Joint Standing Committee on the National Disability Insurance Scheme

NDIS participant experience in rural, regional and remote Australia

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Abbreviations and acronyms

AAO	Administrative Arrangements Order
ACCHO	Aboriginal Community Controlled Health Organisations
ACCO	Aboriginal Community Controlled Organisations
AFDO	Australian Federation of Disability Organisations
AHMRC	Aboriginal Health & Medical Research Council of NSW
AMS	Aboriginal Medical Services
ASD	Autism Spectrum Disorder
CALD	Culturally and Linguistically Diverse
CALD Strategy	NDIS Cultural and Linguistic Diversity Strategy 2024–2028
CBS	Community Bridging Services
CFPs	coordinated funding proposals
committee	Joint Standing Committee on the National Disability Insurance Scheme
Congress	Central Australian Aboriginal Congress
DANA	Disability Advocacy Network Australia
DIDO	drive-in, drive-out
DHDA	Department of Health, Disability and Ageing
DRAS	Disability Rights Advocacy Service
DSS	Department of Social Services
FIFO	fly-in, fly-out
First Nations Strategy	NDIS First Nations Strategy 2025-2030
FNAC	First Nations Advisory Council
FPDN	First Peoples Disability Network
HSU	Health Services Union
IAC	Independent Advisory Council
IRO	Indigenous and Remote Operations
LACs	Local Area Coordinators
MMM	Modified Monash Model
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aboriginal and Islanders Day Observance Committee
NDIA or Agency	National Disability Insurance Agency
NDIS or Scheme	National Disability Insurance Scheme
NDIS Review	2023 Independent Review into the NDIS
NDS	National Disability Services
NEDA	National Ethnic Disability Alliance
NIAA	National Indigenous Australians Agency

NYP Women's Council	Ngaanyatjarra Pitjantatjara Yankunytjatjara Women's Council
PRECI	Professionals and Researchers in Early Childhood Intervention
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCC	Remote Community Connectors
RFDS	Royal Flying Doctor Service
RIAC	Rights Information and Advocacy Centre
RRR	rural, regional and remote
RVA	Rare Voices Australia
SAHMRI	South Australian Health & Medical Research Institute
strategy	NDIA Rural and Remote Strategy 2016–2019
SWAN	South West Autism Network
TRS	Trusted Referee Statement
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
VicRAN	Victorian Rural Advocacy Network

List of recommendations

Recommendation 1

6.5 The committee recommends that the National Disability Insurance Agency develop and implement a plan to further simplify and streamline the National Disability Insurance Scheme (NDIS) application process and create and publish accessible guidance materials for rural, regional and remote communities, consistent with the recommendations of the NDIS Review and the evidence received by the committee.

Recommendation 2

6.8 The committee recommends that the Department of Health, Disability and Ageing and the National Disability Insurance Agency, through co-design with disability communities in rural, regional and remote Australia, develop a training and cultural awareness program for National Disability Insurance Scheme staff and contractors operating in rural, regional and remote (RRR) communities, focusing on:

- **building knowledge and understanding of disability;**
- **developing cultural awareness and competency;**
- **understanding and responding to the challenges for people with disability in RRR communities;**
- **greater flexibility in delivering services to meet the needs of people with disability; and**
- **more access to interpreters in RRR communities.**

Recommendation 3

6.11 The committee recommends that the Department of Health, Disability and Ageing, in consultation with the National Disability Insurance Agency, work with the medical profession and communities in rural, regional and remote areas to explore practices and initiatives to ensure that people with disability in rural, regional and remote communities obtain timely access to medical and allied health services.

Recommendation 4

6.17 The committee recommends the Department of Health, Disability and Ageing work with the medical profession, the National Disability Insurance Agency and disability communities in rural, regional and remote (RRR) areas to explore initiatives that could help address shortages of medical professionals, allied health professionals and National Disability Insurance Scheme (NDIS) workers in RRR areas of Australia, including:

- **incentives for NDIS service providers to attract and retain workers based in rural, regional and remote areas;**
- **incentives for medical professionals, allied health professionals and NDIS workers to live and work in rural, regional and remote areas;**
- **incentives and supports for people living in rural, regional and remote areas to undertake local education and training towards medical, allied health or NDIS worker qualifications;**
- **initiatives to attract qualified workers in Australia and overseas to live and work in rural, regional and remote areas; and**
- **working with state and territory skills departments to build capacity and encourage attainment of accreditation in First Nations language interpreting, which builds workforce capacity in rural, regional and remote communities.**

Recommendation 5

6.21 The committee recommends that the National Disability Insurance Agency incorporate greater flexibility to facilitate travel for National Disability Insurance Scheme participants who live in remote and very remote areas.

