We heard - NDIS

Limited and unregulated quality and safety standards across non-First Nations disability service providers present challenges for First Nations people with disability and the level of care they're provided.

- Undefined cultural safety baseline training for mainstream organisations working with First Nations people under the NDIS.
- Often services can separate a participant from the community (for example, travelling to the city for extended treatment) with no cultural assistance or support in place.
- There is a lack of support when someone transitions from a clinical setting back into their community.

3.7 We heard - NDIS

First Nations people's NDIS plans are underutilised due to thin markets or unavailability of culturally appropriate services.

- There were multiple examples of First Nations people with disability underutilising their NDIS plans due to the unavailability of services or culturally appropriate NDIS service providers. This has two material impacts on the sector:
 - ACCOs are often required to step in and 'fill the gap' to provide support to community members when they don't feel safe accessing mainstream services. ACCOs and ACCHOs may not be registered under the NDIS, and as such, the essential services they are delivering are unrecognised by State and Territory Governments.

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- The NDIS continues to receive data that suggests First Nations people are not using the full capacity of their plan without nuance or appreciation of the circumstances surrounding why. The sector highlighted commonly the NDIS plans of First Nations people with disability are underutilised due to unavailability of services and unavailability of culturally appropriate services which leads to a reduction in funding on individual NDIS plans, and further marginalises First Nations people with disability.

'NDIS plans go underutilised because there are no services available.'

- *Aboriginal Community Controlled Organisation*

3.8 We heard - NDIS

NDIS reporting requirements place compounding pressure on Aboriginal Community Controlled Organisations who are already under resourced and at capacity.

- Stakeholders highlighted the crucial role that Community Organisations play in communities, Community Organisations are often stretched thin and are operating at capacity. This, combined with workforce constraints, can cause a delay in reporting which in turn reduces the amount of funding the community organisation can access, contributing to the cycle of capacity and funding constraints.

4. Service delivery reform

4.1 We heard

First Nations people with cognitive disability frequently sit at a vulnerable intersection between disability and the justice system.

- First Nations people with cognitive disability are not readily detected or given appropriate care.
- First Nations people with cognitive disabilities are overrepresented in prisons and the justice system.
- Guardianship laws hinder safe and appropriate First Nations disability support, and breach principles of self-determination (where the person can make decisions but is not fully supported).
- Stigma and discrimination heavily affect health and disability outcomes for First Nations people with mental health issues and/or cognitive disabilities.

'First Nations people with] Acquired brain injuries generally fall through the gaps in the system.'

- *Aboriginal advocacy group*

4.2 We heard

There is a need to decentralise the execution of service delivery across the states and territories utilising regional governance approaches.

- There is a need for sector governance that includes First Nations voice, decision making and strategy, with a focus on decentralised service delivery and a regional governance body.
- There is a need for First Nations and non-First Nations owned service providers to partner across sectors, to alleviate some of the pressures felt within the under-resourced sectors.

‘We need structures that bring community together and an information hub to support people.’
- *First Nations academic*

4.3 We heard

The sector highlighted the need to reconsider the use of guardianship by the public trustee and the unintended consequences it has for First Nations people with disability.

- Stakeholders spoke to the issue of guardianship under the public trustee; whereby when a First Nations person with disability is on a guardianship order, they essentially lose choice and control over their lives (their affairs are managed on their behalf).
- The sector highlighted the need to continually assess guardianship orders and whether the lives of individuals who are under guardianship orders are improving.
- The sector emphasised the need to consider flexible approaches and flexible funding models to support individuals under guardianship orders to have more choice and agency.

‘First Nations people under guardianship orders] Essentially get locked into segregated settings whilst they’re under guardianship. They have no choice or control over where they live or what they do.’
- *Disability advocate*

4.4 We heard – complex sector interfaces

The interface between disability, the NDIS and other sectors is challenging to navigate and may be causing further trauma and harm to First Nations people with disability:¹³¹

- First Nations people are often ‘shuffled’ between various service organisations and sectors when attempting to access services, this presents multiple challenges for individuals who have multilayered and interconnected support requirements.
- Organisations and individuals often must engage with multiple sectors simultaneously, most notably disability, health, aged care, justice, and education. A more integrated and holistic approach to service delivery would be beneficial and would likely lead to improved efficiencies.

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- It is common for sectors to not communicate with each other, often leaving people without services or suspended between systems.
 - First Nations people have needed extra support in managing, navigating, and communicating their needs with these different sectors.

‘The education system cannot provide support where NDIS plan is in place, but the NDIS does not fund education support.’

- *Aboriginal Community Controlled Organisation*

‘The NDIS does not cover transport for children on NDIS plans due to parental responsibility, however, First Nations people are disproportionately affected by compounding factors which prevent them from being able to complete this.’

- *Aboriginal Community Controlled Organisation*

4.5 We heard - complex sector interfaces

Case management support needs to be able to cross-cut sectors and provide holistic lifecycle support.

The sector highlighted multidisciplinary and holistic approaches to case management as an important factor to consider when taking a holistic view of the needs of First Nations people with disability. A broader scope of case management will allow case workers to navigate various sectors to achieve improved outcomes for the individual.

‘It seems like there is no coordination or system and structure – everyone is operating in their own narrow band of health or disability – none of the bits are communicating well with each other.’

- *Aboriginal Community Controlled Organisation*

4.6 We heard - complex sector interfaces

Stakeholders highlighted the importance of taking a ‘life-cycle’ approach to service delivery, whereby service delivery is coordinated to address the unique and holistic needs of First Nations people with disability across different sectors and systems.

- The sector highlighted the need to rethink cross-sector collaboration and identified establishing multidisciplinary teams that cross-cut sectors as a potential solution to break down systemic barriers to different sectors working together and siloed approaches to service delivery.
- Current service delivery arrangements are siloed, and each sector assumes responsibility for their respective areas of relevance. This approach often fundamentally neglects the unique and holistic needs of First Nations people with disability.

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- Sector funding and knowledge is siloed, which requires First Nations people with disability to navigate multiple sectors for support. This problem is exacerbated for First Nations communities by several barriers (cultural, technological, linguistic, and geographical) alongside trauma and discrimination.

‘The nature of the problem lies within how the systems and organisations are set up; they’re set up thematically to solve a specific problem – they sit within the comfort zone of the knowledge they have. The system isn’t designed to bring two different depths of knowledge together and having to work together.’

- *First Nations academic*

4.7 We heard

The Community Connector/Local Area Coordinator role is essential to the delivery of disability services inside and outside of the NDIS.

- Many Community Organisations emphasised the need for sector governance that includes First Nations voices, decision making and strategies, with a specific request for decentralised service delivery and a regional governance body.

‘[First Nations] People in our rural areas generally must engage directly with the NDIS; LACs or Community Connectors are rare.’

- *Aboriginal Community Controlled Organisation*

‘The Community Connector role should be funded centrally and offered in every community uniformly.’

- *Peak body*

4.8 We heard

Western diagnostic tools are not always applicable in a First Nations context.

- There is concern with western diagnostic tools being applied to First Nations people with disability due to their limitations in adjusting for First Nations culture. As a result, western models of care can require First Nations people to be labelled and/or double labelled, which increase causes for community concern around stigma of disability.

‘A classroom of First Nations students was asked, using a western diagnostic tool, to identify whether the students had hearing issues. Using the diagnostic tool, one of the 30 students identified that they had a hearing issue. However, when the same cohort of students had their hearing tested, nine of the 30 students were identified as having a hearing issue.’

- *First Nations academic*

4.9 We heard - NDIS

The NDIS is an important mechanism to build and grow the First Nations disability service delivery sector and additional support mechanisms are required for the intention of the NDIS to be realised.

- The sector identified the market-driven model and the principles underpinning the NDIS as an important factor to consider when conceptualising approached to sector-build and maturity building.
- Stakeholders pointed to the success and growth of the First Nations business sector using economic mechanisms, like funding and procurement targets, as important mechanisms to consider.
- The sector highlighted the absence of an independent First Nations disability organisation to oversee sector development.

‘We need to build something fit for purpose to grow the sector.’

- *Commissioner Andrea Mason, 6 July 2021, Disability Royal Commission*

4.10 We heard - NDIS

The application process for the NDIS is complex, traumatising and is difficult to navigate for First Nations people with disability.

- ACCOs often play the support role for First Nations people with disability in assisting them to become registered under the NDIS, however, are often not funded for this work. There is little to no support for ACCOs, or dedicated and funded capability in ACCOs to support people to become registered under the NDIS; they do it because of their cultural responsibilities and values.
- Often First Nations people with disability must endure the application process multiple times which leads to individuals not wanting to pursue admission, meaning often, ACCOs take responsibility for service delivery (which is often unpaid and unrecognised).
- There is an appetite for block-funded advocacy and Community Connector positions co-located with ACCOs to deliver front-end access and application support.

‘Some people feel like the NDIS is abusing the ACCHO sector. NDIS are dictating what the ACCHOs are doing, and it should be the other way around.’

- *Aboriginal Community Controlled Health Organisation*

4.11 We heard - NDIS

There is a desire for a culturally appropriate NDIS communications strategy to raise awareness, understanding of and most importantly access to the NDIS amongst First Nations people and communities.

- The complexity of applications and navigating the scheme as well as the complex language and guidance material is a profound systemic barrier that inhibits First Nations people with disability from becoming registered under the scheme, and as such, accessing the essential services they require.
- It was suggested that building community knowledge around NDIS and other options is necessary in many rural or remote areas where many people aren't aware of NDIS's purpose.
- It was suggested that the NDIS should consider the design and delivery of communication materials in major First Nations language groups (and across all major language groups) to engage with First Nations people with disability who don't speak English as their first language.

'Plans are written in English which is incomprehensible to our people.'

- *Aboriginal Community Controlled Organisation*

4.12 We heard - NDIS

The NDIS wasn't designed to consider a First Nations view on disability or a social model of disability.

- The NDIS has fundamental incompatibilities with First Nations cultures, particularly when it comes to concepts of disability and the western deficit view on disability.
- NDIS does not consider the strength and utility of First Nations kinship nor the opportunity to support the family and community dynamic.
- There is negative stigma associated with possible outcomes for First Nations people who are classified as having disability.
- NDIS plans are usually reviewed by workers with no knowledge or understanding of cultural obligations.

4.13 We heard - NDIS

In rural and remote contexts, the unavailability of services and culturally appropriate services undermines principles of choice and self-determination.

- While there is general support for the concept of the NDIS, the unavailability of culturally appropriate services undermines the intention and principles of the scheme.
- The systemic barriers to accessing the NDIS limits choice and personal agency for First Nations people with disability.

‘Perceived or promoted agency and choice is undermined by access to services and thin markets [in service delivery].’

- *Aboriginal Community Controlled Organisation*

4.14 We heard - NDIS

Thin Markets under the NDIS directly affect availability of culturally appropriate services in remote, regional, and urban contexts.

- NDIS unit prices create barriers to entry for smaller providers in regional and remote contexts, whereby the unit price increase for regional and remote service delivery is not sufficient to encourage service provision in regional and remote areas.
- Where thin markets exist, competition between services is non-existent and an environment is created where one provider creates a monopoly on service delivery. This considerably reduces choice and agency of First Nations NDIS participants.
- Quantitative performance measures are often given greater weight over qualitative insights, which means that First Nations cultural outcomes are not measured or prioritised under the NDIS.
- ACCOs are having issues transitioning to NDIS as it is not financially sustainable due to ongoing costs (for example, auditing, compliance, and staff retention) and lack of capacity and/or resources.
- Individual funded plans reduce flexibility to pool resources for community-centred care.

‘A thin market approach doesn’t work in rural remote because of the undisclosed demand that exists.’

- *First Nations academic*

4.15 We heard - NDIS

The funding model of the NDIS at times is unsuitable for First Nations service delivery and doesn't enable the full spectrum of needs and cultural needs to be met.

- The short-term funding of NDIS plans, generally 12 to 18 months, does not provide First Nations service providers with certainty over future service delivery requirements.
- Many providers (predominately Aboriginal organisations), run their disability portfolio at a deficit and fund through their other service delivery portfolios, such as Health.
- There is an absence of funding to support both individuals and organisations to become service providers or receive a NDIS plan.
- The current funding model for Community Organisations is inflexible, and grants are often one to three years in duration. This leads to many organisations providing unfunded services to First Nations people with disability.
- Flexibility is needed in NDIS plans to allow funding of supports that will strengthen connections to family, community, and culture. Travel to Country and First Nations healing initiatives and supports are currently not recognised under NDIS arrangements. Additionally, in remote communities, plans have no contingency funding for basic needs (food and shelter) which would directly enhance the participant's quality of life.

'[First Nations] People live collectively and so funds must recognise that. First Nations cannot remain on Country without family support'.

- *Aboriginal Community Controlled Organisation*

4.16 We heard - NDIS

Non-collaborative funding arrangements between the NDIS and other sectors, most notably Health, causes individuals to fall into a grey area and often do not have their basic needs met.

- Non-collaborative funding models between sectors do not allow intersecting issues to be dealt with cohesively and are causing people to fall through sector gaps.
- Collaborative funding arrangements would lead to improved holistic support for First Nations people with disability.
- Stakeholders often spoke to the example of First Nations young people in school requiring supports. The lack of supports provided in the schooling environment is largely due to inadequate funding.

'A move back to block funding arrangements would mean we could better support people in our remote community with disability.'

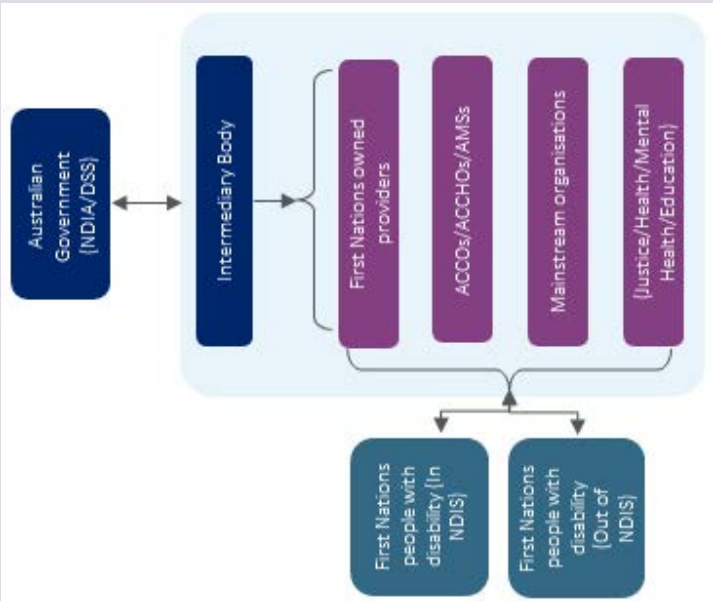
- *Aboriginal Community Controlled Organisation*

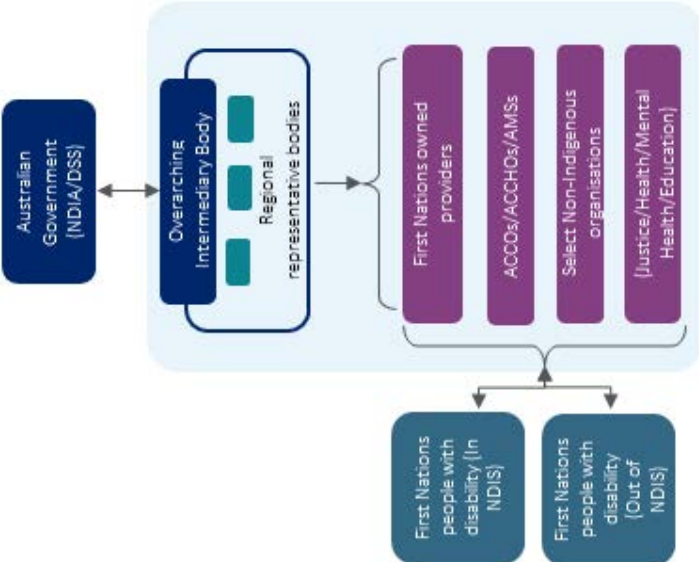
'Relationship between justice and disability – "there is none".'

- *Aboriginal Community Controlled Health Organisation*

Appendix B: Analysis of structural options for an Intermediary Body

Table 6. Options description

Option	Key features	Risks, benefits, and considerations
 <p>Option One: Intermediary Body oversees service delivery</p>	<p>There is a single Intermediary Body that governs the operations of the entire First Nations disability sector</p> <p>The Intermediary Body is made up of representatives of each regional community</p> <p>The Intermediary Body makes funding recommendation on behalf of providers of each region</p> <p>This presents a moderate level of coordination across the sector but means that region specific issues are less visible due to the volume of information being processed by a single group.</p>	<p>Benefits</p> <ul style="list-style-type: none"> Requires minimal resources to establish and implement. Low costs associated with the ongoing maintenance and governance of a single Intermediary Body. Able to adapt depending on changing political and economic landscapes. <p>Risks</p> <ul style="list-style-type: none"> Does not maximise the autonomy and self-determination of First Nations people as regional communities are not consulted during the decision-making process. Low level of interaction with regional providers and First Nations people with disability; body may not be able to adequately represent their needs.

Option	Key features	Risks, benefits, and considerations
	<p>There are region specific Intermediary representatives who oversee the operations of a single region and report to a National Intermediary Body which governs the entire sector. This presents a high level of coordination and collective Voice but also maintains a high level of representation of region-specific issues.</p>	<p>Benefits Regional committees increase transparency and self-determination for First Nations people. First Nations people are directly involved in decision making processes. The Intermediary is fully informed about regional demand for infrastructure. Increased ability to influence accountability, targeted funding, and timely decision-making processes. Able to adapt depending on changing political and economic landscapes.</p> <p>Risks Equity concerns between representative bodies if not appropriately governed. Requires extensive mapping to ensure representative bodies are appropriately created.</p>

Option Two: Regional Intermediary Body
oversees service delivery

Option	Key features	Risks, benefits, and considerations
 <p>Option Three: Regional Intermediary Body delivers services</p>	<p>The Intermediary Body unifies all disability support providers by having representatives of each within the board. This represents a very high level of coordination across the sector and would present an opportunity for all service provider perspectives to be heard, however this process would create a lengthy consensus-building process.</p>	<p>Risks, benefits, and considerations</p> <p>Benefits An Intermediary Body that unifies the disability service delivery sector is highly aligned to First Nations principles as ACCOs will directly influence NDIA and Commonwealth funding decisions and governance structures.</p> <p>Risks Extensive resources and coordination would be required to stand up and maintain. Multiple confidentiality and funding risks that may prevent implementation. High costs associated with creating a decentralised Intermediary Body with a high level of coordination. A decentralised service delivery sector is vulnerable to changes in the political and economic landscapes. Lengthy consensus building processes required.</p>

Table 7. Options evaluation – Summary

Performance criteria	Description	Option one	Option two	Option three
Ease of implementation	The degree of change, length, and number of activities within the development and implementation processes required to for the option to be implemented. This criterion also assesses the willingness of service providers to adopt the option.	High	Medium	Low
Cost	Level of estimated cost associated with development, implementation and maintenance associated with an option. This includes the amount of additional required resources by each stakeholder throughout the process. Additionally, any opportunity costs of the option are considered here.	High	Medium	High
Alignment to First Nations principles	The degree to which each option aligns to the values within the UNDRIP and CRPD.	Low	High	Medium
Adaptability	The degree to which an option can be responsive to changing political and economic landscapes and complexities associated with service provision, governance and change making processes; the extent to which an option can create a future proof NDIS.	Low	High	Low
Risks	The level of risk identified for stakeholders, the degree to which governance mechanisms can mitigate risks, and the level of transparency surrounding risks and associated management approaches.	High	Low	High

Performance criteria	Description	Option one	Option two	Option three
Impact	The opportunities (e.g., any future investment opportunities, tangible community benefits, education and training, economic development of the disability services sector) that are created through this option and the benefits to First Nations people with disability, their communities, and the NDIS stakeholders. This also includes its ability to set an example for First Nations services across Australia.	Medium	High	Medium

Key to Table 7.