Recommendation 6

6.25 The committee recommends that the National Disability Insurance Agency develop and publish plans to implement additional First Nations and Culturally and Linguistically Diverse cultural safety training for its staff and partners.

Recommendation 7

6.29 The committee recommends that the Department of Health, Disability and Ageing and the National Disability Insurance Agency work with First Nations community-controlled organisations to deliver culturally safe National Disability Insurance Scheme services to First Nations participants as preferred providers.

Recommendation 8

6.32 The committee recommends that the National Disability Insurance Agency work in partnership with First Nations community-controlled organisations to develop communications strategies and materials to deliver information about the National Disability Insurance Scheme in First Nations languages, and work with First Nations community-controlled organisations to create opportunities for First Nations people to undertake interpreter training courses.

Recommendation 9

6.35 The committee recommends that the National Disability Insurance Agency collaborate with Culturally and Linguistically Diverse peak organisations to:

- **improve communications strategies and materials to deliver information about the National Disability Insurance Scheme in community languages; and**
- **improve accessibility and diversity of services from Culturally and Linguistically Diverse providers in rural, regional and remote Australia.**

Recommendation 10

6.38 The committee recommends that the Department of Health, Disability and Ageing and the National Disability Insurance Agency conduct a review of the current alternative commissioning trials, including drawing on the Maningrida and Katanning experience, with a view to understanding best practice before expanding these arrangements to other remote and First Nations communities, in partnership with First Nations representatives and communities.

Foreword

1.1 The Joint Standing Committee on the National Disability Insurance Scheme (committee) first commenced this inquiry during the 47th Parliament, and thanks members for their contribution to this report.

1.2 Since that time, the committee notes the Commonwealth Government and the National Disability Insurance Agency (NDIA) have enacted several changes to the National Disability Insurance Scheme (NDIS or Scheme) and made announcements about the future direction of the Scheme.

1.3 As part of its inquiry, the committee sought to better understand the experience, choice and control of NDIS applicants and participants who live in rural, regional and remote Australia. The committee examined the applicant and participant experience at all stages of the NDIS, and the role of the NDIA in administering the NDIS outside of the major cities.

1.4 The committee received substantial evidence via submissions and public hearings about the NDIS experiences of people with disability, their families and carers who live in rural, regional and remote areas, and the committee thanks all those inquiry participants who shared their experiences.

1.5 The purpose of this report is to present the evidence received throughout the inquiry, and to put forward the committee's important findings about the NDIS participant experience across the country which have informed the committee's recommendations for change.

1.6 It is clear to the committee that the NDIS has assisted many people with disability in these communities. In some instances, the impact has been positively life-changing and profound. However, it is also evident that challenges remain. Some of these are unique to rural, regional and remote communities, others are shared in metropolitan areas, and others are shared but exacerbated in rural, regional and remote areas.

1.7 The committee heard of difficulties in accessing information, services and supports. In the committee's view, it is important that this evidence be presented to the Parliament, along with the committee's recommendations on how to remove these barriers for participants to access the NDIS, regardless of their location across Australia.

1.8 In this report, the committee provides several recommendations directed at improving the applicant and participant experience with the NDIS so that it can provide people with disability with the support necessary to make and communicate decisions that affect their lives.

Chapter 1
Introduction

1.1 The Joint Standing Committee on the National Disability Insurance Scheme (committee) was established in the 48th Parliament by resolution of the House of Representatives on 23 July 2025, and by the Senate on 24 July 2025.[1]

1.2 The committee is composed of five members and five senators, and is tasked with reviewing:

(a) the implementation, performance and governance of the National Disability Insurance Scheme (NDIS or the Scheme);
(b) the administration and expenditure of the NDIS; and
(c) such other matters in relation to the NDIS as may be referred to it by either House of the Parliament.