Rating	Description
Low	Low alignment to desired criteria
Medium	Medium/moderate alignment to desired criteria
High	High alignment to the desired criteria

Table 8. Options Analysis (detailed): Option one – Intermediary Body oversees service delivery

Performance criteria	Rating	Justification
Ease of implementation	High	A single Intermediary Body requires minimal resources to establish and implement Low number of resources required for the implementation means stakeholders are likely to be very willing to accept this recommendation Easily maintained for the duration of the Intermediary Body
Cost	High	Low level of coordination required for a singular Intermediary Body Low costs associated with the ongoing maintenance and governance of a single Intermediary Body
Alignment to First Nations principles	Low	The Intermediary provides transparency and coordination for disability support services for First Nations people with disability. It does not, however, maximise the autonomy and self-determination of First Nations people with disability as a national Intermediary Body cannot fully understand / prioritise regional issues on its own.
Adaptability	Medium	A single national Intermediary Body can adapt depending on changing political and economic landscapes.
Risks	High	The national Intermediary Body has a low level of interaction with regional providers and First Nations people with disability and as a consequence may not be able to adequately represent their needs.
Impact	Medium	A National Intermediary Body creates accountability, transparency, and governance for influencing funding decisions in the First Nations disability service sector First Nations people who are part of the Intermediary board will represent the voices and needs of First Nations people with disability

Table 9: Options Analysis (detailed): Option two – Regional Committees oversees service delivery

Performance criteria	Rating	Justification
Ease of implementation	Medium	An Intermediary with individual regional committees requires a moderate number of people, resources, and coordination. Stakeholders are likely to be willing to support the implementation of the Intermediary group as the positive impact to First Nations people with disability significantly outweighs the investment required.
Cost	Medium	Moderate levels of investment are required to coordinate regional committees, for ongoing maintenance and governance.
Alignment to First Nations principles	High	A national Intermediary Body with regional committees ensures First Nations people with disability have an equal seat at the table for all funding decisions for the disability services sector. First Nations people with disability will hold the Intermediary Body accountable and timely.
Adaptability	High	A national Intermediary Body with regional committees is highly adaptable to changes in the political and economic landscape
Risks	Low	The national Intermediary Body is required to make funding recommendations based on the priority investment opportunities provided to them by the regional Intermediary committees. This means that the Intermediary Body will be required to prioritise what they deem as the most urgent funding opportunities which may leave some communities vulnerable.
Impact	High	The Intermediary Body with supporting regional committees will provide stability, governance, accountability, and transparency to the disability support service sectors. It ensures the voices of First Nations people with disability are at the forefront of all decision-making processes.

Table 10: Options Analysis (detailed): Option three – Regional body delivers services

Performance criteria	Rating	Justification
Ease of implementation	Low	A large level of resources and coordination would be required to create a unified service disability delivery sector. Stakeholders are unlikely to endorse this option as there are confidentiality and funding risks that may prevent implementation.
Cost	High	There are high costs associated with creating an Intermediary Body with a high level of coordination and decentralisation.
Alignment to First Nations principles	Medium	An Intermediary Body that unifies the disability service delivery sector is highly aligned to First Nations principles as ACCOs will be at the forefront of all funding decisions and governance structures.
Adaptability	Low	A decentralised service delivery sector is vulnerable to changes in the political and economic landscapes. Any major change would implicate governance and transparency procedures in each regional committee.
Risks	High	There are a number of confidentiality, funding and governance risks associated with a decentralised Intermediary Body that delivers services across a number of sectors.
Impact	Medium	First Nations people with disability would receive wholistic services across sectors. Service providers would be able to support people with multiple categories of need.

Based on the above analysis, **Option Two (Table 9)** would be the most suitable structure for the Intermediary. Further costings and policy translation are required to develop detailed design and implementation- and this should only be done in consultation with community.

Appendix C: Recommendation Implementation Timeline and Analysis

Table 11. Phase one

No.	Recommendation	Responsible party	Timeframe for completion	Estimated cost
21	In the next revision of the Commonwealth Implementation Plan for the Closing the Gap Target, outcomes should explicitly include First Nations people with disability.	Intermediary Body	Jan 2023 – Jul 2023	Low
14	The NDIA should form partnerships with ACCOs and regional tertiary institutions to offer flexible course options for disability care accreditations which form pathways to becoming a registered NDIS provider- including those already providing unfunded and unqualified support.	NDIA	Jan 2023 – Jun 2025	Medium
9	The NDIS Workforce Plan 2021-2025 should be revised to include the unique strategies required for the acceleration and growth of a First Nations disability workforce.	NDIA	Jan 2023 – Jul 2023	Low
19	The NDIS Quality and Safeguards Commission should appoint a First Nations Disability Commissioner.	NDIA	Jul 2023 - Aug 2023	Low
13	The NDIA should, in partnership with First Nations communities, academics and professionals, define and regulate the attitudes, skills and behaviours which encompass a culturally safe, competent, and trauma-informed approach to First Nations health and disability. This agreed standard should be upheld by all registered providers and used as a guideline for providers outside of the NDIS.	NDIA	Jul 2023 – Dec 2024	Low
18	The NDIA should mandate cultural safety training for all non-Indigenous disability service providers that provide service to First Nations people with disability.	NDIA	Jul 2023 – Jul 2024	Medium
15	The NDIA should block fund Aboriginal Community Controlled Organisations to deliver educational programs which aim to inform First Nations communities about careers in the disability sector, including possible pathways, accreditation options and career entry points.	NDIA	Jul 2023 – Jun 2025	Low

No.	Recommendation	Responsible party	Timeframe for completion	Estimated cost
1	There should be an Intermediary Body to govern sector development, improvements in service delivery, quality assurance for the First Nations disability sector and establish a regional governance structure which hears and values the voices of First Nations people with disability.	Australian Government	Jul 2023 – Jun 2025	High
7	The NDIA should facilitate cross-sector collaboration to address the unique and holistic needs of First Nations people with disability.	NDIA	Jul 2023 – Jul 2026	Low
22	The First Nations NDIS Quality and Safeguards Commissioner, in partnership, should design a National Quality Assurance and Cultural Framework to guide sector development and to clearly define quality and safety standards.	NDIA	Jun 2023 – Jul 2025	Low
3	The Intermediary should define and oversee a national Community Connector program to ensure uniform application, responsibility, and availability of the role in each community.	Intermediary Body	Jul 2024 – Jul 2026	High

Table 12. Phase two

No.	Recommendation	Responsible party	Timeframe for completion	Estimated cost
10	The Australian Government should implement strategies to increase the First Nations disability workforce by 13,000 workers by 2031 to meet projected demand.	Intermediary Body	Jul 2024 - onwards	Medium
5	The Intermediary Body should investigate the use of guardianship orders by the Public Trustee and illustrate impacts and experiences of First Nations people with disability under guardianship orders.	Intermediary Body	Jul 2024 – Jan 2025	Low
8	The Intermediary should establish a global Community of Practice, most notably with Māori organisations from Aotearoa New Zealand and First Nations organisations from Canada to share learnings and accelerate sector development.	Intermediary Body	Jul 2024 – Jun 2025	Low

No.	Recommendation	Responsible party	Timeframe for completion	Estimated cost
12	The NDIA, in partnership with the Intermediary Body and Aboriginal Community Controlled Organisations, should design and develop guidance on best practice formal partnerships and engagement between First Nations and non-Indigenous providers and create an identifier for those businesses who meet the guidelines.	NDIA	Jul 2024 – Jun 2025	Low
4	Where the assessment is made that a thin market is unlikely to resolve itself under current market conditions, the NDIA should block fund Aboriginal Community Controlled Organisations or preferred providers for disability service delivery.	NDIA	Jul 2025 – Jul 2026	Medium
17	The Community Connector should deliver NDIA assessments in person, in a culturally safe way in community, especially in regional, remote, and very remote areas.	NDIA	Jul 2025 – Jul 2026	Medium
11	The Intermediary Body, in partnership with the Aboriginal Community Controlled Organisations, should establish a First Nations disability workers hub which is nationally managed but regionally implemented. It will facilitate support groups, networking, and mentoring programs among First Nations disability workers both within Aboriginal Community Controlled Organisations and within non-Indigenous organisations.	Intermediary Body	Jul 2025 – Jun 2026	Low
16	The Intermediary, in partnership with the NDIA and industry should design and deploy a professional and capability development program to support community organisations with the skills to manage increased inflows of capital from the First Nations Disability Economic Development Policy.	Intermediary Body	Jul 2025 – Jul 2026	Low
2	The Intermediary should co-design, with First Nations people with disability and with industry, a First Nations Disability Development Policy to increase and safeguard investment into the First Nations disability sector.	Intermediary Body	Jul 2025 – Jul 2026	Low

Table 13. Phase three

No.	Recommendation	Responsible party	Timeframe for completion	Estimated cost
20	Federal and jurisdictional governments should invest in a First Nations Community Controlled Disability Research and Data Agenda, as outlined by First Peoples Disability Network.	Intermediary Body	Jul 2025 – Jul 2027	Low
6	The NDIA should identify unfunded supply to, and undisclosed demand from, First Nations people with disability delivered outside of the NDIS and compensate providers who are bridging the gap.	NDIA	Jul 2025 – Jul 2027	High

Appendix D: Quantitative Analyses

– detailed approach

The following section specifies the data, methodology and assumptions used in the quantitative analyses.

Data obtained

The Disability Royal Commission provided the following data obtained by exercise of its extraordinary powers:

- National Disability Insurance Scheme (NDIS) data from the National Disability Insurance agency (NDIA): provided as de-identified unit record data on a quartered basis and comprised:
 - **NDIS Plan applications:** Participant ID, Applicant Number, Application Status, Application Status description, Access request decision data, plan approved date, days from decision to plan approval.
 - **NDIS payment information:** Participant ID, Payment amount, Year of payment, Quarter of payment, Support class of payment, Support category of payment, Payment destination (Provider ID if not 'Paid to Participant'), Plan ID.
 - **Plan budget information:** Participant ID, Plan ID, plan effective date, Plan expiry date, committed support budget amount for each financial year, Support classes of committed amounts, Support category of committed amounts.
 - **Participant Demographic Characteristics:** Participant ID, Record Year, Quarter of caseload, State or territory, Gender, NDIS Age Band, Cultural and Linguistic Diversity Status, Aboriginal and Torres Strait Islander Status, Modified Monash Model Remoteness Code, Statistical Area description, Normalised assessment tool score, Primary disability group, Disability Count.
- Disability Employment Services (DES) program data from the Department of Social Services (DSS): provided as de-identified unit record data on a quartered basis and comprised:
 - **Participant Demographic Characteristics:** Participant ID, State or Territory, Statistical Area (SA2), Statistical Area (SA3), Modified Monash Model Remoteness Code, Aboriginal and Torres Strait Islander indicator, Cultural and Linguistic Diversity indicator, Homeless indicator, Refugee indicator, Primary disability group, Year of caseload, Quarter of caseload, Funding level, Job Seeker Classification Instrument Score, Work capacity hours at caseload, Disability count, Employer Services Assessment test/Job Capacity Assessment, Number of barriers, Interventions, Number of interventions.
 - **DES Payment information:** Date of claim, Participant ID, claim creation date, Claim ID, DES Claim group – Tier 1, DES Claim Group – Tier 2, Provider ID, Amount.

Additionally, for the purpose of the quantitative analysis we relied on the following data:

- **The Australian Bureau of Statistics (ABS):** data publicly available through the following publications and data collections:
 - **The 2016 Census:** which contains a range of information on the First Nations and total Australian population and on the labour, force engaged in caring for people with a disability.¹³²
 - **Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026:** which provides projections of First Nations people over time used to grow populations estimated in more recent data.¹³³
 - **The Survey of Disability, Ageing and Carers:** which includes information on people with a disability, including the severity of any core activity limitations.¹³⁴
- **Deloitte Access Economics proprietary data assets:** Demographic projections based on modelling conducted by Deloitte Access Economics as part of a regular suite of forecasting and analysis. These projections draw on a range of demographic data from the ABS, together with Deloitte Access Economics assumptions to predict detailed population figures into the future.

The tables below summarise key statistics from the primary datasets obtained:

NDIS Data

Table 14. Participant Characteristics (Total records = 5,842,303, Total fields = 15)

Calendar Year	Number of data records	Total number of people in December of each Calendar Year	Data file source name
2016	60,367	60,367	CTD.9999.0060.0001
2017	403,006	129,324	CTD.9999.0060.0001
2018	737,618	224,629	CTD.9999.0060.0002
2019	1,163,265	327,372	CTD.9999.0060.0002
2020	1,586,950	429,206	CTD.9999.0060.0003
2021	1,891,097	499,426	CTD.9999.0060.0003

Table 15. NDIS Claims (Total records = 22,332,103, Total fields = 8)

Year of payment	Total Dollar amount reflected	Unique number of Participants	Data file source name
2016	\$411,092,048	39,952	CTD.9999.0056.0001
2017	\$2,568,283,930	107,484	CTD.9999.0056.0001
2018	\$5,885,706,915	196,141	CTD.9999.0056.0001
2019	\$11,913,245,614	305,667	CTD.9999.0056.0001
2020	\$18,150,843,649	402,200	CTD.9999.0056.0001
2021	\$23,876,643,579	473,030	CTD.9999.0056.0001
1 Jan- March 2022	\$6,561,324,499	468,600	CTD.9999.0056.0001

Table 16. NDIS Plan Approval (Total records = 1,045,916, Total fields = 8)

Decision Year	Number of records	Source
Missing	389,182	CTD.9999.0055.0001
2013	13	CTD.9999.0055.0001
2014	100	CTD.9999.0055.0001
2015	119	CTD.9999.0055.0001
2016	39,600	CTD.9999.0055.0001
2017	104,323	CTD.9999.0055.0001
2018	157,683	CTD.9999.0055.0001
2019	131,722	CTD.9999.0055.0001
2020	113,690	CTD.9999.0055.0001
2021	109,484	CTD.9999.0055.0001

Table 17. NDIS Committed Supports (Total records = 2,036,759, Total fields = 25)

Calendar Year	Number of records	Source
2016	46,293	CTD.9999.0057.0001
2017	148,781	CTD.9999.0057.0001
2018	267,218	CTD.9999.0057.0001
2019	386,827	CTD.9999.0057.0001
2020	488,876	CTD.9999.0057.0001
2021	487,501	CTD.9999.0057.0001
2022	211,263	CTD.9999.0057.0001

DES Data

Table 18. DES Caseload (Total records = 7,053,897, Total fields = 25)

Financial Year	Number of records	Total number of people at June of each Financial Year	Source
2014	316,066	159,280	CTD.9999.0059.0008
2015	672,951	173,041	CTD.9999.0059.0008
2016	710,109	182,768	CTD.9999.0059.0008
2017	746,960	187,066	CTD.9999.0059.0008
2018	772,013	193,441	CTD.9999.0059.0008
2019	882,726	238,327	CTD.9999.0059.0008
2020	1,096,462	283,981	CTD.9999.0059.0008
2021	1,231,004	315,926	CTD.9999.0059.0008
2022	625,606	-	CTD.9999.0059.0008

Table 19. DES Claims (Total records = 6,036,583, Total fields = 9)

Financial Year	Total Dollar amount reflected	Unique Participants	Source
2014	\$840,732,365	204,157	CTD.9999.0059.0009
2015	\$843,577,096	209,208	CTD.9999.0059.0009
2016	\$842,463,903	213,537	CTD.9999.0059.0009
2017	\$868,652,565	213,335	CTD.9999.0059.0009
2018	\$856,457,002	235,081	CTD.9999.0059.0009
2019	\$1,152,140,155	283,275	CTD.9999.0059.0009
2020	\$1,359,473,416	327,292	CTD.9999.0059.0009
2021	\$1,499,749,066	351,305	CTD.9999.0059.0009

We have undertaken the following limited reasonableness checks:

- High level comparisons against published statistics
- checks on summaries of data fields against our expectations
- checks on missing values.

We have not and it should not be construed that we have completed a quality assurance process of data provided.

Approach used to analyse service demand

The likelihood of an individual accessing disability services is influenced by a range of factors related to the individual, provider, program or environmental factors. To understand these factors and analyse their impact on the availability and accessibility of disability services for First Nations people, we have applied Generalised Linear modelling (GLM), a statistical regression technique.

A GLM family of statistical model is an umbrella term that encompasses many models, which allow a response variable to have an error distribution other than normal. In general, a GLM is used over a regular linear model when the relationships between the target and response variables are non-linear (and hence likely to result in non-normal error distributions), homoscedasticity in the error terms or when the response variable is discrete or categorical. In our specific circumstance, our objective to model the proportion of persons with disability that ultimately access a service through the NDIS led to the use of a logit link GLM, otherwise commonly referred to as logistic regression.

The steps in our GLM model development approach were:

1. Perform initial data preparation, including data cleansing, internal and external consistency checks, and basic exploratory data analysis.
2. Combine the claims and demographic data for the NDIS data to produce a unified NDIS dataset. This was also done separately for the DES data, to create a separate unified DES dataset
3. Group NDIS participants by various features such as age band (9 groupings), location (7 MMM score categories), primary disability type (17 categories), First Nations and non-Indigenous status, gender (2 categories, excluding 'U') and severity type (3 categories)
4. Estimate the corresponding Australian resident population statistics using the groupings determined above based on population projections drawn from public sources and Deloitte Access Economics modelling.
5. Derive NDIS participation rates and DES participation rates for each of the groupings determined above.
6. Perform the statistical regression analyses (in this case, the GLM) to identify likelihoods of NDIS participation and DES participation for participants with various characteristics and the parameter estimates (or effect) of various factors including in the final GLM model on the likelihood of access to the NDIS.
7. Apply a control cycle approach to variable selection by performing initial univariate analysis on factors, accounting for statistical significance, prior experience/expectations and relevant insights from consultations and literature. From a subset of selected variables, perform backwards selection while considering balance between model parsimony, fit and stakeholder requirements.

-
8. Perform model diagnosis to ensure good fit (and resolve issues of overfit) by considering no-info rate, confusion matrix, sensitivity/specificity and ROC. Repeat step 6 and 7 if necessary.

Development of population projections

In estimating the GLM presented in this report we have calculated participation rates for both the NDIS and DES across a range of characteristics. These rates are based on projections of the Australian population with each combination of characteristics across age, sex, First Nations status, region, and severity of disability.

To construct these projections, we combine information from public sources with population projections produced by Deloitte Access Economics. These population projections are developed from trends in fertility, mortality and migration over time which alter the structure of the Australian population.

There is no single source for population estimates which include all the information required for our analysis. Instead, we combine:

- Detailed population estimates by age, sex, First Nations status and region from the Census (which create a starting point for the projections).
- ABS Projections of the First Nations population.
- Deloitte Access Economics projections of population by age, sex, and region.
- Information on the severity of core activity limitations by age, sex, and First Nations status from the Survey of Disability, Ageing and Carers.

Taken together, these provide the basis for the projections which help form the participation rates used throughout the GLM.

Selection of GLM over other statistical techniques

In general, there are several statistical techniques that can be used to determine the participation likelihood of NDIS participants based on their characteristics. In our analysis, we considered the use of generalised linear models (GLM), decision trees and neural networks. While all three can predict the participation response variable (either as a continuous participation percentage, or discrete cut off percentages), we ultimately selected a GLM for the interpretability of the model parameters. As the intended goal of the exercise is to explain the drivers of NDIS participation based on individual characteristics, a GLM was most suitable as this information is neatly presented in the form of the regression coefficients. In contrast, while a neural network is technically parametric, there are often where many parameters make the model almost impossible to interpret. A decision tree is slightly better than a neural network in this regard, though still less interpretable than a GLM. In particular, when the number of nodes allowed for in the decision tree is increased, we often end up with multiple splits of the same characteristic (e.g., Age > 30 at a node earlier on the path, then Age < 34 at a node later in the path), making interpretations of effects for the characteristic difficult.

A further consideration leading to our decision to use a GLM related to the overall performances of the models. As the intention of the model is not to conduct person level participation likelihood prediction, but rather to explain general macro level trends relating to the impacts of specific characteristics, the comparatively weaker predictive performance of the GLM was not of particular concern (noting that the weaker GLM performance is a general statement, as GLMs can outperform decision trees and neural networks in certain scenarios).

Selection of GLM family

The response variable used in our demand analysis, is the participation rate of NDIS participants based on their combination of characteristics. For each group of characteristics, we calculate the participation rate by taking the ratio of the count of participants in the cohort in the NDIS, with the estimated number of people in Australia with those same characteristics. Hence, the response variable takes values between 0 and 1, with 0 indicating no participation and 1 indicating full participation. In instances where the cohort count in the NDIS was greater than our estimates, we assumed full participation.

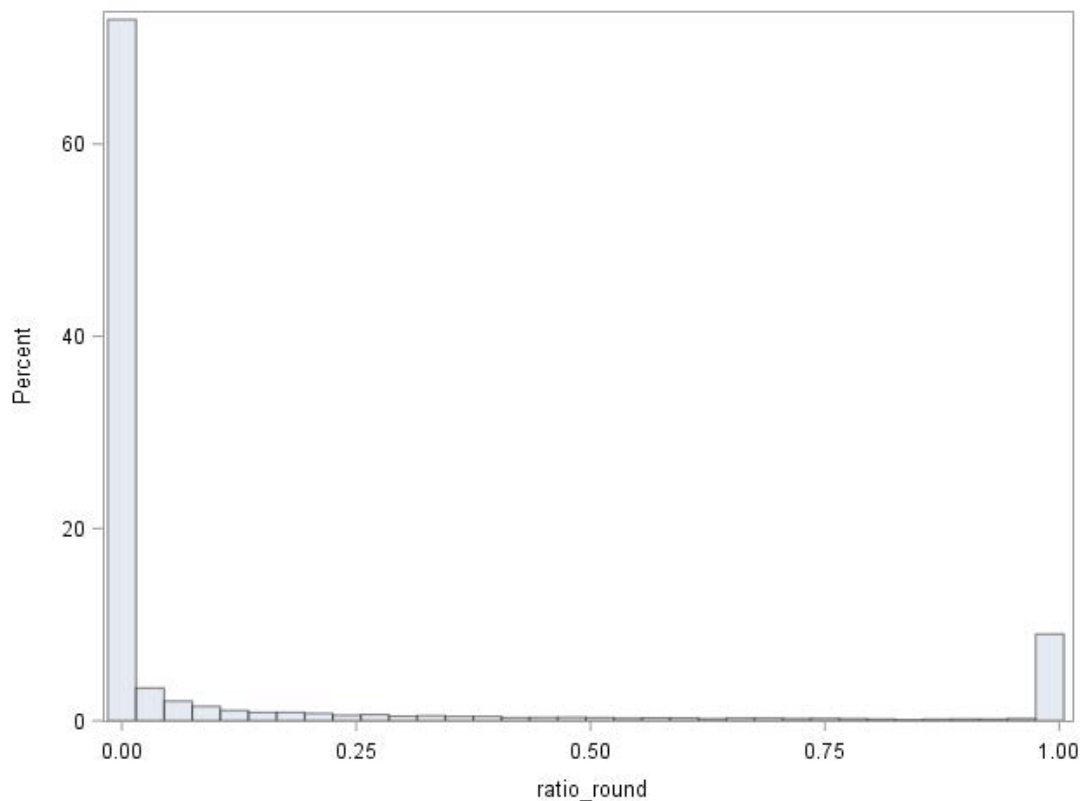


Figure 70. Distribution of response variable (participation rate) for regression analysis

The distribution had two large peaks at 0 and 1, with the remainder spread between (indicating partial participation). By modifying our definition of response variable to 'no participation', and 'at least some participation', whereby any participation less than 5% would be classified as 'no participation', and anything else as 'at least some participation', we obtained binary values that were modelled using a logistic regression.

Selection of this target variable for the GLM accounts for both participants who are currently receiving services, and those who can be classified as having 'unmet need'. Those receiving services are captured by the numerator of the target variable, and those with unmet need are captured by the denominator. As such, the model will implicitly account for cohorts with large proportions of participants who are not accessing NDIS services due to a lack of availability.

Further, a GLM like the one described above is easily replicable across multiple points in time. As the underlying data driving each model captures only records at a single point in time, it is possible to reproduce the model at regular intervals to capture how the impacts of specific demographics have changed. To the analyses in this report, we noted the decreasing impact of a participant's First Nations status in predicting lower access to services (although there still exists a gap in 2021).

Model validation

Figure 71, below shows the confusion matrix for the final regression model used in our demand analysis. The model has a sensitivity rate of 68% and a specificity of 76%.

	Predicted: No participation	Predicted: At least some participation	
Actual: No participation	5500	1753	7253
Actual: At least some participation	1781	3818	5599
	7281	5571	

Figure 71. Participation regression model confusion matrix

The ROC Curve, as seen in Figure 72, below is a separate measure of performance of the classification regression. The final model has an aggregated area of 0.8036 indicating a sufficiently good classification of successes and failures.

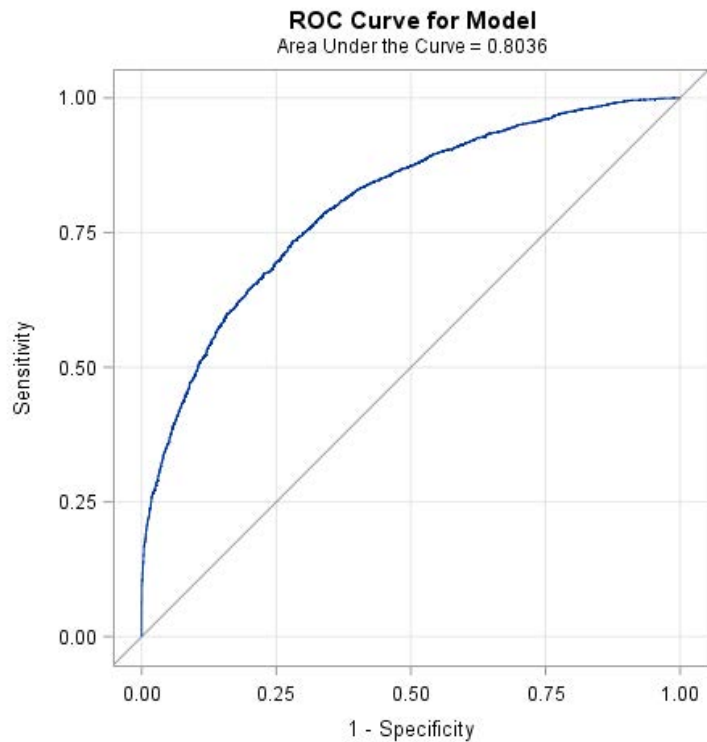


Figure 72. Participation regression model ROC Curve

The actual versus predicted table shows the actual ratio of cohorts with ‘at least some participation’ based on a certain characteristic. For example, 40.5% of First Nations Cohorts had ‘at least some participation’, while the model predicted that 38.6% of First Nations Cohorts had ‘at least some participation’.

Smaller differences between actuals vs predicted indicate a better fit, although, some difference between the two is to be expected, as extremely similar actuals vs predicted results suggests a high likelihood of a model that overfits the data.

	Actual	Predicted
Total Performance	0.436	0.433
	Actual	Predicted
First Nations	0.405	0.386
Non Indigenous	0.466	0.481
	Actual	Predicted
MMM1	0.541	0.600
MMM2	0.493	0.528
MMM3	0.529	0.580
MMM4	0.472	0.485
MMM5	0.352	0.304
MMM6	0.348	0.288
MMM7	0.315	0.251
	Actual	Predicted
Low Severity	0.376	0.345
Moderate or High Severity	0.465	0.478

Figure 73. Actual results versus Predicted results for the selected regression model

Approach used for the determination of First Nations-focused providers

The only provider specific data included in the NDIA data supplied is a unique identifier for the provider which delivered a service.

Within the legislative and timing constraints for data, information about geographic location of providers (e.g., service outlets) was not provided. There is no information available on whether a provider is designated as First Nations-focused and/or whether it is First Nations led.

Information regarding the geographic location of the provider, information about whether the service is First Nations led and whether the provider is First Nations-focused, is not available.

Within these limitations, our approach to analyse First Nation-focused service providers was to:

1. Define providers as First Nations-focused or Other based on the percentage of their clients that identify as First Nations people
2. Explore a range of alternative cut-off percentages for definition of First Nations-focused providers
3. Identify any observable differences in patterns of supports provided by First Nations-focused providers by comparison between the supports they provided to their First Nations and non-Indigenous clients.

Data reconciliation

The NDIA dataset was adjusted for the purpose of this analysis. The following page provides a reconciliation from the full dataset to the analysis dataset as follows while the reconciliation of the records is shown in Table 20, below.

- Total no. records in dataset - this is the total number of claims records in the NDIA dataset
- Exclude: paid to participant – the provider ID in the NDIA data includes either a masked provider ID (combination of letters and numbers), or the phrase 'paid to participant'. As this analysis focuses on providers, we have excluded claims where the provider ID = 'paid to participant'
- Exclude: Missing MMM remoteness – a focus of this analysis is to understand the geography of services being provided. As such, claims which have a missing value for MMM remoteness were excluded
- Exclude: Missing SuppClass – a focus of this analysis is to understand the mix of support services being provided. As such, claims which have a missing value for support class were excluded
- Total records analysed – this is the final dataset used for this analysis

Table 20. Reconciliation of data records for use in the Provider Analyses

Period	Total number of records	Exclude: Paid to participant records	Exclude: Missing MMM remoteness records	Exclude: Missing SuppClass records	Total records analysed	Records analysed as % of total records
Jan-June 2016	185,425	40,505	5,473	-	139,447	75%
July 2016-June 2017	978,746	226,463	13,034	2	739,247	76%
July 2017-June 2018	2,188,360	524,284	4,783	4	1,659,289	76%
July 2018-June 2019	3,941,149	1,001,322	5,149	187	2,934,491	74%
July 2019-June 2020	5,819,811	1,490,263	8,709	16	4,320,823	74%
July 2020-June 2021	7,253,670	1,775,440	11,806	2	5,466,422	75%
July-Dec 2021	1,964,942	466,554	29,014	-	1,469,374	75%

Observations for the one quarter of calendar year 2022 and those where the First Nations status is 'NOT STATED' have been omitted for this analysis.

Support categories and mappings used for analyses

For the analyses shown in the report the NDIS categories of the support have been grouped into 5 distinct categories of Other Core, Daily Activities Core, Capacity Building, Support Coordination and Capital. This follows the mapping outlined in Table 21, below.

Table 21. Mapping of NDIS support categories

Support Category defined for analysis in the report	NDIS Support Categories included	NDIS Support Class
Transport	Transport	Core
Other Core	Consumables, Social Community and Civic Participation	Core
Capacity Building	CB Choice and Control, CB Daily Activity, CB Employment, CB Health and Wellbeing, CB Home Living, CB Lifelong Learning, CB Relationships, CB Social Community and Civic Participation	Capacity Building
Daily Activities Core	Daily Activities	Core
Support Coordination	Support Coordination	Capacity Building
Capital	Assistive Technology, Home modifications	Capital

Classification of First Nations-focused providers

Figure 74 below shows the proportion of payments attributed to First Nations people, that each provider in the NDIS received in across all periods of analysis.

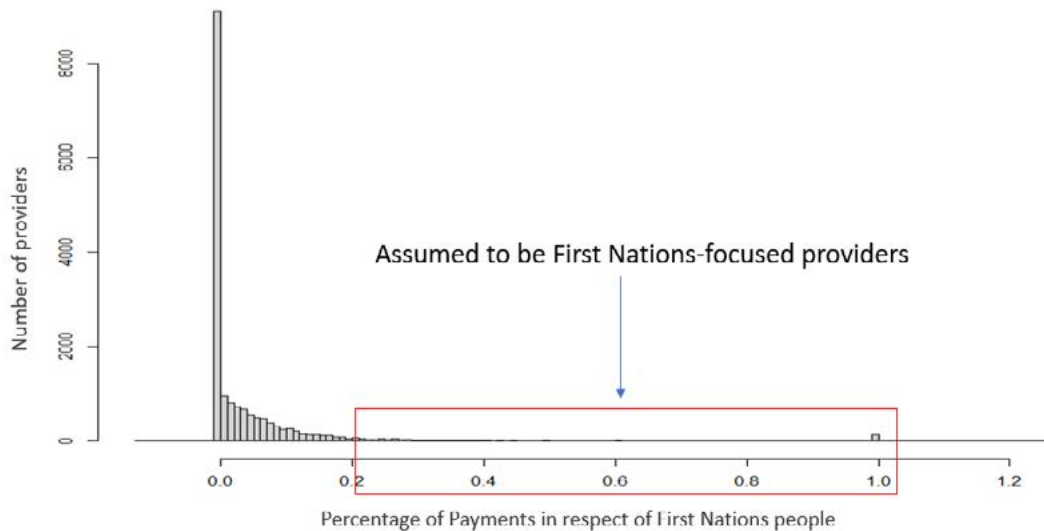


Figure 74. Histogram of NDIS payment amounts received by all providers in respect of First Nations people.

For this analysis we have defined a First Nations-focused provider as someone who has received at least 21% of their payments from claims related to supporting First Nations people. Given that First Nations people comprise 7% of the NDIS population, a cut-off of 21% was chosen to capture those providers which exceeded this mark by 200%. From Figure 84 above we find that this corresponds to a point where the curve appears to flatten out.

- As shown in Figure 81 above we find that there are a large number of providers (53%) who have no payments relating to First Nations people. This then quickly drops off with 4% of providers receiving 1-2% of their payments in respect of First Nations people. From here the distribution slowly declines except for a handful of providers who receive all their payments in respect of First Nations people.
- Under this definition approximately 7% of all providers are classified as First Nations-focused providers.

Appendix E: Analysis of Torres Strait Islands data

The Disability Royal Commission requested specific analyses on Torres Strait Islander people. This section provides descriptive statistics on the Torres Strait Islands.

The analyses below use NDIS data and the SA2 field 'SA2201Desc' to identify those that reside in the Torres Strait Islands. The following SA2 descriptions are used:

- 'Torres Strait Islands'
- 'Torres'

Participants who identify as Torres Strait Islands people, but who reside outside of these SA2 regions have not been counted. No 'Torres Strait Islands status' field exists in the NDIS data supplied.

As the number of participants from the Torres Strait Islands in the NDIS is very low, there is a significant degree of uncertainty related to the results and any trends observed. As such, we have not produced further analyses and investigations into more granular splits of the data (such as by support category).

Figure 75 below shows the Count of Torres Strait Islands participants in the NDIS as well as their share of the scheme across time. The first Torres Strait Islands participants entered in December 2018. Since then, there has been a steady increase in the number of participants, with large increase between July and September 2021. In December 2021, there were 87 participants in the Torres Strait Island region, representing 0.017% of the total NDIS population.

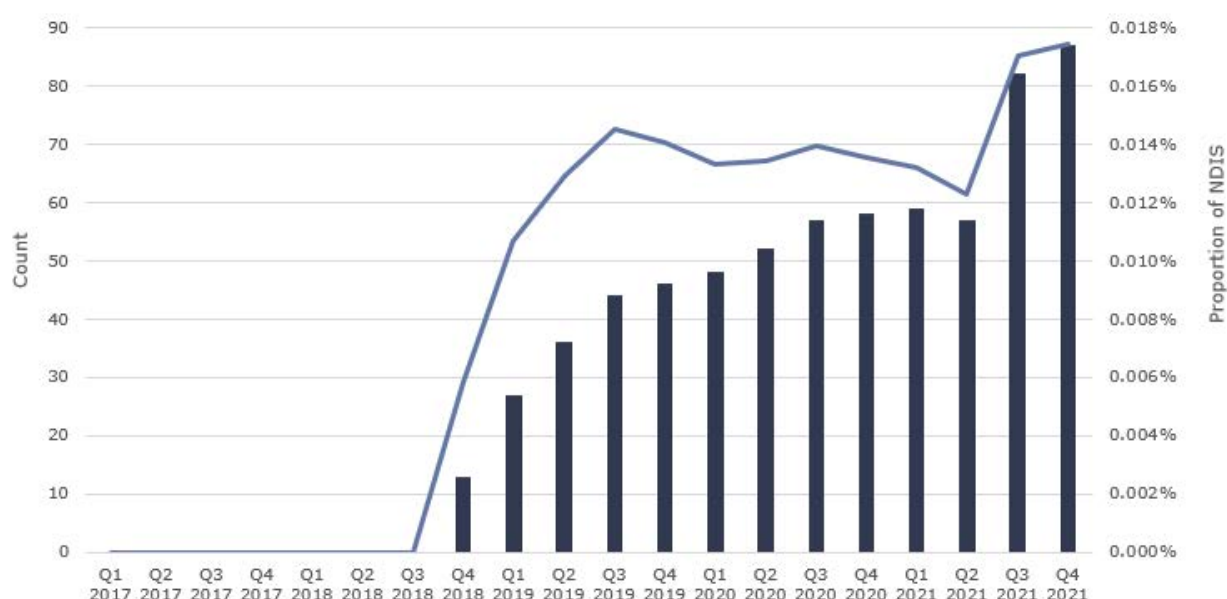


Figure 75. Count and Proportion in the NDIS of Torres Strait Islands participants (NDIS)

Figure 76 below shows the share of primary disabilities of First Nations NDIS participants residing outside of the Torres Strait Islands, Torres Strait Islands residents who are on the NDIS and non-Indigenous NDIS participants.

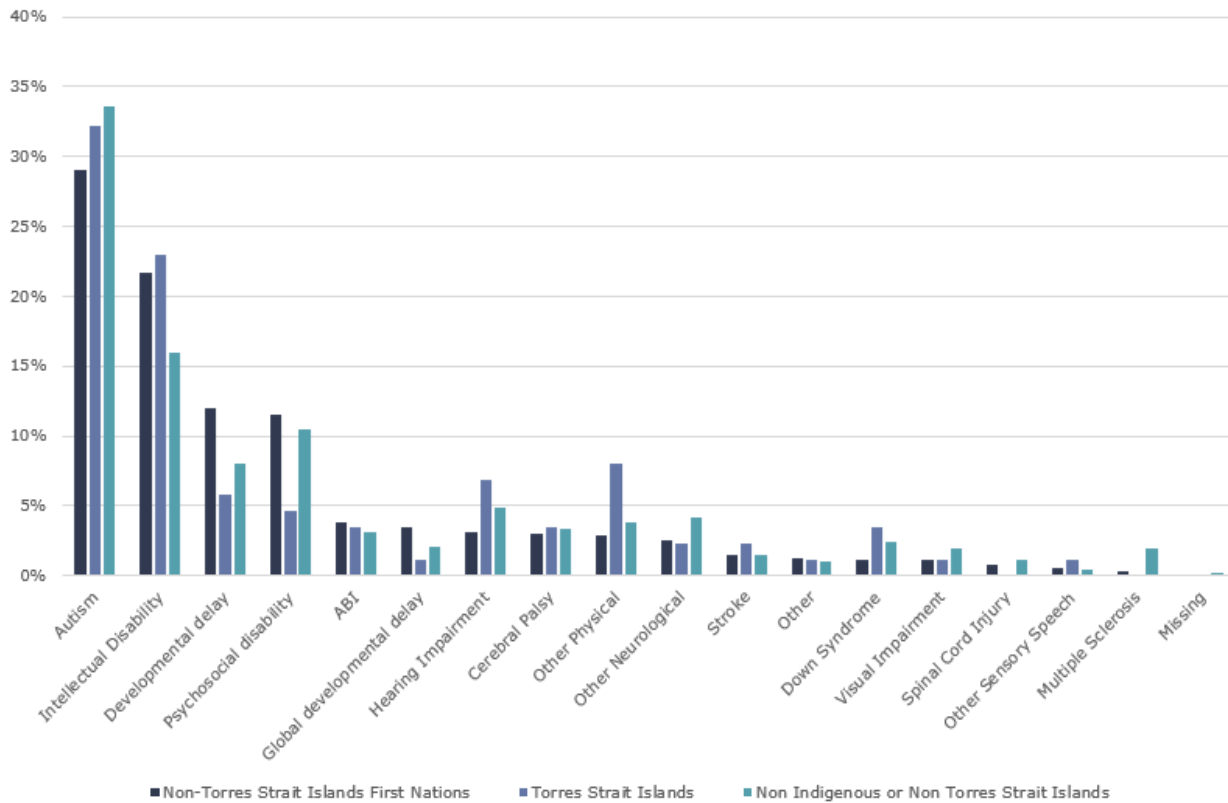


Figure 76. Share of primary disabilities across non-Torres Strait Islands First Nations NDIS participants, Torres Strait Island residents on the NDIS and non-Indigenous NDIS participants (NDIS, 2021)

Figure 77, below shows that on average, participants in the Torres Strait Islands receive 22% less than non-Indigenous or non-Torres Strait Islands participants at \$39,709 per year in 2021. This may be due to a number of reasons, including accessibility of services in particularly remote regions.