1.3 As soon as practicable after 30 June each year, the committee is required to present an annual report to the Parliament on the activities of the committee during the year, including the examination of each annual report of the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission, in addition to reporting on any other matters it considers relevant.[2]

1.4 The committee is also able to inquire into specific aspects of the Scheme.

1.5 On 18 October 2023, the committee agreed to self-refer an inquiry into the NDIS participant experience in rural, regional and remote Australia, with particular reference to:

(a) the experience of applicants and participants at all stages of the NDIS, including application, plan design and implementation, and plan reviews;
(b) the availability, responsiveness, consistency, and effectiveness of the NDIA in serving rural, regional and remote participants;
(c) participants' choice and control over NDIS services and supports including the availability, accessibility, cost and durability of those services;
(d) the particular experience of Aboriginal and Torres Strait Islander participants, participants from culturally and linguistically diverse backgrounds, and participants from low socio-economic backgrounds, with the NDIS; and

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1 House of Representatives, *Votes and Proceedings*, No. 2, 23 July 2025, pp. 53-54; *Journals of the Senate*, No. 3, 24 July 2025, pp. 110-112. In the 47th Parliament, the committee was established by resolution of the House of Representatives on 26 July 2022 and by the Senate on 27 July 2022. References to 'the committee' in this report refer collectively to both the 47th and 48th Parliament iterations.

2 *Journals of the Senate*, No. 3, 24 July 2025, pp. 110-111.

(e) any other related matters.[3]

1.6 The inquiry lapsed when the committee ceased to exist at the dissolution of the House of Representatives on 28 March 2025. Upon its reappointment in the 48th Parliament, the committee determined to re-refer this inquiry in order to present the evidence received during the inquiry and to table this final report.

Conduct of the inquiry

1.7 The committee received a total of 103 public submissions. All submissions are listed at Appendix 1 and are available on the committee's website.[4]

1.8 As part of the inquiry, the committee held five public hearings:

- 16 April 2024 in Darwin, NT
- 18 April 2024 in Broome, WA
- 28 June 2024, Canberra, ACT
- 17 October 2024, Dubbo, NSW
- 1 November 2024, Bendigo, VIC.

1.9 In addition to the formal program of witnesses, the committee heard short statements from individuals with lived experience of disability and the NDIS. Witnesses who appeared at the hearings are listed at Appendix 2.

1.10 Transcripts of the hearings, together with submissions and additional information provided to the inquiry, are available on the committee's inquiry webpage.

Structure of the report

1.11 This report consists of six chapters, as follows:

- Chapter 1 (this chapter) sets out the inquiry's terms of reference and provides general information about the conduct of the inquiry;
- Chapter 2 discusses the classification of rural, regional and remote areas in Australia and how many NDIS participants live in these areas;
- Chapter 3 considers challenges related to navigating access to the NDIS in rural, regional and remote areas;
- Chapter 4 discusses issues related to access to local services and supports, and thin markets;

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3 Joint Standing Committee on the NDIS, inquiry into the NDIS participant experience in rural, regional and remote Australia, Terms of Reference, https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/RuralRegionalandRemote/Terms_of_Reference (accessed 3 November 2025).

4 Joint Standing Committee on the NDIS, inquiry into the NDIS participant experience in rural, regional and remote Australia, submissions, https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/RuralRegionalandRemote/Submissions (accessed 3 November 2025).

- Chapter 5 considers issues related to cultural safety for First Nations participants and other First Nations people with disability; and
- Chapter 6 contains the committee's views and recommendations to address the matters raised in this report, with a view to improving the accessibility and quality of disability services and supports in rural, regional and remote areas.

Note on terminology and references

1.12 References to submissions in this report are to submissions provided to the committee's inquiry into the NDIS participant experience in rural, regional and remote Australia, unless otherwise indicated. References to Committee Hansard are to official transcripts, unless otherwise indicated.

1.13 The committee acknowledges that there are various terms used to reflect the diversity of Aboriginal and Torres Strait Islander cultures and identities. In this report, the terms 'Aboriginal and Torres Strait Islander people' and 'First Nations people' are used, with respect.