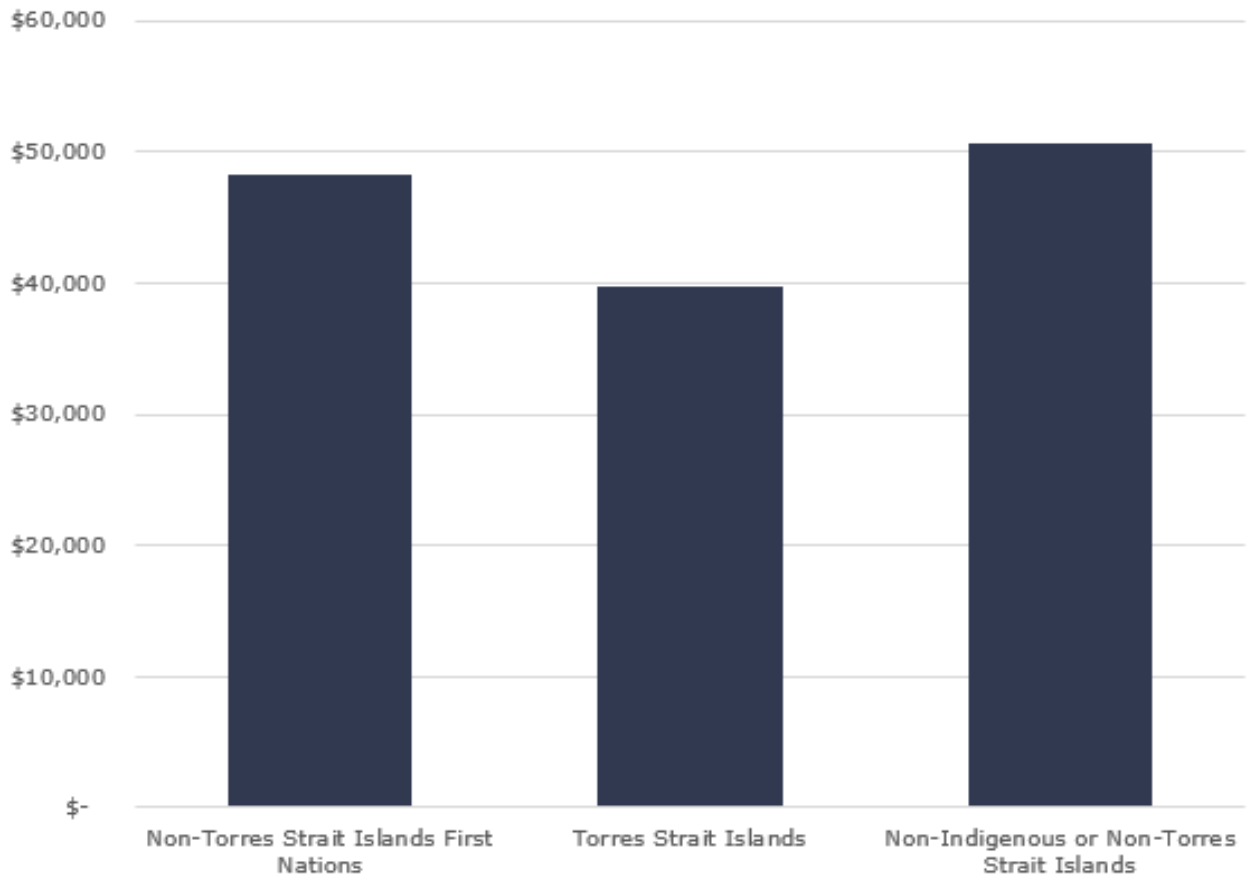


Figure 77. Average cost per participant by non-Torres Strait Islands First Nations, Torres Strait Islands and non-Indigenous or non-Torres Strait status (NDIS, 2021)

Appendix F: Descriptive Tables

We note the following considerations on the tables that follow:

- The information presented in the section that follows is based on the raw data received, i.e., without any adjustments. Hence, the values may differ slightly to the figures presented in the report.
- Decimals have been rounded to the nearest integer, and percentages to the nearest tenth. This may lead to issues where totals do not equal the sum, or percentages don't sum to 100% (e.g., 9 participants divided equally into 3 cohorts, will have percentages 33.3%, 33.3% and 33.3%, which does not sum to 100%)
- Our definition of average payment as outlined in "Data sources and key assumptions" in the body of the report, is not simply the total payments for a given period, divided by the number active participants. Hence, averages cannot be directly calculated from the tables below.
- We have suppressed numbers in tables (np= not provided to maintain suppression and <5 where the count of people is less than 5).

Demographics

The tables that follow provide the demographic details for First Nations and non-Indigenous participants on NDIS and DES, by various breakdowns including Age, Disability Type, State, Remoteness and Support Category.

Table 22. Count of participants on the NDIS on 31 December of each calendar year, First Nations vs non-Indigenous

Year	First Nations	Non-indigenous	Total
2016	3,177	57,190	60,367
2017	6,505	122,819	129,324
2018	12,104	212,525	224,629
2019	19,384	307,988	327,372
2020	28,678	400,528	429,206
2021	35,431	463,995	499,426

Please note: The counts of First Nations and non-Indigenous participants are taken from Q4 of each year.

NDIS Demographics – Age

Table 23. Count of participants on the NDIS on 31 December of each calendar year, First Nations, by age

Year	0 to 6	7 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+	Total
2016	600	1,069	331	312	259	212	207	167	20	3,177
2017	845	2,085	709	739	655	508	533	387	44	6,505
2018	1,814	3,574	1,183	1,319	1,241	1,005	1,028	843	97	12,104
2019	3,759	5,365	1,750	1,832	1,850	1,578	1,710	1,337	203	19,384
2020	5,857	8,016	2,535	2,615	2,657	2,303	2,415	1,927	353	28,678
2021	6,839	10,102	3,176	3,273	3,329	2,847	2,976	2,394	495	35,431

Table 24. Count of participants on NDIS on 31 December of each calendar year, non-Indigenous, by age

Year	0 to 6	7 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+	Total
2016	8,879	16,585	4,940	5,076	4,803	4,599	5,771	5,787	750	57,190
2017	15,362	31,152	10,598	12,071	12,111	11,279	13,713	14,471	2,062	122,819
2018	26,678	51,466	16,332	19,848	21,114	19,838	25,045	27,427	4,777	212,525
2019	46,782	75,095	22,346	25,950	28,450	27,115	34,209	39,446	8,595	307,988
2020	62,971	100,382	29,494	32,405	35,786	33,735	42,111	50,026	13,618	400,528
2021	70,422	119,336	36,166	37,365	40,852	38,192	46,699	56,166	18,797	463,995

NDIS Demographics – Primary Disability Type

Table 25. Count of participants on the NDIS on 31 December of each calendar year, First Nations, by disability type

Year	ABI	Autism	CP*	Developmental delay	Down Syndrome	GDD*	Hearing Impairment	Intellectual Disability	Missing	MS*	Other	Other Neurological	Other Physical	Other Sensory Speech	Psychosocial disability	SCI*	Stroke	Visual Impairment
2016	83	757	126	271	56	129	45	849	156	9	8	103	164	110	218	23	21	49
2017	259	1,696	346	367	134	145	119	1,899	134	29	11	234	249	177	469	59	63	115
2018	519	3,219	598	814	240	272	286	3,337	105	57	19	410	466	228	1,051	141	149	193
2019	829	5,419	823	1,760	324	598	582	4,709	86	76	30	610	723	222	1,837	214	272	270
2020	1,140	8,019	1,002	3,346	370	996	931	6,494	0	99	156	796	970	252	3,066	262	427	352
2021	1,357	10,282	1,076	4,228	395	1,238	1,089	7,698	46	121	442	895	1,040	213	4,095	282	544	390

*GDD=Global Developmental Delay; MS= Multiple Sclerosis; SCI=Spinal Cord Injury; Cerebral Palsy

Table 26. Count of participants on the NDIS on 31 December of each calendar year, non-Indigenous, by disability type

Year	ABI	Autism	CP*	Developmental delay	Down Syndrome	GDD*	Hearing Impairment	Intellectual Disability	Missing	MS*	Other	Other Neurological	Other Physical	Other Sensory Speech	Psychosocial disability	SCI*	Stroke	Visual Impairment
2016	1,359	15,979	2,551	3,430	2,063	1,200	1,341	13,542	2,334	983	136	2,399	2,560	1,741	3,439	426	483	1,224
2017	3,938	34,918	6,393	5,317	5,023	1,502	3,466	30,232	2,049	2,560	225	5,667	4,881	2,426	8,319	1,503	1,444	2,956
2018	7,170	62,187	10,420	8,949	8,079	2,881	7,607	48,512	1,482	4,794	350	10,303	8,939	2,477	17,284	2,827	2,826	5,438
2019	10,082	95,352	13,246	17,357	9,941	5,422	14,206	60,565	1,335	6,454	527	14,251	13,431	2,471	27,852	3,931	4,327	7,238
2020	12,828	128,275	15,114	29,749	10,906	7,733	19,997	69,820	0	7,918	1,946	17,688	17,101	2,505	40,083	4,650	5,903	8,312
2021	14,466	155,625	15,734	37,495	11,039	9,340	22,408	74,061	807	8,957	4,822	19,435	17,948	2,141	48,722	5,062	7,044	8,889

*CP=Cerebral Palsy; GDD=Global Developmental Delay; MS= Multiple Sclerosis; SCI=Spinal Cord Injury

NDIS Demographics – State and Territory

Table 27. Count of participants on the NDIS on 31 December of each calendar year, First Nations, by state

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Missing	Total
2016	221	1,442	139	303	469	140	211	131	121	3,177
2017	226	3,110	498	1,075	596	229	525	161	85	6,505
2018	256	5,375	862	2,654	950	367	1,213	427	np	12,104
2019	274	7,215	1,396	5,094	1,325	557	2,153	1,368	np	19,384
2020	329	9,934	1,880	7,698	2,122	815	3,295	2,601	np	28,678
2021	388	11,942	2,288	9,792	2,600	1,021	4,079	3,310	11	35,431

*np = not provided

Table 28. Count of participants on the NDIS on 31 December of each calendar year, non-Indigenous, by state

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Missing	Total
2016	4,968	26,483	29	2,384	9,224	1,417	8,718	2,688	1,279	57,190
2017	5,373	61,438	176	11,422	13,198	2,659	23,865	3,726	962	122,819
2018	6,011	86,943	720	30,359	21,944	4,512	53,124	8,912	0	212,525
2019	6,570	103,023	1,393	55,810	26,975	6,852	85,836	21,449	80	307,988
2020	7,663	123,928	1,949	76,083	35,581	8,948	112,273	34,069	34	400,528
2021	8,436	140,307	2,287	92,474	40,982	10,349	129,063	40,048	49	463,995

NDIS Demographics – Remoteness

Table 29. Count of participants on NDIS on 31 December of each calendar year, First Nations, by remoteness

Year	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing	Total
2016	1,932	303	243	163	173	55	185	123	3,177
2017	3,025	943	759	528	540	215	404	91	6,505
2018	5,165	1,966	1,693	1,043	1,113	450	674	0	12,104
2019	8,283	3,154	2,604	1,479	1,816	881	1,159	8	19,384
2020	12,413	4,605	3,856	2,181	2,589	1,328	1,689	17	28,678
2021	15,542	5,659	4,725	2,627	3,136	1,667	2,062	13	35,431

Table 30. Count of participants on the NDIS on 31 December of each calendar year, non-Indigenous, by remoteness

Year	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing	Total
2016	44,049	4,260	2,738	2,071	2,446	279	61	1,286	57,190
2017	81,447	14,169	10,581	6,713	8,187	561	184	977	122,819
2018	143,522	22,994	19,194	11,290	14,020	1,128	364	13	212,525
2019	212,720	31,884	26,196	14,773	19,950	1,844	524	97	307,988
2020	279,465	41,087	33,190	18,123	25,324	2,494	824	21	400,528
2021	324,881	47,879	37,710	20,512	29,079	2,919	1,001	14	463,995

NDIS Demographics – Remoteness and Primary Disability Type

Table 31. Proportion of disability types for First nations participants on the NDIS split by remoteness on 31 December of 2017

Remoteness/Primary Disability Type	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
ABI	2.5%	5.3%	3.4%	3.8%	3.7%	11.6%	8.9%	6.6%
Autism	28.2%	24.6%	29.1%	30.3%	32.0%	9.8%	4.0%	20.9%
Cerebral Palsy	4.3%	6.6%	5.9%	4.9%	3.9%	15.8%	4.7%	9.9%
Developmental delay	6.9%	4.9%	4.2%	5.1%	4.8%	1.9%	4.0%	6.6%
Down Syndrome	1.8%	1.8%	2.9%	2.7%	2.6%	2.3%	1.7%	1.1%
Global developmental delay	3.0%	1.5%	0.8%	1.9%	2.2%	0.9%	2.0%	1.1%
Hearing Impairment	1.8%	1.4%	2.1%	1.3%	1.5%	1.4%	4.0%	1.1%
Intellectual Disability	26.9%	33.8%	33.2%	29.4%	27.6%	38.1%	24.5%	33.0%
Missing	2.6%	1.0%	0.9%	0.6%	1.5%	0.5%	6.2%	3.3%
Multiple Sclerosis	0.5%	0.5%	0.4%	0.6%	0.4%	0.0%	0.5%	0.0%
Other	0.2%	0.0%	0.1%	0.4%	0.0%	0.5%	0.5%	0.0%
Other Neurological	2.9%	3.1%	3.4%	4.4%	3.5%	4.2%	9.2%	4.4%
Other Physical	3.7%	2.9%	2.5%	3.0%	3.3%	3.3%	11.6%	3.3%
Other Sensory Speech	3.7%	1.1%	1.4%	2.7%	3.5%	2.3%	1.7%	0.0%
Psychosocial disability	8.2%	7.8%	5.4%	6.4%	5.4%	2.8%	7.9%	6.6%
Spinal Cord Injury	0.5%	1.3%	1.2%	0.8%	0.9%	1.4%	2.5%	0.0%
Stroke	0.7%	0.8%	0.9%	1.3%	1.1%	0.5%	3.2%	1.1%
Visual Impairment	1.7%	1.7%	2.0%	0.6%	2.0%	2.8%	3.0%	1.1%

Table 32. Proportion of disability types for First nations participants on the NDIS split by remoteness on 31 December of 2022

Remoteness/Primary Disability Type	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Town	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
ABI	3.3%	3.5%	3.5%	3.4%	3.2%	6.7%	8.8%	7.7%
Autism	31.7%	28.6%	30.2%	31.2%	32.0%	16.4%	9.9%	7.7%
Cerebral Palsy	2.7%	3.6%	3.0%	2.5%	2.7%	4.6%	3.8%	0.0%
Developmental delay	10.9%	14.1%	14.0%	14.3%	14.7%	7.3%	5.5%	23.1%
Down Syndrome	1.0%	1.2%	1.2%	1.2%	1.2%	1.4%	1.3%	0.0%
Global developmental delay	4.4%	2.1%	3.2%	2.6%	3.3%	3.2%	3.1%	0.0%
Hearing Impairment	2.8%	3.1%	2.8%	2.7%	3.3%	2.7%	6.1%	0.0%
Intellectual Disability	20.4%	22.1%	23.9%	22.9%	20.2%	26.3%	22.7%	23.1%
Missing	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%
Multiple Sclerosis	0.4%	0.3%	0.3%	0.3%	0.5%	0.1%	0.1%	0.0%
Other	0.9%	1.5%	1.0%	0.7%	1.3%	2.9%	3.0%	7.7%
Other Neurological	2.3%	2.5%	1.9%	2.2%	2.8%	4.5%	4.2%	0.0%
Other Physical	2.5%	2.6%	2.1%	2.7%	3.3%	4.8%	7.3%	15.4%
Other Sensory Speech	0.6%	0.5%	0.5%	0.9%	0.7%	0.7%	0.6%	0.0%
Psychosocial disability	13.1%	10.6%	9.4%	9.3%	8.0%	11.8%	15.6%	15.4%
Spinal Cord Injury	0.7%	1.0%	0.6%	0.7%	0.6%	1.3%	1.5%	0.0%
Stroke	1.0%	1.6%	1.3%	1.4%	1.5%	3.7%	4.2%	0.0%
Visual Impairment	1.0%	0.9%	1.1%	0.8%	0.8%	1.9%	2.1%	0.0%

Table 33. Proportion of disability types for non-Indigenous participants on the NDIS split by remoteness on 31 December of 2017

Remoteness/Primary Disability Type	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
ABI	2.9%	3.5%	3.8%	4.0%	3.9%	3.4%	6.5%	2.4%
Autism	28.6%	28.0%	27.9%	25.7%	29.6%	35.8%	28.3%	27.7%
Cerebral Palsy	5.1%	5.9%	5.4%	5.0%	5.2%	7.5%	4.3%	5.4%
Developmental delay	4.6%	3.7%	3.8%	4.0%	3.8%	4.8%	6.5%	4.7%
Down Syndrome	3.8%	4.6%	5.1%	4.9%	4.4%	4.1%	2.2%	2.5%
Global developmental delay	1.4%	0.9%	0.8%	0.7%	1.2%	1.6%	0.5%	1.3%
Hearing Impairment	3.1%	2.8%	1.6%	2.0%	2.1%	2.3%	5.4%	2.9%
Intellectual Disability	23.2%	25.7%	31.2%	29.8%	24.2%	17.6%	17.4%	25.4%
Missing	2.0%	0.9%	1.0%	1.0%	1.0%	2.9%	1.1%	2.4%
Multiple Sclerosis	2.2%	2.0%	1.7%	1.7%	2.4%	0.9%	2.7%	1.7%
Other	0.2%	0.2%	0.1%	0.1%	0.2%	0.0%	0.0%	0.2%
Other Neurological	4.6%	4.9%	3.8%	4.5%	5.4%	3.9%	3.8%	4.3%
Other Physical	3.9%	4.0%	3.2%	4.8%	4.6%	5.0%	8.2%	3.9%
Other Sensory Speech	2.2%	1.1%	1.2%	1.6%	2.1%	3.2%	3.3%	1.9%
Psychosocial disability	7.3%	7.2%	4.8%	5.5%	4.5%	2.7%	5.4%	8.9%
Spinal Cord Injury	1.1%	1.3%	1.4%	1.6%	1.8%	2.5%	1.1%	0.7%
Stroke	1.3%	0.9%	0.8%	1.0%	1.4%	0.4%	2.2%	1.6%
Visual Impairment	2.5%	2.4%	2.4%	2.2%	2.2%	1.4%	1.1%	2.0%

Table 34. Proportion of disability types for non-Indigenous participants on the NDIS split by remoteness on 31 December of 2021

Remoteness/Primary Disability Type	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
ABI	3.0%	3.3%	3.5%	3.5%	3.4%	3.2%	3.8%	7.1%
Autism	33.9%	33.7%	32.2%	30.4%	32.9%	35.7%	32.5%	21.4%
Cerebral Palsy	3.4%	3.5%	3.4%	3.4%	2.9%	3.3%	2.3%	0.0%
Developmental delay	7.8%	9.8%	8.1%	8.5%	8.3%	6.9%	6.2%	7.1%
Down Syndrome	2.3%	2.4%	2.7%	2.8%	2.6%	2.7%	2.3%	0.0%
Global developmental delay	2.2%	1.5%	1.5%	1.4%	1.5%	2.5%	2.6%	0.0%
Hearing Impairment	5.1%	4.6%	3.5%	3.9%	4.5%	4.6%	8.0%	7.1%
Intellectual Disability	15.3%	16.2%	19.5%	19.4%	16.3%	14.6%	14.6%	14.3%
Missing	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%
Multiple Sclerosis	1.9%	1.9%	1.8%	1.7%	2.5%	1.6%	1.6%	0.0%
Other	1.0%	1.1%	1.0%	1.2%	1.4%	1.5%	2.0%	7.1%
Other Neurological	4.2%	4.2%	4.0%	4.3%	4.6%	4.5%	4.6%	7.1%
Other Physical	3.7%	3.7%	4.0%	4.2%	4.9%	4.7%	7.6%	7.1%
Other Sensory Speech	0.5%	0.4%	0.5%	0.6%	0.5%	0.7%	0.9%	0.0%
Psychosocial disability	11.0%	9.2%	9.9%	9.8%	8.4%	7.2%	6.0%	21.4%
Spinal Cord Injury	1.0%	1.2%	1.1%	1.2%	1.6%	2.0%	2.0%	0.0%
Stroke	1.5%	1.5%	1.4%	1.6%	1.8%	2.2%	2.2%	0.0%
Visual Impairment	2.0%	1.7%	1.8%	2.0%	1.9%	2.0%	0.9%	0.0%

NDIS Demographics – Primary Disability type

Table 35. Proportion of participants on the NDIS on 31 December of each calendar year, First Nations, split by primary disability

Year	ABI	Autism	CP*	Developmental delay	Down Syndrome	GDD*	Hearing Impairment	Intellectual Disability	Missing	MS*	Other	Other Neurological	Other Physical	Other Sensory Speech	Psychosocial disability	SCI*	Stroke	Visual Impairment
2016	2.6%	23.8%	4.0%	8.5%	1.8%	4.1%	1.4%	26.7%	4.9%	0.3%	0.3%	3.2%	5.2%	3.5%	6.9%	0.7%	0.7%	1.5%
2017	4.0%	26.1%	5.3%	5.6%	2.1%	2.2%	1.8%	29.2%	2.1%	0.4%	0.2%	3.6%	3.8%	2.7%	7.2%	0.9%	1.0%	1.8%
2018	4.3%	26.6%	4.9%	6.7%	2.0%	2.2%	2.4%	27.6%	0.9%	0.5%	0.2%	3.4%	3.8%	1.9%	8.7%	1.2%	1.2%	1.6%
2019	4.3%	28.0%	4.2%	9.1%	1.7%	3.1%	3.0%	24.3%	0.4%	0.4%	0.2%	3.1%	3.7%	1.1%	9.5%	1.1%	1.4%	1.4%
2020	4.0%	28.0%	3.5%	11.7%	1.3%	3.5%	3.2%	22.6%	0.0%	0.3%	0.5%	2.8%	3.4%	0.9%	10.7%	0.9%	1.5%	1.2%
2021	3.8%	29.0%	3.0%	11.9%	1.1%	3.5%	3.1%	21.7%	0.1%	0.3%	1.2%	2.5%	2.9%	0.6%	11.6%	0.8%	1.5%	1.1%