1.14 The committee also notes that some submitters and witnesses may refer to NDIS participants and other people with disability as 'clients' of particular services. This report may use the term 'client' when quoting from a submission or a hearing transcript. Otherwise, the report uses the terms 'participant', 'person with disability' and 'people with disability', with respect.

1.15 The committee recognises that people use many terms when talking about disability. The committee is aware that there are people in the community who prefer 'people first language', people who prefer 'identity first language', and people who use terms interchangeably.

1.16 People first language seeks to put the person before their disability and avoid the disability becoming the primary, defining characteristic of an individual. For example, 'person with disability'. Identity first language reflects the belief that being disabled is a core part of a person's identity which cannot, and should not, be treated as separate. For example, 'disabled person'.

1.17 The committee recognises there is no consensus as to which language should be used, and that each member of the community will have their own opinion on terminology. The committee also understands that each person will have a preferred way of communicating and self-describing. The committee respects that language is an individual and highly personal choice.

1.18 In the context of this inquiry, the committee has used people first language in its report to ensure consistency with the terms of reference.

Government agency changes

1.19 Under an Administrative Arrangements Order (AAO) made on 13 May 2025 (and amended on 26 June 2025), responsibility for the following matters moved

from the Department of Social Services (DSS) to the Department of Health, Disability and Ageing (DHDA):

- services and policy for the NDIS; and
- services and policy for Foundational Supports.[5]

1.20 The changes bring health, disability and social services together. DSS has retained responsibility for services to help people with disability to obtain employment and, specifically, the following:

- income security and support policies and programmes for families with children, carers, the aged, people with disabilities and people in hardship; and
- policy and services to help people with disability obtain employment.[6]

1.21 The evidence received during this inquiry was prior to the amendments made by the AAO, and the change in administrative functions. References to DSS and other departments throughout this report should be considered in that context.

1.22 Recommendations made by the committee to a government department reflect the arrangements in place following commencement of the AAO.

Acknowledgements

1.23 The committee thanks all those who have contributed to the inquiry by lodging submissions, appearing at public hearings, providing additional information, and sharing their views via correspondence. The submissions and other evidence received by the committee, including through hearings across the country, have shed light on a broad range of issues concerning the operation of the NDIS in rural, regional and remote communities.

1.24 In particular, the committee acknowledges the contributions of people with disability, their families and carers who shared their experiences. The evidence of people with lived experience is crucial to understanding the experience of participants living in rural, remote and regional Australia. The committee appreciates the time and effort that people have generously taken to share their deeply personal accounts. It is this tremendous effort and courage that has made this important inquiry possible.

[5] Department of the Prime Minister and Cabinet, *Administrative Arrangements Order*, 13 May 2025, pp. 20–22.

[6] Department of the Prime Minister and Cabinet, *Amendment to the Administrative Arrangements Order*, 26 June 2025.

Chapter 2
NDIS participants in rural, regional and remote Australia

Introduction

2.1 National Disability Insurance Scheme (NDIS) participants live all around Australia, including in very remote and isolated communities. In conducting this inquiry into the experience of NDIS participants living in rural, regional and remote (RRR) Australia, it was important to the committee to first understand how these areas are classified, how many people with disability live in these communities and how many are accessing the NDIS.

Classification of rural, regional and remote communities

2.2 The National Disability Insurance Agency (NDIA) uses a modified version[1] of the Modified Monash Model (MMM) to classify the remoteness of areas according to their population size and isolation. The MMM includes seven categories of remoteness:

(1) MMM1: Major cities
(2) MMM2: Regional areas with population > 50 000
(3) MMM3: Regional areas with population between 15 000 and 50 000
(4) MMM4: Regional areas with population between 5 000 and 15 000
(5) MMM5: Regional areas with population < 5000
(6) MMM6: Remote areas
(7) MMM7: Very Remote areas.[2]

2.3 The NDIA uses the MMM to set pricing for services based on remoteness. In essence, the more remote a location is classified, the higher the price allocated for services in that area.[3]

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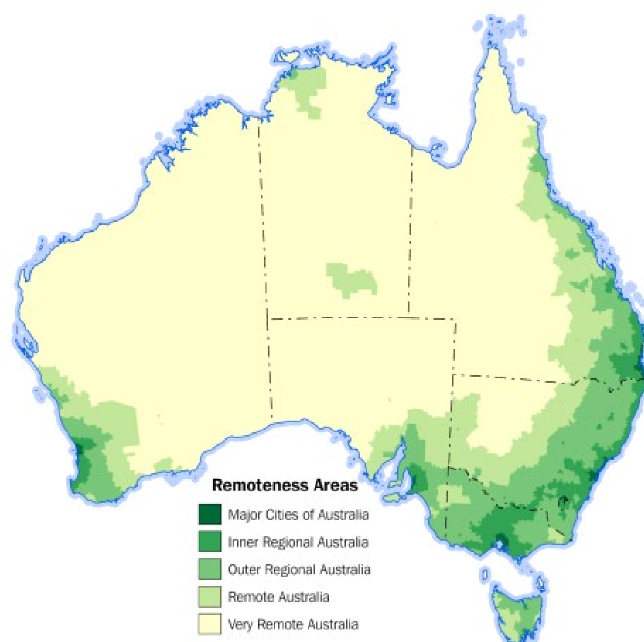
[1] The National Disability Insurance Agency (NDIA) sometimes reclassifies the MMM rating for isolated towns for pricing purposes.

[2] NDIA, *Participants across remoteness classifications*, data.ndis.gov.au/media/2486/download?attachment (accessed 15 January 2025).

[3] NDIA, *NDIS Pricing Arrangements and Price Limits 2024–25*, ndis.gov.au/media/7150/download?attachment (accessed 5 February 2025).

2.4 The figure below provides a visual representation of these remoteness areas across the country using the MMM model.[4]

Figure 2.1 Remoteness Areas for Australia



NDIS participants in RRR areas

2.5 The NDIA reports on the number of active NDIS participants by their remoteness, First Nations Peoples status and Culturally and Linguistically Diverse (CALD) status, in addition to other factors.

2.6 As at the time of this report, the most recent statistics reveal there are 739 413 active NDIS participants nationally.[5] Of those 739 413 participants:

- 220 704 live in regional Australia;[6]
- 6784 live in remote Australia; and
- 4436 live in very remote Australia.[7]

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4 Australian Bureau of Statistics (ABS), *Remoteness Areas*, abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas (accessed 4 February 2025).

5 NDIA, *Explore data Q4 FY24/25*, dataresearch.ndis.gov.au/explore-data (accessed 14 October 2025). Data current as of 4 September 2025.

6 This figure includes participants living in areas classified as MMM2–MMM5.

7 NDIA, *Explore data Q4 FY24/25*, dataresearch.ndis.gov.au/explore-data (accessed 14 October 2025).

2.7 The NDIA reports that there are 60 529 First Nations participants, comprising approximately 8 per cent of all participants, and 64 697 CALD participants who comprise nearly 9 per cent of all participants.[8]

2.8 NDIA data shows that, of the states and territories, Queensland has the highest proportion of participants living outside of major cities, with over 38 per cent living in regional areas alone. This is followed by New South Wales, where approximately 30 per cent live in regional areas, and Victoria, which has over 27 per cent. Western Australia and South Australia have 21 per cent and 25 per cent, respectively, of participants who live in regional areas.

2.9 In relation to remote and very remote communities, the Northern Territory has the highest proportion of participants living in these areas, comprising approximately 22 per cent and 20 per cent, respectively. Western Australia has the next highest, but the figures drop significantly to approximately 2.8 per cent living in remote areas, and 1.6 per cent in very remote areas. All other states and territories have lower proportions still.

2.10 The below table shows the number of active participants nationally and in each state and territory by remoteness (based on Q4, 2024–25 data).[9] A comprehensive breakdown of these statistics is included at Appendix 3.

Table 2.1 NDIS participants by remoteness

	Major cities	**Regional**	**Remote**	**Very Remote**	**Total***
NSW	153 116	63 961	733	92	217 913
VIC	144 859	54 640	70	0	199 580
QLD	98 653	57 837	1447	1314	159 262
WA	51 330	10 782	1839	< 1072	65 034
SA	47 140	14 037	1135	522	62 845
TAS	0	15 641	158	< 42	15 841
ACT	12 030	< 11	0	0	12 052
NT	0	3806	1402	< 1332	6551

* Total number of participants includes participants recorded as 'missing' and therefore are not listed as living in a particular area. Figures correct as of 4 September 2025.