*CP=Cerebral Palsy; GDD=Global Developmental Delay; MS= Multiple Sclerosis; SCI=Spinal Cord Injury

Table 36. Proportion of participants on the NDIS on 31 December of each calendar year, non-Indigenous, split by primary disability

Year	ABI	Autism	CP*	Developmental delay	Down Syndrome	GDD*	Hearing Impairment	Intellectual Disability	Missing	MS*	Other	Other Neurological	Other Physical	Other Sensory Speech	Psychosocial disability	SCI*	Stroke	Visual Impairment
2016	2.4%	27.9%	4.5%	6.0%	3.6%	2.1%	2.3%	23.7%	4.1%	1.7%	0.2%	4.2%	4.5%	3.0%	6.0%	0.7%	0.8%	2.1%
2017	3.2%	28.4%	5.2%	4.3%	4.1%	1.2%	2.8%	24.6%	1.7%	2.1%	0.2%	4.6%	4.0%	2.0%	6.8%	1.2%	1.2%	2.4%
2018	3.4%	29.3%	4.9%	4.2%	3.8%	1.4%	3.6%	22.8%	0.7%	2.3%	0.2%	4.8%	4.2%	1.2%	8.1%	1.3%	1.3%	2.6%
2019	3.3%	31.0%	4.3%	5.6%	3.2%	1.8%	4.6%	19.7%	0.4%	2.1%	0.2%	4.6%	4.4%	0.8%	9.0%	1.3%	1.4%	2.4%
2020	3.2%	32.0%	3.8%	7.4%	2.7%	1.9%	5.0%	17.4%	0.0%	2.0%	0.5%	4.4%	4.3%	0.6%	10.0%	1.2%	1.5%	2.1%
2021	3.1%	33.5%	3.4%	8.1%	2.4%	2.0%	4.8%	16.0%	0.2%	1.9%	1.0%	4.2%	3.9%	0.5%	10.5%	1.1%	1.5%	1.9%

*CP=Cerebral Palsy; GDD=Global Developmental Delay; MS= Multiple Sclerosis; SCI=Spinal Cord Injury

NDIS Demographics – Support category and Primary Disability Type

Table 37. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2017, First Nations, by primary disability

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	104	29	125	109	104	93
Autism	993	73	364	486	428	197
Cerebral Palsy	190	94	146	156	117	106
Developmental delay	316	11	29	40	66	np
Down Syndrome	77	13	53	72	37	42
Global developmental delay	132	7	24	29	43	np
Hearing Impairment	43	11	13	22	26	15
Intellectual Disability	888	95	653	717	780	558
Missing	140	29	73	71	78	35
Multiple Sclerosis	15	7	15	12	11	14
Other	7	np	6	6	<5	5
Other Neurological	134	53	104	103	89	78
Other Physical	159	69	130	99	100	104
Other Sensory/Speech	127	6	19	15	40	5
Psychosocial disability	196	10	201	203	216	165
Spinal Cord Injury	33	21	32	37	25	31
Stroke	26	18	25	29	25	24
Visual Impairment	54	17	42	46	29	55

*np= not provided

Table 38. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2022, First Nations, by primary disability

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	1,207	285	998	1,017	1,143	701
Autism	8,592	225	3,180	4,947	3,729	1,319
Cerebral Palsy	986	562	654	804	671	419
Developmental delay	4,117	94	399	1,061	948	26
Down Syndrome	356	44	224	309	194	165
Global developmental delay	1,152	53	151	355	405	11
Hearing Impairment	774	52	230	493	349	113
Intellectual Disability	6,337	491	3,657	4,486	5,222	2,638
Multiple Sclerosis	109	55	109	96	89	88
Other	351	144	223	258	269	161
Other Neurological	844	282	667	706	691	476
Other Physical	1,012	494	733	803	672	595
Other Sensory/Speech	219	np	22	55	89	np
Psychosocial disability	3,355	127	2,837	2,981	3,477	2,223
Spinal Cord Injury	272	193	250	250	215	208
Stroke	509	206	446	447	460	345
Visual Impairment	349	55	256	298	228	252

*np= not provided

Table 39. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2017, non-Indigenous, by primary disability

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	2,075	637	2,084	2,096	1,708	2,057
Autism	24,122	1,414	8,814	11,751	8,237	5,437
Cerebral Palsy	4,188	1,945	2,882	3,112	1,933	2,515
Developmental delay	5,121	302	483	653	648	83
Down Syndrome	3,009	443	2,416	2,971	1,391	2,457
Global developmental delay	1,574	149	264	357	298	38
Hearing Impairment	1,575	752	327	807	583	258
Intellectual Disability	17,416	2,501	13,124	16,373	11,306	13,754
Missing	2,225	709	1,228	1,301	1,068	821
Multiple Sclerosis	1,705	857	1,654	1,250	920	1,466
Other	156	72	104	96	91	99
Other Neurological	3,683	1,568	3,049	2,739	2,044	2,763
Other Physical	3,580	1,848	2,713	2,193	1,657	2,456
Other Sensory/Speech	2,248	120	218	273	347	58
Psychosocial disability	4,170	232	3,764	3,938	4,030	3,614
Spinal Cord Injury	903	581	897	881	506	803
Stroke	884	401	784	661	534	764
Visual Impairment	1,704	594	1,142	1,078	716	1,719

Table 40. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2022, non-Indigenous, by primary disability

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	13,402	4,213	11,988	11,775	11,176	10,138
Autism	136,827	4,492	52,954	83,071	33,744	25,713
Cerebral Palsy	15,068	8,931	10,956	12,635	7,222	8,146
Developmental delay	38,973	1,174	5,034	13,681	2,756	452
Down Syndrome	10,301	2,080	7,805	9,584	4,914	7,136
Global developmental delay	9,526	720	1,491	3,605	936	152
Hearing Impairment	14,474	2,055	4,608	12,039	2,728	1,913
Intellectual Disability	66,102	12,149	47,332	56,554	39,708	41,122
Multiple Sclerosis	8,543	4,326	8,163	7,131	5,568	7,037
Other	3,802	1,600	2,716	2,830	2,096	2,098
Other Neurological	19,108	8,126	16,553	16,156	12,950	13,256
Other Physical	16,996	9,493	13,795	14,208	7,176	10,580
Other Sensory/Speech	2,177	37	410	713	288	129
Psychosocial disability	43,244	1,826	38,300	37,383	40,797	31,151
Spinal Cord Injury	4,722	3,428	4,553	4,529	2,686	3,413
Stroke	6,696	3,048	6,162	5,840	4,667	5,362
Visual Impairment	7,583	1,500	6,220	6,653	2,802	6,920

NDIS Demographics – Remoteness and Support Category

Table 41. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2017, First Nations, by MMM remoteness

MMM Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	2,042	293	966	1,082	1,098	719
Regional Centres	483	85	340	369	399	237
Large Rural Towns	300	65	218	257	181	197
Medium Rural Towns	251	33	156	175	138	124
Small Rural Towns	238	33	126	157	101	108
Remote Communities	51	9	63	42	46	34
Very Remote Communities	165	30	124	96	173	69
Missing	104	16	61	74	82	44

Table 42. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2022, First Nations, by MMM remoteness

MMM Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	13,267	1,445	6,783	8,432	7,708	4,340
Regional Centres	4,849	616	2,420	3,362	2,956	1,628
Large Rural Towns	4,109	400	1,904	2,491	2,336	1,297
Medium Rural Towns	2,298	205	1,054	1,423	1,228	745
Small Rural Towns	2,730	276	1,157	1,572	1,411	770
Remote Communities	1,439	196	766	947	1,357	413
Very Remote Communities	1,832	225	946	1,129	1,836	547
Missing	17	<5	6	10	19	6

Table 43. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2017, non-Indigenous, by MMM remoteness

MMM Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	57,364	11,190	31,071	35,285	26,985	27,542
Regional Centres	8,243	1,480	5,350	6,277	4,619	4,693
Large Rural Towns	5,077	812	3,702	4,154	2,148	3,585
Medium Rural Towns	3,648	649	2,391	2,846	1,672	2,314
Small Rural Towns	4,287	713	2,526	2,961	1,667	2,381
Remote Communities	337	72	160	164	135	93
Very Remote Communities	93	19	61	50	48	34
Missing	1,289	190	686	793	743	520

Table 44. Count of participants on the NDIS who have made at least one claim in a support category on 31 December of 2022, non-Indigenous, by MMM remoteness

MMM Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	292,620	48,522	168,033	208,398	126,397	122,467
Regional Centres	42,561	6,941	23,687	31,742	18,191	17,403
Large Rural Towns	34,278	5,730	20,117	24,749	16,012	15,035
Medium Rural Towns	18,596	3,134	11,101	13,498	8,412	8,288
Small Rural Towns	25,964	4,283	14,377	17,643	10,606	10,371
Remote Communities	2,614	429	1,312	1,774	1,872	889
Very Remote Communities	892	157	402	569	706	256
Missing	19	np	11	14	18	9

*np= not provided

DES Demographics

Table 45. Count of people on DES on 30 June of each financial year, First Nations vs non-Indigenous

Year	First Nations	non-Indigenous	Total
2014	7,627	151,653	159,280
2015	8,516	164,525	173,041
2016	9,608	173,160	182,768
2017	10,612	176,454	187,066
2018	11,476	181,965	193,441
2019	15,482	222,845	238,327
2020	19,646	264,335	283,981
2021	21,781	294,145	315,926

Table 46. Count of participants on DES on 30 June of each financial year, First Nations, by disability type

Year	Acquired brain injury	Autism	Deaf blind	Hearing	Intellectual	Neurological	Physical	Psychiatric	Specific Learning	Speech	Unknown	Vision
2014	130	191	np	139	433	298	3,078	2,760	484	np	np	85
2015	147	257	np	143	530	317	3,409	3,129	478	np	np	78
2016	142	285	11	158	527	355	3,833	3,706	488	19	8	76
2017	144	348	11	142	536	345	4,163	4,288	503	16	8	108
2018	136	271	11	141	485	394	4,929	4,446	342	10	209	102
2019	213	488	10	170	801	486	5,655	6,858	617	28	37	119
2020	260	614	9	184	838	616	7,028	9,174	745	26	16	136
2021	267	728	10	200	847	691	8,088	10,020	749	31	19	131

*np= not provided

Table 47. Count of participants on DES on 30 June of each financial year, non-Indigenous, by disability type

Year	Acquired brain injury	Autism	Deaf blind	Hearing	Intellectual	Neurological	Physical	Psychiatric	Specific Learning	Speech	Unknown	Vision
2014	2,119	5,182	160	2,698	7,649	6,407	66,419	52,418	6,248	281	53	2,019
2015	2,080	5,904	169	2,633	7,789	6,704	72,594	58,149	6,143	321	35	2,004
2016	1,991	6,279	161	2,608	7,479	7,093	77,055	62,372	5,712	320	115	1,975
2017	1,998	6,730	195	2,512	7,319	6,949	76,966	65,770	5,517	337	110	2,051
2018	1,716	5,759	151	2,347	5,566	7,080	86,638	62,471	3,799	223	4,231	1,984
2019	2,390	9,129	202	2,817	8,853	8,376	92,778	88,873	6,128	377	426	2,496
2020	2,681	10,420	179	3,042	9,184	9,804	110,348	108,442	6,879	376	217	2,763
2021	2,871	11,581	183	3,215	9,127	10,916	127,873	117,551	7,251	416	234	2,927

NDIS Payments

The tables that follow provide payment details for First Nations and non-Indigenous participants on NDIS and DES, by various breakdowns including Age, Disability Type, State, Remoteness and Support Category.

Note, the averages shown in this section are of average payment size and not average payment per participant and therefore cannot be derived by taking total payments and dividing by the count of participants shown in the previous section.

Table 48. Average payment size on the NDIS per calendar year, First Nations vs non-Indigenous

Year	First Nations	non-Indigenous
Jun-Dec 2016	\$5,967	\$6,194
2017	\$24,172	\$23,905
2018	\$26,962	\$30,182
2019	\$37,146	\$39,097
2020	\$43,924	\$45,245
2021	\$48,291	\$50,665

Table 49. Total payments on NDIS per calendar year, First Nations vs non-Indigenous

Year	First Nations	non-Indigenous	Total
June – Dec 2016	\$11,158,807	\$229,372,145	\$240,530,953
2017	\$118,517,283	\$2,448,780,765	\$2,567,298,049
2018	\$261,881,205	\$5,622,982,861	\$5,884,864,066
2019	\$626,764,290	\$11,285,178,922	\$11,911,943,212
2020	\$1,112,736,555	\$17,036,861,064	\$18,149,597,619
2021	\$1,562,760,746	\$22,313,190,394	\$23,875,951,140

Table 50. Average payment size on NDIS per calendar year, First nations, by age

Year	0 to 6	7 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
Jun-Dec 2016	\$2,736	\$3,554	\$5,632	\$10,333	\$10,667	\$9,526	\$10,923	\$8,246	\$1,804
2017	\$7,160	\$10,017	\$21,498	\$45,401	\$52,391	\$42,461	\$43,845	\$30,617	\$12,027
2018	\$6,976	\$9,750	\$23,905	\$48,022	\$39,112	\$50,162	\$52,955	\$37,746	\$27,599
2019	\$8,083	\$12,054	\$28,698	\$59,806	\$78,151	\$68,224	\$68,424	\$52,629	\$52,083
2020	\$10,254	\$15,528	\$38,556	\$71,698	\$85,486	\$79,747	\$82,710	\$73,658	\$73,115
2021	\$12,306	\$17,954	\$40,176	\$80,832	\$86,805	\$88,421	\$89,383	\$85,398	\$95,688

Table 51. Average payments size on NDIS per calendar year, non-Indigenous, by age

Year	0 to 6	7 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
June-Dec 2016	\$2,892	\$2,831	\$4,545	\$8,350	\$10,130	\$9,857	\$9,945	\$8,741	\$6,975
2017	\$7,584	\$9,632	\$18,868	\$36,509	\$42,618	\$41,249	\$40,245	\$34,870	\$13,494
2018	\$8,163	\$10,587	\$23,092	\$44,090	\$49,850	\$49,127	\$45,960	\$38,548	\$38,950
2019	\$9,577	\$12,929	\$29,533	\$56,560	\$67,650	\$64,671	\$61,889	\$53,891	\$54,528
2020	\$12,344	\$15,603	\$35,147	\$63,427	\$75,618	\$73,937	\$73,791	\$67,654	\$69,525
2021	\$14,009	\$17,333	\$37,334	\$69,376	\$83,158	\$81,909	\$83,152	\$81,051	\$82,759

Table 52. Total payments for participants on NDIS per calendar year, First Nations, by age

Year	0 to 6	7 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+	Total
Jun-Dec 2016	\$1,075,277	\$2,142,868	\$923,707	\$1,953,025	\$1,589,436	\$1,305,080	\$1,234,292	\$915,274	\$19,848	\$11,158,807
2017	\$5,520,388	\$12,781,135	\$9,136,738	\$21,202,363	\$23,890,319	\$15,583,061	\$16,222,473	\$8,082,949	\$6,097,858	\$118,517,283
2018	\$11,845,008	\$25,945,524	\$21,395,322	\$47,685,723	\$40,050,498	\$41,785,168	\$45,753,524	\$25,516,111	\$1,904,327	\$261,881,205
2019	\$26,780,540	\$53,726,265	\$41,096,207	\$94,972,572	\$129,808,611	\$97,628,186	\$110,093,804	\$65,470,600	\$7,187,506	\$626,764,290
2020	\$58,079,161	\$100,416,411	\$82,972,565	\$153,649,068	\$201,489,637	\$170,978,012	\$189,653,340	\$136,634,667	\$18,863,692	\$1,112,736,555
2021	\$87,703,443	\$152,378,800	\$109,239,117	\$220,185,757	\$261,630,299	\$237,763,870	\$255,456,700	\$199,744,831	\$38,657,929	\$1,562,760,746
Total	\$191,003,817	\$347,391,003	\$264,763,657	\$539,648,508	\$658,458,799	\$565,043,378	\$618,414,132	\$436,364,433	\$72,731,160	\$3,693,818,887

Table 53. Total payments for participants on NDIS per calendar year, non-Indigenous, by age

Year	0 to 6	7 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+	Total
Jun-Dec 2016	\$17,298,896	\$28,375,471	\$11,676,410	\$27,771,634	\$34,552,866	\$31,167,903	\$39,294,298	\$34,979,883	\$4,254,784	\$229,372,145
2017	\$112,004,349	\$211,793,310	\$136,829,832	\$313,285,731	\$381,856,486	\$350,618,262	\$419,956,383	\$368,999,549	\$153,436,863	\$2,448,780,765
2018	\$222,877,648	\$445,752,355	\$314,700,811	\$734,007,884	\$928,859,902	\$874,560,343	\$1,031,386,315	\$946,198,794	\$124,638,809	\$5,622,982,861
2019	\$451,788,644	\$849,523,551	\$584,192,099	\$1,329,559,987	\$1,822,627,140	\$1,707,260,518	\$2,098,667,500	\$2,092,579,461	\$348,980,024	\$11,285,178,922
2020	\$823,666,629	\$1,364,702,104	\$889,917,485	\$1,803,472,344	\$2,521,554,429	\$2,423,741,021	\$3,089,609,420	\$3,394,215,951	\$725,981,682	\$17,036,861,063
2021	\$1,076,217,508	\$1,835,368,879	\$1,144,525,610	\$2,265,830,459	\$3,176,206,185	\$3,052,079,622	\$3,881,133,515	\$4,619,254,190	\$1,262,574,427	\$22,313,190,394
Total	\$2,703,853,673	\$4,735,515,669	\$3,081,842,247	\$6,473,928,038	\$8,865,657,007	\$8,439,427,669	\$10,560,047,430	\$11,456,227,828	\$2,619,866,589	\$58,936,366,152

Table 54. Average payment size on the NDIS per calendar year, First Nations, by disability type

Year	ABI	Autism	Cerebral Palsy	Developmental delay	Down Syndrome	Global developmental delay	Hearing Impairment	Intellectual Disability	Missing
Jun-Dec 2016	\$12,996	\$4,289	\$9,997	\$2,397	\$5,088	\$2,639	\$5,211	\$8,318	\$7,425
2017	\$45,949	\$15,474	\$43,237	\$6,435	\$24,511	\$8,106	\$10,812	\$33,577	\$27,326
2018	\$62,121	\$16,985	\$19,339	\$5,446	\$36,863	\$6,058	\$6,497	\$40,195	\$28,919
2019	\$80,028	\$19,178	\$87,481	\$6,166	\$47,286	\$7,497	\$9,513	\$50,136	\$48,844
2020	\$105,054	\$23,491	\$105,203	\$7,362	\$64,331	\$10,194	\$10,915	\$57,983	
2021	\$123,839	\$26,072	\$121,374	\$9,387	\$76,158	\$12,528	\$13,145	\$62,653	

Table 55. Average payment size on the NDIS per calendar year, First Nations, by disability type

Year	Multiple Sclerosis	Other	Other Neurological	Other Physical	Other Sensory Speech	Psychosocial disability	Spinal Cord Injury	Stroke	Visual Impairment
Jun-Dec 2016	\$3,056	\$8,118	\$8,073	\$5,623	\$2,775	\$5,362	\$6,469	\$7,757	\$7,780
2017	\$22,398	\$21,026	\$26,197	\$20,601	\$6,453	\$20,775	\$45,114	\$23,147	\$20,187
2018	\$31,773	\$54,236	\$42,692	\$21,168	\$6,036	\$25,872	\$54,825	\$29,105	\$20,378
2019	\$46,480	\$60,616	\$63,649	\$29,967	\$6,363	\$39,186	\$91,039	\$56,559	\$28,630
2020	\$67,996	\$39,844	\$85,291	\$44,175	\$7,671	\$52,961	\$139,752	\$83,362	\$34,877
2021	\$79,224	\$46,672	\$101,367	\$48,477	\$8,807	\$61,034	\$161,864	\$101,066	\$40,789

Table 56. Average payment size on NDIS per calendar year, non-Indigenous, by disability type

Year	ABI	Autism	Cerebral Palsy	Developmental delay	Down Syndrome	Global developmental delay	Hearing Impairment	Intellectual Disability	Missing
Jun-Dec 2016	\$10,297	\$4,465	\$9,799	\$2,475	\$8,521	\$3,032	\$2,489	\$8,708	\$8,329
2017	\$37,401	\$15,076	\$38,232	\$6,853	\$31,604	\$9,120	\$5,558	\$35,419	\$39,867
2018	\$49,372	\$18,179	\$58,453	\$6,644	\$45,242	\$7,722	\$5,717	\$45,651	\$55,327
2019	\$72,441	\$22,026	\$84,146	\$7,073	\$63,342	\$9,241	\$6,741	\$62,011	\$66,743
2020	\$92,815	\$25,913	\$100,809	\$8,469	\$73,282	\$11,779	\$7,659	\$72,113	\$17,565
2021	\$107,968	\$28,885	\$114,316	\$9,890	\$86,584	\$13,169	\$8,932	\$81,643	-

Table 57. Average payment size on NDIS per calendar year, non-Indigenous, by disability type

Year	Multiple Sclerosis	Other Neurological	Other Physical	Other Sensory Speech	Psychosocial disability	Spinal Cord Injury	Stroke	Visual Impairment
Jun-Dec 2016	\$6,356	\$4,471	\$5,597	\$1,952	\$5,219	\$10,808	\$6,024	\$3,704
2017	\$22,975	\$23,106	\$24,326	\$6,390	\$17,895	\$40,754	\$21,146	\$12,543
2018	\$33,654	\$35,709	\$24,478	\$6,458	\$21,801	\$59,823	\$30,464	\$14,295
2019	\$51,734	\$44,680	\$32,959	\$7,804	\$29,228	\$80,375	\$48,548	\$19,387
2020	\$66,527	\$34,083	\$42,784	\$8,774	\$41,138	\$106,073	\$69,591	\$24,815
2021	\$73,293	\$47,149	\$48,459	\$9,877	\$51,556	\$117,951	\$88,097	\$29,065

Table 58. Total payments for NDIS per calendar year, First Nations, by disability type

Year	ABI	Autism	Cerebral Palsy	Developmental delay	Down Syndrome	Global developmental delay
Jun-Dec 2016	\$506,836	\$1,981,586	\$839,790	\$421,900	\$183,174	\$232,274
2017	\$9,006,058	\$18,120,629	\$11,328,075	\$2,110,697	\$2,647,231	\$1,086,213
2018	\$26,152,736	\$42,173,621	\$9,398,879	\$3,883,114	\$7,483,162	\$1,411,518
2019	\$61,221,674	\$86,897,531	\$65,697,881	\$8,762,144	\$14,705,947	\$3,681,015
2020	\$111,777,874	\$158,914,182	\$98,785,351	\$21,893,288	\$23,287,881	\$9,031,743
2021	\$160,991,128	\$230,480,472	\$123,437,818	\$39,076,851	\$29,016,284	\$14,720,209
Total	\$369,656,306	\$538,568,021	\$309,487,794	\$76,147,994	\$77,323,679	\$30,162,972

Table 59. Total payments for NDIS per calendar year, First Nations, by disability type

Year	Hearing Impairment	Intellectual Disability	Missing	Multiple Sclerosis	Other	Other Neurological
Jun-Dec 2016	\$62,535	\$3,759,639	\$816,796	\$27,501	\$48,709	\$492,450
2017	\$778,494	\$45,866,020	\$4,262,799	\$470,368	\$210,260	\$4,794,080
2018	\$1,299,309	\$104,868,516	\$3,181,065	\$1,525,089	\$922,017	\$14,771,601
2019	\$3,890,761	\$209,416,164	\$4,493,645	\$3,439,507	\$1,636,645	\$36,661,741
2020	\$7,640,588	\$329,633,956	-	\$6,459,608	\$3,944,594	\$67,294,727
2021	\$11,318,050	\$434,999,987	-	\$9,189,956	\$17,501,910	\$91,129,186
Total	\$24,989,737	\$1,128,544,283	\$12,754,305	\$21,112,029	\$24,264,134	\$215,143,785

Table 60. Total payments for NDIS per calendar year, First Nations, by disability type

Year	Other Physical	Other Sensory Speech	Psychosocial disability	Spinal Cord Injury	Stroke	Visual Impairment
Jun-Dec 2016	\$539,781	\$160,930	\$675,647	\$90,561	\$93,088	\$225,610
2017	\$4,800,031	\$871,187	\$7,333,627	\$2,120,335	\$995,325	\$1,715,855
2018	\$8,615,181	\$1,201,199	\$21,551,390	\$6,579,049	\$3,521,691	\$3,342,069
2019	\$20,827,090	\$1,431,694	\$62,697,590	\$20,028,515	\$13,630,669	\$7,644,079
2020	\$43,865,665	\$1,679,901	\$146,224,370	\$36,614,977	\$34,178,323	\$11,509,526
2021	\$52,210,141	\$1,972,684	\$231,317,099	\$45,807,375	\$53,969,366	\$15,622,230
Total	\$130,857,888	\$7,317,595	\$469,799,723	\$111,240,811	\$106,388,463	\$40,059,369

Table 61. Total payments for participants on NDIS per calendar year, non-Indigenous, by disability type

Year	ABI	Autism	Cerebral Palsy	Developmental delay	Down Syndrome	Global developmental delay
Jun-Dec 2016	\$8,875,786	\$43,891,435	\$16,864,876	\$5,920,761	\$12,210,483	\$2,765,189
2017	\$120,654,217	\$415,152,936	\$197,811,934	\$35,600,199	\$132,832,644	\$14,691,544
2018	\$313,757,592	\$948,215,147	\$547,876,921	\$59,568,604	\$332,214,494	\$21,280,601
2019	\$711,438,217	\$1,895,676,415	\$1,088,603,058	\$113,323,911	\$621,198,182	\$46,963,420
2020	\$1,157,871,919	\$3,003,469,552	\$1,482,898,737	\$245,236,691	\$791,082,399	\$91,232,065
2021	\$1,547,940,261	\$4,050,368,556	\$1,771,435,810	\$387,917,629	\$954,590,941	\$126,027,099
Total	\$3,860,537,991	\$10,356,774,041	\$5,105,491,336	\$847,567,795	\$2,844,129,143	\$302,959,918

Table 62. Total payments for participants on NDIS per calendar year, non-Indigenous, by disability type

Year	Hearing Impairment	Intellectual Disability	Missing	Multiple Sclerosis	Other	Other Neurological
Jun-Dec 2016	\$1,421,485	\$74,691,760	\$15,941,734	\$4,487,639	\$353,200	\$10,552,042
2017	\$12,921,274	\$888,592,664	\$96,837,871	\$49,649,277	\$4,852,277	\$127,566,377
2018	\$29,493,687	\$1,956,584,493	\$89,574,503	\$148,382,352	\$12,212,352	\$329,286,548
2019	\$68,946,385	\$3,660,235,740	\$92,638,656	\$327,942,518	\$22,250,711	\$771,235,016
2020	\$118,968,410	\$4,821,662,704	\$122,952	\$517,912,024	\$44,853,654	\$1,342,496,566
2021	\$157,646,936	\$5,822,405,504	-	\$650,547,469	\$191,567,406	\$1,836,376,009
Total	\$389,398,177	\$17,224,172,865	\$295,115,715	\$1,698,921,280	\$276,089,599	\$4,417,512,557

Table 63. Total payments for participants on NDIS per calendar year, non-Indigenous, by disability type

Year	Other Physical	Other Sensory Speech	Psychosocial disability	Spinal Cord Injury	Stroke	Visual Impairment
Jun-Dec 2016	\$8,921,575	\$2,307,692	\$12,207,643	\$3,393,681	\$2,023,952	\$2,541,212
2017	\$110,682,718	\$14,615,055	\$120,520,523	\$50,249,272	\$24,656,451	\$30,893,534
2018	\$196,806,830	\$18,031,008	\$318,026,065	\$155,180,243	\$77,347,118	\$69,144,303
2019	\$434,004,562	\$20,624,909	\$758,356,679	\$310,648,459	\$203,851,734	\$137,240,351
2020	\$738,716,276	\$21,908,902	\$1,562,921,777	\$488,783,237	\$405,646,037	\$201,077,163
2021	\$884,627,601	\$21,729,318	\$2,439,856,780	\$598,718,599	\$620,113,148	\$251,321,328
Total	\$2,373,759,562	\$99,216,883	\$5,211,889,467	\$1,606,973,490	\$1,333,638,439	\$692,217,891

Table 64. Average payment size on the NDIS per calendar year, First Nations, by state

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Jun-Dec 2016	\$4,812	\$5,729	\$19,378	\$4,058	\$2,841	\$9,118	\$5,046	\$13,343
2017	\$20,094	\$22,951	\$40,340	\$27,965	\$10,074	\$35,269	\$15,218	\$44,992
2018	\$24,411	\$27,415	\$50,355	\$26,086	\$12,939	\$33,815	\$14,842	\$34,389
2019	\$33,881	\$33,069	\$88,060	\$37,543	\$30,647	\$38,054	\$21,636	\$33,490
2020	\$38,113	\$36,716	\$107,890	\$44,221	\$43,500	\$40,885	\$27,418	\$43,854
2021	\$41,346	\$39,283	\$107,085	\$49,492	\$50,230	\$46,185	\$33,621	\$53,622

Table 65. Average payment size on the NDIS per calendar year, non-Indigenous, by state

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Jun-Dec 2016	\$9,237	\$6,379	\$4,414	\$3,678	\$2,936	\$10,822	\$5,575	\$9,950
2017	\$34,160	\$26,252	\$62,472	\$23,416	\$9,657	\$39,404	\$18,851	\$36,954
2018	\$39,590	\$37,674	\$55,666	\$25,619	\$14,667	\$48,527	\$22,866	\$28,348
2019	\$43,556	\$45,963	\$57,106	\$41,976	\$34,480	\$53,499	\$30,998	\$28,789
2020	\$46,741	\$50,755	\$67,012	\$50,253	\$43,085	\$58,406	\$36,438	\$39,893
2021	\$48,194	\$53,648	\$64,940	\$54,295	\$47,796	\$62,395	\$44,800	\$50,360

Table 66. Total payments for participants on NDIS per calendar year, First Nations, by state

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Missing
Jun-Dec 2016	\$716,942	\$4,920,986	\$1,046,397	\$458,592	\$886,547	\$838,897	\$625,749	\$1,307,592	\$357,105
2017	\$4,139,271	\$53,980,042	\$13,715,608	\$21,001,575	\$4,835,449	\$5,501,983	\$5,235,150	\$6,478,811	\$3,629,394
2018	\$5,736,540	\$124,819,119	\$35,198,382	\$50,372,222	\$9,406,853	\$9,603,424	\$14,337,800	\$9,216,237	\$3,190,628
2019	\$8,605,821	\$211,211,193	\$112,364,939	\$162,035,384	\$37,726,624	\$18,380,029	\$39,333,525	\$37,106,776	-
2020	\$11,281,587	\$324,937,779	\$192,260,076	\$299,110,258	\$82,127,396	\$29,355,678	\$78,333,529	\$95,294,179	\$36,073
2021	\$14,553,703	\$433,174,390	\$232,267,867	\$440,530,379	\$118,241,900	\$43,413,527	\$124,398,841	\$156,040,990	\$139,149
Total	\$45,033,864	\$1,153,043,509	\$586,853,268	\$973,508,410	\$253,224,769	\$107,093,537	\$262,264,594	\$305,444,586	\$357,105

Table 67. Total payments for participants on NDIS, non-Indigenous, by state

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Missing
Jun-Dec 2016	\$35,518,102	\$100,021,195	\$83,863	\$3,913,906	\$19,671,934	\$10,497,124	\$31,805,635	\$22,169,527	\$5,690,859
2017	\$175,753,496	\$1,364,720,033	\$9,433,325	\$206,856,071	\$110,644,280	\$77,901,487	\$335,880,155	\$128,414,473	\$39,177,445
2018	\$222,853,924	\$3,060,163,240	\$26,330,231	\$631,778,857	\$276,508,106	\$182,802,982	\$1,029,536,452	\$175,731,133	\$17,277,936
2019	\$274,966,528	\$4,525,459,741	\$71,781,932	\$2,141,740,787	\$932,637,798	\$332,439,905	\$2,457,926,047	\$547,921,103	\$305,081
2020	\$335,603,226	\$5,992,122,544	\$122,229,582	\$3,574,584,831	\$1,449,973,382	\$483,249,515	\$3,822,506,822	\$1,254,887,284	\$1,703,878
2021	\$383,770,425	\$7,209,595,745	\$141,828,499	\$4,727,225,435	\$1,865,514,254	\$607,231,029	\$5,493,976,610	\$1,881,682,981	\$2,365,416
Total	\$1,428,465,700	\$22,252,082,498	\$371,687,432	\$11,286,099,886	\$4,654,949,754	\$1,694,122,042	\$13,171,631,721	\$4,010,806,501	\$5,690,859

Table 68. Average payment size on the NDIS per calendar year, First nations, by state

Year	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
Jun-Dec 2016	\$5,859	\$6,551	\$4,501	\$4,494	\$3,668	\$12,600	\$12,237	\$5,135
2017	\$23,322	\$39,543	\$19,240	\$18,907	\$12,103	\$35,402	\$17,563	\$27,427
2018	\$25,891	\$25,539	\$24,575	\$22,406	\$15,723	\$93,398	\$27,240	\$62,618
2019	\$34,325	\$53,138	\$30,952	\$29,638	\$21,328	\$77,869	\$31,988	\$18,974
2020	\$42,140	\$58,569	\$36,646	\$31,823	\$25,774	\$88,461	\$40,017	\$16,839
2021	\$47,237	\$63,288	\$40,471	\$36,414	\$30,855	\$90,178	\$40,659	\$24,013

Table 69. Average payment size on the NDIS per calendar year, non-Indigenous, by state

Year	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
Jun-Dec 2016	\$6,309	\$6,214	\$6,116	\$5,900	\$3,587	\$3,052	\$3,148	\$6,911
2017	\$24,699	\$25,435	\$22,696	\$21,266	\$16,096	\$17,052	\$9,205	\$24,646
2018	\$29,394	\$35,297	\$35,716	\$29,021	\$23,562	\$22,781	\$17,587	\$36,815
2019	\$38,876	\$43,565	\$44,607	\$36,556	\$29,569	\$34,645	\$25,648	\$25,809
2020	\$45,779	\$47,813	\$48,880	\$41,764	\$34,183	\$39,786	\$30,654	\$33,667
2021	\$51,524	\$53,317	\$52,966	\$46,284	\$37,805	\$45,475	\$34,099	\$31,368

Table 70. Total payments for participants on NDIS per calendar year, First Nations, by remoteness

Year	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
Jun-Dec 2016	\$7,540,945	\$897,523	\$531,126	\$346,022	\$315,467	\$201,606	\$966,692	\$359,425
2017	\$57,909,052	\$27,126,213	\$9,408,304	\$6,598,540	\$4,163,341	\$4,496,007	\$5,058,287	\$3,757,540
2018	\$108,898,172	\$38,717,539	\$33,471,655	\$18,821,312	\$13,742,210	\$30,354,254	\$14,682,568	\$3,193,495
2019	\$249,266,174	\$143,685,520	\$70,415,381	\$38,291,863	\$32,227,285	\$58,401,957	\$34,419,187	\$56,923
2020	\$458,446,446	\$240,132,809	\$122,286,767	\$59,731,368	\$59,950,099	\$109,603,034	\$62,266,095	\$319,937
2021	\$665,139,875	\$328,022,379	\$175,199,589	\$87,576,028	\$87,905,183	\$139,053,815	\$79,407,632	\$456,246
Total	\$1,547,200,663	\$778,581,982	\$411,312,822	\$211,365,132	\$198,303,585	\$342,110,674	\$196,800,461	\$8,143,566

Table 71. Total payments for participants on NDIS per calendar year, non-Indigenous, by remoteness

Year	Metropolitan	Regional Centres	Large Rural Towns	Medium Rural Towns	Small Rural Towns	Remote Communities	Very Remote Communities	Missing
Jun-Dec 2016	\$186,633,286	\$15,931,947	\$9,523,223	\$6,826,341	\$4,332,592	\$347,962	\$81,852	\$5,694,942
2017	\$1,734,258,879	\$286,835,834	\$175,327,487	\$108,689,433	\$95,497,187	\$7,213,127	\$1,353,183	\$39,605,636
2018	\$3,667,511,671	\$722,993,740	\$605,344,583	\$293,405,885	\$289,344,817	\$21,117,606	\$5,188,293	\$18,076,267
2019	\$7,766,143,862	\$1,290,579,419	\$1,102,687,454	\$512,983,478	\$541,017,646	\$58,272,244	\$12,823,797	\$671,022
2020	\$11,948,222,531	\$1,918,645,928	\$1,528,228,418	\$670,271,464	\$852,772,980	\$93,774,767	\$22,285,255	\$2,659,720
2021	\$15,902,277,506	\$2,406,958,111	\$1,906,760,638	\$905,408,361	\$1,033,779,286	\$125,100,706	\$32,121,590	\$784,197
Total	\$41,205,047,735	\$6,641,944,979	\$5,327,871,803	\$2,497,584,961	\$2,816,744,508	\$305,826,411	\$73,853,970	\$67,491,784

Table 72. Total payments for NDIS participants by calendar year, First Nations, by Support Category

Year	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport	Total
Jun-Dec 2016	\$2,500,047	\$346,027	\$5,912,044	\$1,549,269	\$557,896	\$293,524	\$11,158,807
2017	\$17,624,657	\$2,642,633	\$68,372,025	\$21,321,933	\$6,104,047	\$2,451,988	\$118,517,283
2018	\$39,612,958	\$8,652,515	\$159,861,937	\$56,988,196	-\$8,633,201*	\$5,398,800	\$261,881,205
2019	\$88,025,326	\$20,383,239	\$358,616,029	\$122,994,914	\$26,568,054	\$10,161,984	\$626,749,545
2020	\$170,395,056	\$34,511,305	\$640,830,165	\$200,005,425	\$52,251,815	\$14,742,789	\$1,112,736,555
2021	\$264,180,858	\$33,804,699	\$857,720,860	\$313,702,166	\$75,077,440	\$18,274,724	\$1,562,760,746
Total	\$582,338,901	\$100,340,418	\$2,091,313,061	\$716,561,904	\$151,926,051	\$51,323,807	\$3,693,804,142

*Negative value is due to a clawback

Table 73. Total payments for NDIS participants by calendar year, non-Indigenous, by Support Category

Year	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Jun-Dec 2016	\$45,480,300	\$8,750,460	\$120,765,657	\$38,632,515	\$7,988,949	\$7,754,264
2017	\$389,045,134	\$73,018,933	\$1,295,701,687	\$537,805,845	\$83,670,790	\$69,528,497
2018	\$881,799,433	\$208,260,752	\$2,942,477,588	\$1,291,360,478	\$159,545,447	\$139,535,530
2019	\$1,748,832,564	\$462,523,783	\$6,057,960,861	\$2,484,192,951	\$290,162,699	\$241,213,711
2020	\$2,876,270,543	\$760,942,395	\$9,243,994,934	\$3,354,615,020	\$483,819,577	\$317,175,245
2021	\$3,868,224,243	\$702,430,353	\$12,057,236,557	\$4,682,185,623	\$642,608,303	\$360,505,096
Total	\$9,809,652,217	\$2,215,926,675	\$31,718,137,284	\$12,388,792,431	\$1,667,795,765	\$1,135,712,342

Table 74. Total payments for participants on the NDIS for calendar years 2017, First Nations, by primary disability and support category

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	\$515,065	\$69,815	\$6,862,082	\$1,077,535	\$350,225	\$131,337
Autism	\$5,150,315	\$117,969	\$7,582,132	\$3,874,182	\$1,055,859	\$340,171
Cerebral Palsy	\$873,492	\$525,820	\$7,634,612	\$1,797,056	\$340,506	\$156,589
Developmental delay	\$1,695,650	\$20,084	\$203,926	\$101,310	\$85,683	\$4,045
Down Syndrome	\$341,723	\$27,346	\$1,224,040	\$881,600	\$104,918	\$67,604
Global developmental delay	\$869,405	\$3,693	\$68,650	\$86,896	\$52,236	\$5,334
Hearing Impairment	\$123,051	\$22,196	\$403,296	\$151,421	\$54,517	\$24,013
Intellectual Disability	\$4,425,803	\$366,885	\$29,253,311	\$8,522,963	\$2,345,883	\$951,177
Missing	\$922,980	\$152,917	\$2,270,765	\$635,577	\$213,886	\$66,673
Multiple Sclerosis	\$36,774	\$38,600	\$317,429	\$42,942	\$10,741	\$23,882
Other	\$15,137	\$4,696	\$116,053	\$59,123	\$3,968	\$11,282
Other Neurological	\$479,876	\$295,234	\$2,640,718	\$983,041	\$281,796	\$113,415
Other Physical	\$498,970	\$498,645	\$2,705,116	\$717,633	\$215,046	\$164,621
Other Sensory/Speech	\$617,364	\$20,158	\$91,291	\$40,314	\$93,787	\$8,273
Psychosocial disability	\$719,242	\$15,896	\$4,255,545	\$1,467,359	\$653,445	\$222,140
Spinal Cord Injury	\$80,576	\$310,428	\$1,373,536	\$223,276	\$83,822	\$48,698
Stroke	\$79,005	\$51,297	\$599,919	\$163,557	\$69,402	\$32,145
Visual Impairment	\$180,229	\$100,954	\$769,605	\$496,150	\$88,327	\$80,590