[8] NDIA, *Explore data, Q4 FY24/25*, dataresearch.ndis.gov.au/explore-data (accessed 14 October 2025).

[9] NDIA, *Explore data Q4 FY24/25*, dataresearch.ndis.gov.au/explore-data (accessed 14 October 2025).

NDIA Rural and Remote Strategy 2016–2019

2.11 The NDIA Rural and Remote Strategy 2016–2019 (strategy) was developed to guide the roll out of the NDIS in rural and remote Australia. The strategy recognises that people with disability in rural and remote Australia may require additional support to access and utilise the NDIS.[10] The strategy's overarching vision is that:

> … people with disability in rural and remote Australia, including Aboriginal and Torres Strait Islander Communities, are supported to participate in social and economic life to the extent of their ability, to contribute as valued members of their community and to achieve good life outcomes.[11]

2.12 The strategy identifies many of the barriers raised by RRR communities about the NDIS and sets out the following goals:

- easy access and contact with the NDIA;
- effective, appropriate supports available wherever people live;
- creative approaches for individuals within their communities;
- harnessing collaborative partnerships to achieve results; and
- support and strengthen local capacity of rural and remote communities.[12]

2.13 While not set out in the strategy itself, the NDIA has outlined actions taken by the government to support the goals identified above, including:

- engaging Remote Community Connectors (RCCs);
- adapting the NDIS Price Guide, including increasing the funding in NDIS plans of remote and very remote participants;
- investing in the NDIS Ready project 2020–22 to increase the number of Aboriginal Community Controlled Health Organisations (ACCHO) registered to deliver NDIS services; and
- conducting thin market trials, including market facilitation, coordinated funding proposals and direct commissioning.[13]

2.14 While the strategy is now out of date, the NDIS advised that it is now guided by its Remote Service Delivery Framework that is aligned, in principle, to the intent of the strategy. The framework provides a 'substantially stronger operational

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[10] ABS, *Remoteness Areas*, abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas (accessed 15 January 2025).

[11] NDIA, *NDIA Rural and Remote Strategy 2016–2019*, p. 3.

[12] NDIA, *NDIA Rural and Remote Strategy 2016–2019*, p. 3.

[13] NDIA, *Rural and Remote Strategy*, ndis.gov.au/about-us/strategies/rural-and-remote-strategy (accessed 7 February 2025).

approach and resourcing to ensure that people with disability in non-partnered Australia have access to the full range of NDIS supports'.[14]

[14] National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

Chapter 3
Accessing the National Disability Insurance Scheme

Introduction

3.1 During this inquiry, the committee travelled around the country to hear directly from National Disability Insurance Scheme (NDIS) applicants and participants in rural, regional and remote (RRR) Australia to better understand their experiences with the NDIS. Evidence received by the committee from applicants to the NDIS, family members and advocacy organisations indicated there are several unique challenges faced by people with disability seeking to access the scheme in RRR communities.

3.2 This chapter considers the experiences of people with disability in RRR communities at the very first stage of the process when applying for access to the scheme, as well as the initial planning stage. It also considers proposed solutions to address these challenges.

NDIS application requirements

3.3 Many people in RRR communities reported improvements in their quality of life once they were on the scheme. However, throughout the course of this inquiry, the committee heard of challenges faced by people with disability across the country with the NDIS application process.

3.4 During the inquiry, the committee received accounts of the difficulties faced by those seeking to get on the scheme, including concerns regarding the complexity of the process and specificity of documentation required. As the Centre for Excellence in Child and Family Welfare noted, the 'application and extension forms are confusing, long and repetitive'.[1]

3.5 People seeking NDIS services and supports are required to complete and submit an NDIS Access Request Form. This form requires an applicant to provide information about themselves and their disability and contains sections for an applicant's treating medical professional to complete. The form requires supporting documentation in relation to an applicant's identity, residence, diagnosis, early intervention support needs, existing assessments, and evidence of functional capacity.[2]

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1 Centre for Excellence in Child and Family Welfare, *Submission 12*, p. 2.