Table 75. Total payments for participants on the NDIS for calendar years 2021, First Nations, by primary disability and support category

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	\$10,648,444	\$3,042,835	\$111,988,411	\$27,887,064	\$6,132,163	\$1,292,212
Autism	\$84,077,875	\$1,119,925	\$85,640,588	\$46,543,307	\$10,735,600	\$2,363,176
Cerebral Palsy	\$12,014,220	\$6,816,500	\$79,819,955	\$20,582,420	\$3,217,107	\$987,617
Developmental delay	\$33,489,982	\$499,146	\$1,795,387	\$1,483,933	\$1,787,626	\$20,777
Down Syndrome	\$3,493,491	\$364,826	\$16,348,229	\$7,724,656	\$703,013	\$382,070
Global developmental delay	\$11,087,553	\$351,999	\$1,432,331	\$940,423	\$898,587	\$9,316
Hearing Impairment	\$4,146,188	\$275,070	\$2,427,505	\$3,248,889	\$1,024,961	\$195,436
Intellectual Disability	\$54,485,531	\$4,222,298	\$253,333,471	\$96,014,615	\$21,583,458	\$5,360,614
Multiple Sclerosis	\$1,039,859	\$665,736	\$5,088,047	\$1,917,120	\$318,199	\$160,994
Other	\$2,154,842	\$1,800,140	\$9,729,804	\$2,592,433	\$1,020,548	\$204,143
Other Neurological	\$8,514,092	\$3,299,752	\$59,649,162	\$15,194,908	\$3,610,685	\$860,588
Other Physical	\$7,188,940	\$5,371,601	\$25,455,358	\$10,194,029	\$2,927,365	\$1,072,849
Other Sensory/Speech	\$1,368,339	\$2,852	\$133,637	\$281,256	\$173,793	\$12,807
Psychosocial disability	\$21,044,664	\$935,049	\$129,140,173	\$59,759,634	\$16,576,397	\$3,861,182
Spinal Cord Injury	\$2,908,663	\$2,701,018	\$32,833,281	\$5,663,361	\$1,294,865	\$406,187
Stroke	\$4,448,651	\$1,939,091	\$35,533,760	\$9,169,120	\$2,296,243	\$582,501
Visual Impairment	\$2,069,524	\$396,862	\$7,371,761	\$4,504,997	\$776,832	\$502,255

Table 76. Total payments for participants on the NDIS for calendar years 2017, non-Indigenous, by primary disability and support category

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	\$8,510,001	\$2,697,180	\$77,178,279	\$24,714,926	\$4,513,520	\$3,030,936
Autism	\$128,080,040	\$2,548,701	\$162,521,691	\$96,846,844	\$15,411,312	\$9,744,348
Cerebral Palsy	\$19,162,207	\$11,317,053	\$112,040,087	\$46,334,660	\$4,350,077	\$4,607,851
Developmental delay	\$28,035,220	\$851,060	\$3,232,371	\$2,546,713	\$792,421	\$142,415
Down Syndrome	\$17,316,569	\$1,309,374	\$67,999,580	\$38,629,813	\$2,962,342	\$4,614,966
Global developmental delay	\$10,217,522	\$498,899	\$2,269,750	\$1,257,380	\$382,411	\$65,582
Hearing Impairment	\$6,103,540	\$1,937,210	\$1,559,083	\$2,214,774	\$722,417	\$384,249
Intellectual Disability	\$86,076,296	\$9,897,225	\$516,777,826	\$222,346,112	\$27,738,177	\$25,757,028
Missing	\$16,598,318	\$4,743,781	\$52,236,804	\$18,398,763	\$3,018,022	\$1,842,182
Multiple Sclerosis	\$4,884,514	\$4,191,883	\$31,448,599	\$5,189,671	\$1,979,639	\$1,954,466
Other	\$578,982	\$343,527	\$2,570,280	\$985,131	\$218,469	\$155,886
Other Neurological	\$13,739,736	\$9,829,509	\$73,826,503	\$21,766,436	\$4,508,405	\$3,895,787
Other Physical	\$11,705,484	\$12,929,370	\$62,742,469	\$16,215,168	\$3,471,075	\$3,619,151
Other Sensory/Speech	\$12,167,788	\$125,868	\$1,189,355	\$670,128	\$380,720	\$81,195
Psychosocial disability	\$15,203,182	\$587,137	\$65,356,126	\$24,832,550	\$9,755,646	\$4,785,881
Spinal Cord Injury	\$2,648,051	\$4,833,450	\$36,539,205	\$4,080,778	\$1,041,372	\$1,106,415
Stroke	\$2,954,876	\$2,111,660	\$13,206,392	\$4,174,620	\$1,245,723	\$963,180
Visual Impairment	\$5,062,809	\$2,266,045	\$13,007,287	\$6,601,375	\$1,179,040	\$2,776,978

Table 77. Total payments for participants on the NDIS for calendar years 2021, non-Indigenous, by primary disability and support category

Primary Disability	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
ABI	\$140,297,259	\$42,398,260	\$1,011,774,642	\$287,284,921	\$46,314,589	\$19,870,589
Autism	\$1,402,273,900	\$24,892,653	\$1,633,898,307	\$838,154,625	\$99,522,709	\$51,626,361
Cerebral Palsy	\$188,023,936	\$108,890,385	\$1,095,518,705	\$330,352,521	\$27,180,274	\$21,469,990
Developmental delay	\$345,797,925	\$5,866,901	\$16,796,240	\$14,453,917	\$4,870,084	\$132,562
Down Syndrome	\$104,284,011	\$13,037,332	\$547,432,318	\$256,316,320	\$15,093,876	\$18,427,084
Global developmental delay	\$104,040,758	\$4,535,375	\$10,064,680	\$5,645,314	\$1,681,484	\$59,489
Hearing Impairment	\$67,806,379	\$6,292,275	\$21,076,225	\$53,458,086	\$5,816,597	\$3,197,274
Intellectual Disability	\$618,218,860	\$104,067,370	\$3,455,316,041	\$1,405,114,020	\$141,535,942	\$98,153,272
Multiple Sclerosis	\$80,401,282	\$48,433,933	\$402,822,871	\$86,727,311	\$18,520,711	\$13,641,361
Other	\$28,120,365	\$23,836,239	\$98,102,397	\$31,249,189	\$7,171,716	\$3,087,500
Other Neurological	\$190,651,145	\$101,481,744	\$1,181,422,632	\$289,767,167	\$48,606,892	\$24,446,429
Other Physical	\$128,752,225	\$113,068,708	\$437,221,209	\$161,982,246	\$24,084,223	\$19,518,990
Other Sensory/ Speech	\$15,783,752	\$102,999	\$2,278,099	\$2,700,134	\$630,825	\$233,508
Psychosocial disability	\$290,019,753	\$12,342,588	\$1,254,385,236	\$663,651,566	\$165,398,050	\$54,059,466
Spinal Cord Injury	\$50,250,514	\$50,610,089	\$404,618,405	\$75,718,630	\$10,442,628	\$7,078,332
Stroke	\$70,817,979	\$30,806,407	\$387,052,754	\$103,532,614	\$18,498,776	\$9,404,618
Visual Impairment	\$42,684,200	\$11,767,093	\$97,455,794	\$76,077,042	\$7,238,928	\$16,098,271

Table 78. Total payments for participants on the NDIS for calendar years 2017, First Nations, by support category and remoteness

Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	\$11,241,932	\$1,491,252	\$29,753,899	\$11,091,538	\$3,066,697	\$1,263,735
Regional Centres	\$1,924,951	\$403,199	\$19,635,839	\$3,637,520	\$1,113,955	\$410,748
Large Rural Towns	\$1,124,945	\$227,271	\$4,801,979	\$2,445,341	\$503,487	\$305,281
Medium Rural Towns	\$944,751	\$116,522	\$3,496,269	\$1,565,958	\$313,053	\$161,987
Small Rural Towns	\$1,027,120	\$202,650	\$1,394,816	\$1,155,207	\$246,348	\$137,199
Remote Communities	\$398,327	\$43,686	\$3,575,987	\$329,038	\$113,624	\$35,345
Very Remote Communities	\$382,148	\$106,141	\$3,585,862	\$489,593	\$423,678	\$70,865
Missing	\$580,483	\$51,912	\$2,127,376	\$607,738	\$323,205	\$66,828

Table 79. Total payments for participants on the NDIS for calendar years 2021, First Nations, by support category and remoteness

Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	\$126,421,269	\$15,248,053	\$353,273,579	\$132,036,200	\$29,932,218	\$8,228,555
Regional Centres	\$40,617,400	\$6,110,096	\$196,046,533	\$69,540,980	\$12,710,539	\$2,996,832
Large Rural Towns	\$31,286,323	\$4,213,318	\$91,054,306	\$38,508,313	\$7,604,909	\$2,532,421
Medium Rural Towns	\$17,136,586	\$2,032,187	\$43,430,841	\$19,590,600	\$3,983,631	\$1,402,184
Small Rural Towns	\$20,039,094	\$2,800,902	\$37,791,415	\$21,401,906	\$4,418,142	\$1,453,725
Remote Communities	\$14,740,435	\$1,798,901	\$94,965,723	\$19,740,257	\$7,067,175	\$741,324
Very Remote Communities	\$13,854,251	\$1,601,243	\$41,061,444	\$12,700,224	\$9,280,557	\$909,914
Missing	\$85,501		\$97,020	\$183,687	\$80,270	\$9,768

Table 80. Total payments for participants on the NDIS for calendar years 2017, non-Indigenous, by primary disability and remoteness

Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	\$295,052,618	\$53,453,488	\$896,184,600	\$379,053,794	\$60,946,143	\$49,558,357
Regional Centres	\$34,372,237	\$7,484,086	\$168,205,844	\$60,300,845	\$9,032,552	\$7,440,270
Large Rural Towns	\$18,882,453	\$3,596,654	\$106,363,571	\$36,828,753	\$4,904,414	\$4,751,641
Medium Rural Towns	\$14,414,280	\$2,875,701	\$56,347,122	\$28,448,140	\$3,276,656	\$3,327,534
Small Rural Towns	\$17,725,368	\$4,093,732	\$42,510,072	\$24,697,826	\$3,079,307	\$3,390,882
Remote Communities	\$1,565,082	\$501,193	\$3,659,620	\$1,178,905	\$168,806	\$139,521
Very Remote Communities	\$325,597	\$84,535	\$575,073	\$211,651	\$114,180	\$42,146
Missing	\$6,707,499	\$929,544	\$21,855,784	\$7,085,931	\$2,148,733	\$878,146

Table 81. Total payments for participants on the NDIS for calendar years 2022, non-Indigenous, by primary disability and remoteness

Remoteness	Capacity Building	Capital	Daily Activities Core	Other Core	Support Coordination	Transport
Metropolitan	\$2,862,603,895	\$498,118,419	\$8,600,355,097	\$3,229,510,116	\$458,164,066	\$253,525,693
Regional Centres	\$358,776,421	\$70,184,939	\$1,338,734,199	\$537,859,928	\$66,461,622	\$34,941,002
Large Rural Towns	\$273,381,837	\$53,979,572	\$1,077,040,179	\$419,499,109	\$51,388,068	\$31,471,873
Medium Rural Towns	\$144,170,730	\$29,645,568	\$469,026,424	\$218,730,428	\$26,786,011	\$17,049,200
Small Rural Towns	\$195,303,049	\$45,064,431	\$496,266,357	\$244,015,457	\$31,910,397	\$21,219,595
Remote Communities	\$26,224,965	\$3,896,463	\$61,903,252	\$25,608,768	\$5,653,561	\$1,813,698
Very Remote Communities	\$7,646,105	\$1,536,749	\$13,621,803	\$6,668,664	\$2,185,448	\$462,821
Missing	\$117,240	\$4,212	\$289,246	\$293,152	\$59,132	\$21,214

Table 82. Total payments for each support class split by First Nations and Non-Indigenous Focused Providers in 2017

Support Category Name	Non-Indigenous Focused Providers	First Nations Focused Providers	Total
Assistive Technology	\$63,046,432	\$650,966	\$63,697,398
Capacity Building NFC	\$9,375		\$9,375
CB Choice and Control	\$10,659,636	\$326,147	\$10,985,782
CB Daily Activity	\$279,495,733	\$4,483,409	\$283,979,143
CB Employment	\$69,728,078	\$228,702	\$69,956,780
CB Health and Wellbeing	\$3,908,938	\$70,093	\$3,979,031
CB Home Living	\$359,198	\$10,360	\$369,558
CB Lifelong Learning	\$137,413	\$12,488	\$149,900
CB Relationships	\$12,723,459	\$275,107	\$12,998,565
CB Social Community and Civic Participation	\$23,000,910	\$1,250,121	\$24,251,031
Consumables	\$25,822,031	\$208,922	\$26,030,953
Daily Activities	\$1,284,863,149	\$79,210,564	\$1,364,073,712
Home Modifications	\$11,345,311	\$618,857	\$11,964,168
In Kind Transport	\$505	\$0	\$505
Social Community and Civic Participation	\$518,257,422	\$14,839,404	\$533,096,825
Support Coordination	\$86,254,478	\$3,520,358	\$89,774,837
Transport	\$71,852,124	\$128,361	\$71,980,485
Grand Total	\$2,461,464,190	\$105,833,859	\$2,567,298,049

Table 83. Total payments for each support class split by First Nations and Non-Indigenous Focused Providers in 2021

Support Category Name	Non-Indigenous Focused Providers	First Nations Focused Providers	Total
Assistive Technology	\$503,722,778	\$6,486,407	\$510,209,185
Capacity Building NFC	\$220	\$0	\$220
CB Choice and Control	\$358,111,229	\$6,570,495	\$364,681,723
CB Daily Activity	\$3,139,642,276	\$50,031,721	\$3,189,673,997
CB Employment	\$150,698,672	\$1,259,762	\$151,958,434
CB Health and Wellbeing	\$40,018,210	\$230,883	\$40,249,093
CB Home Living	\$885,814	\$17,812	\$903,627
CB Lifelong Learning	\$148,424	\$635	\$149,059
CB Relationships	\$258,334,909	\$10,536,004	\$268,870,913
CB Social Community and Civic Participation	\$112,043,243	\$3,875,011	\$115,918,254
Consumables	\$466,592,776	\$5,042,184	\$471,634,960
Daily Activities	\$12,427,370,846	\$487,586,570	\$12,914,957,416
Home Modifications	\$221,585,068	\$4,440,799	\$226,025,866
Social Community and Civic Participation	\$4,396,486,346	\$127,766,482	\$4,524,252,829
Support Coordination	\$674,753,044	\$42,932,699	\$717,685,744
Transport	\$376,482,188	\$2,297,631	\$378,779,819
Grand Total	\$23,126,876,045	\$749,075,095	\$23,875,951,140

DES Demographics

Table 84. Count of First Nations participants in DES by State or Territory and Year (Financial year)

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
2016	69	3,639	149	3,177	638	381	1,015	540
2017	75	3,983	148	3,512	775	430	1,145	543
2018	81	4,186	182	3,793	868	457	1,253	654
2019	121	5,665	239	4,946	1,188	683	1,674	962
2020	159	7,089	303	6,215	1,562	858	2,151	1,305

Table 85. Count of non-Indigenous participants in DES by State or Territory and Year (Financial year)

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
2016	1,366	53,092	485	39,591	15,694	4,448	48,346	10,117
2017	1,470	52,858	499	40,650	17,329	4,629	48,767	10,230
2018	1,663	53,514	484	41,885	19,075	4,635	49,767	10,914
2019	2,214	64,894	654	51,754	22,832	6,211	59,755	14,492
2020	2,728	76,078	782	60,927	26,925	7,311	70,803	18,737

DES Payments

Table 86. Average payments for First Nations DMS participants by State or Territory and Financial Year (DES)

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
2016	\$2,856	\$3,581	\$3,233	\$3,296	\$3,603	\$3,546	\$3,498	\$2,901
2017	\$2,921	\$3,692	\$3,028	\$3,615	\$3,466	\$3,879	\$3,479	\$3,416
2018	\$3,451	\$3,163	\$2,573	\$3,184	\$3,064	\$3,364	\$3,038	\$2,850
2019	\$4,224	\$3,424	\$2,863	\$3,513	\$3,504	\$3,889	\$3,191	\$3,007
2020	\$3,215	\$3,390	\$3,526	\$3,287	\$3,545	\$3,354	\$3,280	\$3,040
2021	\$3,100	\$3,656	\$3,702	\$3,553	\$3,696	\$3,778	\$3,240	\$3,227

Table 87. Average payments for non-Indigenous DMS participants by State or Territory and Financial Year (DES)

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
2016	\$3,627	\$3,546	\$3,376	\$3,414	\$3,322	\$3,297	\$3,385	\$2,955
2017	\$3,400	\$3,717	\$3,228	\$3,546	\$3,420	\$3,598	\$3,484	\$3,130
2018	\$2,975	\$3,322	\$2,932	\$3,221	\$3,156	\$3,222	\$3,143	\$2,833
2019	\$3,210	\$3,759	\$3,752	\$3,492	\$3,799	\$3,689	\$3,366	\$3,102
2020	\$3,348	\$3,767	\$3,911	\$3,360	\$3,605	\$3,353	\$3,240	\$3,245
2021	\$3,074	\$3,888	\$3,784	\$3,577	\$3,762	\$3,643	\$3,331	\$3,555

Table 88. Average payments for First Nations ESS participants by State or Territory and Financial Year (DES)

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
2016	\$5,167	\$4,989	\$3,338	\$4,852	\$5,042	\$5,311	\$5,014	\$4,527
2017	\$6,377	\$5,069	\$3,875	\$5,026	\$5,394	\$5,666	\$4,827	\$4,509
2018	\$3,762	\$4,342	\$3,283	\$4,338	\$4,772	\$4,400	\$3,974	\$3,702
2019	\$3,618	\$4,413	\$3,613	\$4,270	\$4,853	\$4,938	\$3,914	\$3,768
2020	\$4,157	\$4,808	\$4,179	\$4,703	\$4,922	\$4,978	\$4,452	\$4,415
2021	\$3,966	\$5,011	\$4,815	\$4,851	\$4,761	\$4,855	\$4,343	\$4,403

Table 89. Average payments for non-Indigenous ESS participants by State or Territory and Financial Year (DES)

Year	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
2016	\$5,256	\$4,574	\$3,830	\$4,460	\$4,341	\$4,434	\$4,084	\$4,492
2017	\$4,739	\$4,707	\$4,276	\$4,672	\$4,415	\$4,434	\$4,127	\$4,388
2018	\$4,222	\$4,186	\$3,448	\$4,119	\$4,078	\$3,849	\$3,702	\$3,914
2019	\$4,613	\$4,781	\$4,336	\$4,371	\$5,089	\$4,823	\$4,141	\$4,364
2020	\$4,950	\$5,056	\$4,533	\$4,525	\$5,282	\$4,809	\$4,299	\$4,848
2021	\$4,702	\$5,161	\$4,485	\$4,696	\$5,199	\$4,799	\$4,303	\$4,992

Endnotes

- 1 Included in full in our complete Summary of Key Findings report.
- 2 Data obtained by the Disability Royal Commission was deidentified, as such we could not explicitly identify 'First Nations focused' providers. Our analysis explored whether there is any evidence to support a hypothesis of differentiated service provision between First Nations-focused providers and Other providers in the NDIS. For this purpose, we assume that NDIS providers who deliver a threshold level of services to First Nations people with disability (as a proportion of all their clients) can be considered as First Nations focused providers.
- 3 The NDIS commits funding in plans for people with a disability and differences exist due to a range of factors in the utilisation rate of plan funding. These differences in utilisation impact analysis of claim payments. We have not analysed committed supports due to constraints within the data supplied.
- 4 'About us', *Australian Institute of Health and Welfare*, web page. [About us - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/about-us).
- 5 'Disability Services National Minimum Data Set (DSNMDS)', *Australian Institute of Health and Welfare*, web page. [Disability Services National Minimum Data Set \(DSNMDS\) - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/disability-services-national-minimum-data-set).
- 6 *United Nations Convention on the Rights of Persons with Disabilities*.
- 7 'About the Royal Commission', *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, web page. [About the Royal Commission | Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability](https://www.rcvna.gov.au/about-the-royal-commission)
- 8 'About us', *First Peoples Disability Network Australia*, web page. [About Us - FPDN](https://www.fpdn.org.au/about-us).
- 9 'Free Prior and Informed Consent - An Indigenous Peoples' right and a good practice for local communities - FAO', *United Nations Department of Economic and Social Affairs*, web page. [Free Prior and Informed Consent – An Indigenous Peoples' right and a good practice for local communities – FAO | United Nations For Indigenous Peoples](https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/2019/02/Free-Prior-and-Informed-Consent-An-Indigenous-Peoples-right-and-a-good-practice-for-local-communities-FAO-United-Nations-For-Indigenous-Peoples.pdf).
- 10 'Free, Prior and Informed Consent', *Food and Agriculture Organization of the United Nations*, webpage. [Free, Prior and Informed Consent | Indigenous Peoples | Food and Agriculture Organization of the United Nations \(fao.org\)](https://www.fao.org/indigenous-peoples/food-and-agriculture-organization-of-the-united-nations).
- 11 'Delivering Indigenous Data Sovereignty', *Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)*, web page. [Delivering Indigenous Data Sovereignty | AIATSIS](https://www.aiatsis.gov.au/delivering-indigenous-data-sovereignty).
- 12 'Indigenous Data Sovereignty Principles', *Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing*, web page. [Indigenous Data Sovereignty Principles - Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing - ANU \(mkstudy.com.au\)](https://www.mayikuwayu.org.au/indigenous-data-sovereignty-principles).
- 13 'About us', *National Disability Insurance Scheme (NDIS)*, web page. [About us | NDIS](https://www.ndis.gov.au/about-us).
- 14 *National Disability Insurance Scheme Act 2013 (Cth) s.8*.
- 15 'Understanding the NDIS', *National Disability Insurance Scheme (NDIS)*, web page. [Understanding the NDIS | NDIS](https://www.ndis.gov.au/understanding-the-ndis).
- 16 The right to self-determination is based on the simple acknowledgement that Indigenous peoples are Australia's first people, as was recognised by law in the historic Mabo judgement.
- 17 'Right to self-determination', *Australian Human Rights Commission*, web page. [Right to self-determination | Australian Human Rights Commission](https://www.hrc.gov.au/right-to-self-determination).
- 18 'Self-determination', *Working with Indigenous Australians*, web page. [Self-Determination : Working with Indigenous Australians](https://www.workingwithindigenousaustralians.gov.au/self-determination).
- 19 'Right to self-determination', *Australian Government Attorney-General's Department*, web page. [Right to self-determination | Attorney-General's Department \(ag.gov.au\)](https://www.ag.gov.au/right-to-self-determination).
- 20 'UN Declaration on the Rights of Indigenous Peoples', *Australian Human Rights Commission*, web page. [UN Declaration on the Rights of Indigenous Peoples | Australian Human Rights Commission](https://www.hrc.gov.au/un-declaration-on-the-rights-of-indigenous-peoples).
- 21 'Core Values and Principles', *First Peoples Disability Network*, web page. [Our Core Values & Principles - FPDN](https://www.fpdn.org.au/core-values-and-principles).
- 22 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Interim Report*, October 2020
- 23 *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*.
- 24 *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*

25 *Convention on the Rights of Persons with Disabilities (CRPD)*

26 Note: analysis should consider the changing nature of support, longer life expectancy and rising prevalence of certain disability types.

27 Literature review may be requested from Deloitte.

28 We were unable to consult with the Torres Strait.

29 Exempt in accordance with National Statement of Ethical Conduct in Human Research and Ethical Considerations in Quality Assurance and Evaluation Activities (NHMRC 2014). Further detail is available upon request.

30 See 'Our Recommendations' section for more information.

31 Projections of disability services demand for First Nations people were developed by our Deloitte Access Economics team. The information required for this was derived from a combination of NDIS data on existing participants, Deloitte Access Economics models of Australian population demographics and NDIS projections of future trends in overall usage of the NDIS. These models use expected trends in births, deaths and migration – including within Australia – to project the size and structure of the Australian population. As a result of these detailed demographics our projections of service demand account for changes in aged structure, life expectancy and location over time.

32 The Disability Royal Commission obtained data by exercise of its extraordinary powers under the *Royal Commissions Act 1902 (Cth)*. The NDIA produced NDIS data covering quarterly periods between December 2016 to December 2021. The DSS produced quarterly DES data covering the period between March 2014 and December 2021.

33 First Nations people aged 50 years and over can begin to access aged care services, while this transition occurs at 65 years for non-Indigenous people.

34 <https://www.aihw.gov.au/getmedia/778f54f3-5618-428f-a094-40c347ed3c7f/ctgc-rs36.pdf.aspx?inline=true#:~:text=Although%20there%20are%20no%20national,Australians%20than%20non%2DIndigenous%20Australians>

35 The NDIS compares disability severity across cases by using a Normalised Assessment Tool Score (NATS), which ranges from 1 to 15 (with 15 being lower level of function (lof), and hence, more severe disability). Using these scores, Deloitte has used the AIHW definition of severity classification: “1-5 indicates – high lof, 6-10 medium lof, 11-15 indicates low lof”. Further, we acknowledge this is a western definition of function and does not represent the overall contribution or ‘function’ of the individual to their community.

36 A higher score indicates a lower capacity to work. We note that this is not a measure of disability severity, although generally, higher severities are correlated with higher JSCI scores.

37 <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-download>

38 We note that some of the low level of provision is explained by the NIAA’s Community Development Program (CDP), which responsible for the services to First Nations people in remote communities.

39 Analyses based on generalised linear modelling of NDIS participation rates, using actual data of those under the NDIS and Deloitte’s estimated distribution of the population under groups such as age category, location, gender, severity/function level and primary disability group.

40 Access for adults with greater care needs is stronger for First Nations people, meaning average levels of service provision are closer to the NDIS average. Accounting for different levels of care need shows that overall service provision to First Nations people with a disability also lags behind when demand factors are considered, but the gap is smaller. The NDIS commits funding in plans for people with a disability and differences exist due to a range of factors in the utilisation rate of plan fundings. These differences in utilisation impact analysis of claim payments. We have not analysed committed supports due to constraints within the data supplied.

41 The interpretation should read as “Compared to the reference group and keeping all else equal, this cohort is on average x% more/less likely to participate in the NDIS”.

42 Over the last four years. This is driven by the large representation in the younger age categories and significant representation in Metro areas and Small to Large rural areas.

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- 43 Average payment differs from the NDIS scheme actuary report (“PB NDIS Annual Financial Sustainability Report 2021-22”) due to different methodology in calculating the average payment, as well as small differences in total \$ in the data vs NDIS scheme actuary report. Differences include the use of payments made vs payments incurred, no annualization of payments, differences in the application of NDIS membership for inclusion in the calculation and the metric reflected on a calendar year basis vs a financial year basis.
- 44 Analysis done by consolidating MMM index Remoteness Regions for large, medium, and small rural towns into ‘rural’ and consolidating remote and very remote communities into ‘remote’.
- 45 In 2018 there were a significant number of negative payments for First Nations participants in the Support Coordination Support Class. As these do not change our interpretation of the trends, we have left them in the analysis. We are informed that negative payments are likely indications of clawbacks.
- 46 In 2018 the DSS conducted a reform of the DES program with the aim of improving participant outcomes by encouraging long-term jobs. From July 2018 onwards, participants were given more flexibility to choose their providers, and change if they were not happy.
- 47 S Johnson and D Gifford, National Disability Insurance Scheme Annual Financial Sustainability Report 2021-2022, National Disability Insurance Scheme, n.d.
- 48 These projected outcomes use our modelling of demographic factors underpinning First Nations participation in the NDIS, which include consideration of life expectancy and location. They also draw on projections from the NDIS scheme actuary which include expected changes in rates of participation in the scheme as well as movements in types, level, and cost of service over time.
- 49 Statistical consideration was made by observing the distribution of the share of payments received by providers in respect of First Nations people and understanding the impact of provider classification at various levels of cut off. A 21% cut off also aligns with an assumption that a First Nations-focused provider would be one that services First Nation people at least 1 day of a 5-day week.
- 50 “Other Core” includes Consumables, Social Community and Civic Participation
“Daily Activities Core” includes Daily Activities.
“Capacity Building” includes CB Choice and Control, CB Daily Activity, CB Employment, CB Health and Wellbeing, CB Home Living, CB Lifelong Learning, CB Relationships, CB Social Community and Civic Participation.
“Support Coordination” includes Support Coordination.
“Capital” includes Assistive Technology and Home Modifications.
- 51 Department of Social Services, NDIS National Workforce Plan 2021-2025. 2021.
- 52 Australian Government Department of Health and Aged Care, National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031, March 2022.
- 53 Note that detailed data from the 2021 Census has not been released in Table builder at the time of our analysis.
- 54 Australian Bureau of Statistics Labour Force Survey (2016) data shows that of workers moving into key care sector occupations of aged and disabled carers, indigenous health workers, welfare support workers and Nursing Support and Personal Care Workers: 22.7% used to be nurses, 16.0% used to be welfare or social workers, 10.5% came from cleaners or kitchen hands – many of which are likely to have had connections to the care sector through work for providers.
- 55 ‘2016 Census’, *Australian Bureau of Statistics Census*, web page. [2016 Census \(abs.gov.au\)](https://abs.gov.au).
- 56 Gilroy et al., ‘Twelve factors that can influence the participation of Aboriginal people in disability services’ 2016, vol 16(1), *Australian Indigenous Health Bulletin*.
- 57 Indigenous Allied Health Australia, Remote and rural Indigenous allied health: Community report, 2020.
- 58 S Avery, *Culture is Inclusion: A narrative of Aboriginal and Torres Strait Islander people with disability*, 2018.
- 59 Remote service provision is characterised by what are known as ‘thin markets. These are areas in which few NDIS providers operate, limiting the choices available to people with a disability and reducing the benefits of competition which help to increase the quality and efficiency of services over time. First Nations focused and First Nations led providers play an important role in these thin markets, where they can be the only available choice.

60 From 2025 – 2029, the workforce requirements will grow in line with the real growth in annual
NDIS payments as per the Annual Financial Sustainability Report. From 2030 onwards, the
workforce requirement is extrapolated at a Compound Annual Growth Rate of 2.0% per annum in
line with our broader forecast for the care and support workforce.

61 If the First Nations share of all participants converges on 9% (currently 7.3% and growing, with
new participants representing 9.1%) and the workforce requirement relative to total payments is
consistent across First Nations and non-Indigenous participants

62 Sourced from National Centre for Vocational Education Research Data Builder.

63 Tujague and Ryan, 'Ticking the box of 'cultural safety' is not enough: Why trauma-informed
practice is critical to Indigenous healing', 2021, vol 21(3), *Rural Remote Health*.

64 Rice et al., People Don't Know What Good Looks Like: Creating Equity For People With Disability
In The Fitzroy Valley, 2021.

65 The best comparison of this model is the National Aged Care Advocacy Program which sits at
\$150m. Other examples include Murray Darling Basin Commission (~\$280m), Tourism Australia
(~\$160m). NDIA is a \$1.3B program.

66 National Indigenous Australians Agency, Indigenous Procurement Policy, 2022.

67 Deloitte, Third Year Evaluation of the Indigenous Procurement Policy, 2019.

68 These considerations would be captured within an assessment criteria which will be guided by a
number of First Nations principles and ways of working.

69 Currently outlined by the NDIA as service connecting Aboriginal and Torres Strait Islander
participants with the Scheme (NDIS). It functions as conduit between the NDIA and their
communities to aid communication and engagement. In addition, they provide the cultural
brokerage necessary to understand and effectively engage with the relationships, infrastructure,
organisational capacity, and networks that exist within communities. (NDIS, 2020).

70 A role that helps those with disability to understand the access the NDIS, create and plan,
implement an individual's plan and review the plan.

71 Including: Aboriginal and Torres Strait Islander (ATSI) communities, Culturally and Linguistically
Diverse (CALD) communities, People experiencing psychosocial disabilities; and Ageing parents
or carers of people with disability (NDIS 2021).

72 FPDN's Community Connector training program was developed via extensive community
engagement with First Nations people who have lived experience of disability and comes with
a set of resources designed to support the Community Connectors in engaging with individuals
around the NDIA and how to develop an individual plan that meets the needs of the participants.
(FPDN, 2022. Community Connector Training).

73 It should be noted that there are cases in which the thinness is transitional and will resolve
itself with time, but this can be sped up with interventions, which would also require greater
investigation by the NDIA.

74 'The National Disability Insurance Scheme: a quick guide', *Parliament of Australia*, webpage. The
National Disability Insurance Scheme: a quick guide – Parliament of Australia (aph.gov.au).

75 Productivity Commission, Inquiry report – disability care and support, 2011.

76 'Guardianship orders', Victoria Legal Aid, webpage. Guardianship orders | Victoria Legal Aid.

77 In some cases, there may be more than one guardian (called 'joint guardians'). 'Guardianship
orders', *Victoria Legal Aid*, webpage. Guardianship orders | Victoria Legal Aid.

78 'What is a guardian? What is a guardianship order?', *Legal Aid ACT*, webpage. What is a
guardian? What is a guardianship order? | Legal Aid ACT

79 'Guardianship and Administration', *Australian Law and Reform Commission*, webpage.
Guardianship and administration | ALRC.

80 It should be noted that, amongst other things, guardians do not have authority to make financial
decisions or consent to a prescribed medical procedure. (*Legal Aid ACT*, 2022).

81 Supports and services funded by the NDIS', *NDIS*, webpage. [https://www.ndis.gov.au/providers/
becoming-ndis-provider/am-i-ready/supports-and-services-funded-ndis](https://www.ndis.gov.au/providers/becoming-ndis-provider/am-i-ready/supports-and-services-funded-ndis)

82 'What is a holistic approach?', *NSW Health*, webpage. What is a holistic approach? - Principles for
effective support (nsw.gov.au).

83 Multi-Partner Trust Fund Office, Designing Pooled Funds for Performance, June 2015.

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- 84 It should be noted that there are cases in which the thinness is transitional and will resolve itself with time, but this can be sped up with interventions, which would also require greater investigation by the NDIA.
- 85 Māori and Pacific support services; *Whaikaha Ministry of Disabled People*, webpage. [Māori and Pacific support services | Whaikaha - Ministry of Disabled People](#)
- 86 'Towards an Accessible Canada', *Government of Canada*, webpage. [Towards an Accessible Canada - Canada.ca](#)
- 87 'Empowering First Nations Persons with Disabilities and First Nations Governments on Distinct First Nations Accessibility/Disability Legislation, *Assembly of First Nations*, webpage. [Empowering First Nations Persons with Disabilities | Assembly of First Nations \(afn.ca\)](#)
- 88 Department of Social Services, NDIS National Workforce Plan: 2021-2025, 2021.
- 89 Detailed analysis of this recommendation can be found in workforce lifecycle considerations.
- 90 First Peoples Disability Network, *National Disability Employment Strategy - Submission*, May 2021.
- 91 S Avery, *Culture is Inclusion: A narrative of Aboriginal and Torres Strait Islander people with disability*, 2018.
- 92 National Aboriginal Community Controlled Health Organisation, *Final Report of The NDIS Capacity Building Project*, September 2019.
- 93 Indigenous Allied Health Australia, *Remote and rural Indigenous allied health: Community report*, 2020.
- 94 First Peoples Disability Network, *National Disability Employment Strategy - Submission*, May 2021.
- 95 Cortis and van Toorn, *Working in new disability markets: A survey of Australia's disability workforce*, 2020.
- 96 National Aboriginal Community Controlled Health Organisation, *Submission to The Senate Standing Committee on the National Disability Insurance Scheme*, 2021.
- 97 Deloitte 2022, Australian Bureau of Statistics 2016.
- 98 Gilroy, Donnelly, Colmar and Parmenter, *Twelve factors that can influence the participation of Aboriginal people in disability services*, 2016.
- 99 *A'Show your commitment'*, Australian Government Prime Minister's Veterans' Employment program, webpage. [Show your commitment | Veterans' Employment Program \(veteransemployment.gov.au\)](#)
- 100 Downing, Kowal and Paradies, *Indigenous Cultural Training For Health Workers in Australia*, 2011.
- 101 National Disability Insurance Scheme Quality and Safeguards Commission, *NDIS Workforce Capability Framework*, 2021.
- 102 Downing, Kowal and Paradies, *Indigenous Cultural Training For Health Workers in Australia*, 2011.
- 103 Coade, Downey and McClung, *Yarning up on trauma: healing ourselves, healing our children and families, healing our communities*, 2008.
- 104 Some of these include *The Healing Foundation and the Australian Indigenous HealthInfoNet*.
- 105 S Avery, *Something Stronger: Truth-telling on hurt and loss, strength and healing, from First Nations people with disability, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, 2020.
- 106 These include (but not limited to)- family, community and Country responsibilities, conscious and unconscious bias, organisational racism, fewer mentors and role models, reduced familiarity with some teaching and training methods, financial constraints, lack of remote resources, culturally unsafe learning, and clinical practice environments (*National Aboriginal and Torres Strait Islander Workforce Strategic Framework and Implementation Plan 2021 – 2031*).
- 107 First Peoples Disability Network, *National Disability Employment Strategy - Submission*, May 2021.
- 108 S Avery, *Culture is Inclusion: A narrative of Aboriginal and Torres Strait Islander people with disability*, 2018.
- 109 Indigenous Allied Health Australia, *Remote and rural Indigenous allied health: Community report*, 2020.

110 Gilroy et al., 'Need for an Australian Indigenous disability workforce strategy: review of the literature', (2017), vol 39(16), *Disability and Rehabilitation*, pp 1664 – 1673.

111 National Aboriginal Community Controlled Health Organisation, Final Report of The NDIS Capacity Building Project, 2019.

112 National Aboriginal Community Controlled Health Organisation, Submission to The Senate Standing Committee on the National Disability Insurance Scheme, 2021.

113 Supply Nation, State of Indigenous Business, 2020.

114 Note that First Nations owned NDIS providers can already access Supply Nation 'status'. This recommendation refers to the capability uplift aspects of the program.

115 PWC, Managing capital projects through controls, processes, and procedures; Toward increased project transparency and accountability, 2014.

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117 Peer Connect, Quick Guide: Aboriginal perspectives on disability, 2015.

118 'Do you meet the disability requirements?', NDIS, webpage. Do you meet the disability requirements? | NDIS.

119 First Peoples Disability Network Australia, Cultural competence, 2022.

120 NDIA, Assessment tools to improve consistency of NDIS access and plans, 2020.

121 NDIS Quality and Safeguards Commission, NDIS Workforce Capability Framework, 2021.

122 Downing, Kowal and Paradies, 'Indigenous cultural training for health workers in Australia', (2011), vol 23(11), *International Journal for Quality in Health Care*, pp 247–257.

123 The current NDIS Quality and Safeguarding Framework does not include anything specific to First Nations people and as such does not adequately cater for their unique needs and has not been updated since 2017 regardless of the changing needs of NDIS participants due to inflation, global events, and a changing political environment. (Department of Social Services, 2017. NDIS Quality and Safeguarding Framework).

124 First Peoples Disability Network Australia, Sector Strengthening Plan: Disability, 2022.

125 First Peoples Disability Network Australia, Sector Strengthening Plan: Disability, 2022.

126 National Indigenous Australians Agency, Closing the Gap Implementation Plan, 2021.

127 Some of the targets have a number of outcomes that directly affect First Nations people: Outcome 4: Aboriginal and Torres Strait Islander children thrive in their early years. Outcome 8: Strong economic participation and development of Aboriginal and Torres Strait Islander people and communities. Outcome 9: Aboriginal and Torres Strait Islander people secure appropriate, affordable housing that is aligned with their priorities and needs.

128 National Indigenous Australians Agency, Closing the Gap Implementation Plan, 2021.

129 Existing programs to be leveraged include The National Framework for Protecting Australia's Children 2009-2020 (Target 12); NDIS Aboriginal and Torres Strait Islander Engagement Strategy and Thin Market Projects; Social Services increase to ACCHOs and National Early Childhood Program and Disability Sector Strengthening Plan.

130 National Indigenous Australians Agency, Closing the Gap Implementation Plan, 2021.

131 We heard from multiple intersections across Education, Justice, Health, Aged Care and Child Services. This data will be analysed in detail in the final report.

132 'A2016 Census, Australian Bureau of Statistics, webpage. 2016 Census (abs.gov.au).

133 '3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026', Australian Bureau of Statistics, webpage. 3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026 (abs.gov.au).

134 'Disability and carers: Census, 2021', Australian Bureau of Statistics, web page. 3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026 (abs.gov.au).



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