2 National Disability Insurance Agency (NDIA), *What is an Access Request Form?* ndis.gov.au/how-apply-ndis/what-access-request-form#completing-your-access-request-form-and-supporting-information (accessed 31 January 2025).

3.6 Evidence to the committee highlighted the numerous challenges that people with disability in RRR communities face with completing the form and providing the required documentation. For example, Kiind put forward evidence from families that the forms were 'complicated [and] specific jargon had to be used', while other families found 'the bureaucratic processes of the NDIS burdensome and confusing'.[3]

3.7 Chapter 5 of this report considers how the evidence received by the committee highlights how some of these challenges affect people with disability from First Nations communities and CALD backgrounds in RRR areas.

3.8 The committee was told that the NDIS is 'not user friendly', and that the planning process is 'often extremely draining and confusing' with 'problems compounded in rural, regional and remote area[s] by the burden of distance'.[4]

3.9 The committee also heard that people with disability in RRR communities can face difficulties where access to the support and professional services required to complete the application process is limited or not locally available. For example, Vision 2020 suggested that:

> … many people and families who are finding the NDIS application difficult and confusing. People living in rural, regional, and remote areas are especially impacted by this complexity because of extra travel costs and less access to specialists.[5]

3.10 As noted by the University of Sydney, the above challenges can be coupled with unstable internet connections, poor digital literacy and the scarcity of resources.[6] The impacts of this were explained by a person who, when asked for additional evidence regarding his attempt to apply for scheme access over the phone, noted he 'had no idea what to do so I did nothing and my application expired'.[7]

Securing support to complete an application

3.11 The above evidence highlighted to the committee the importance of securing support for those seeking to access the Scheme.

3.12 According to the NDIA, support with the application process can be secured by contacting a local NDIA Office or NDIA partner. Additionally, in some remote

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3 Kiind, *Submission 78*, pp. 4 & 9.

4 Victorian Rural Advocacy Network (VicRAN), *Submission 19*, p. 5.

5 Vision 2020, *Submission 11*, p. 4.

6 University of Sydney, *Submission 13*, p. 4. See also: Kin Disability Advocacy, *Submission 36*, p. 6.

7 South West Autism Network, *Submission 86*, p. 6.

and very remote communities, applicants may be able to get support from a Remote Community Connector.[8]

3.13 These supports are critically important for people with disabilities in RRR Australia who may have limited information when seeking to apply for the NDIS. MS Australia made the point that finding such a support was particularly significant for applicants who are new to the disability space.[9] These supports are discussed below.

Local Area Coordinators

3.14 Local Area Coordinators (LACs) are tasked with guiding people with disability to create and work towards their goals, build capacity to make their own decisions and access the supports they need.[10] LACs are not directly employed by the NDIA, but contracted via a NDIA partner agency.[11]

3.15 The NDIA states that LACs can support people in the following ways:

- finding practical information, including where to find online supports and services;
- helping people to understand and access the NDIS, including via workshops;
- assisting people to develop their NDIS plans (noting they cannot create or approve a plan as this is done by the NDIA);
- assisting people to understand and use the supports in their NDIS plans; and
- assisting people to apply for changes to their NDIS plan via a plan reassessment or plan variation.

3.16 According to one submitter, LACs are key to guiding participants through the NDIS process, setting up support goals and connecting people with local resources.[12]

3.17 However, several submitters raised concerns with the supports available. For example, Lifely indicated that some LACs may lack familiarity with the specific geographical, economic and social challenges of RRR participants.[13] The

8 NDIA, *What is a Community Connector?* ndis.gov.au/understanding/what-ndis/whos-delivering-ndis/what-community-connector (accessed 31 January 2025). Note: a Remote Community Connector is an NDIA representative that supports the culturally appropriate delivery of the NDIS in remote communities.

9 MS Australia, *Submission 89*, p. 6.

10 NDIA, *Local area coordination partners*, ndis.gov.au/understanding/what-ndis/whos-delivering-ndis/local-area-coordination-partners (accessed 7 February 2025).

11 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

12 Lifely, *Submission 103*, p. 22.

13 Lifely, *Submission 103*, p. 22.

Disability Advocacy Network Australia (DANA) also advised that, in its experience, some LACs do not have the capacity to meet in person or travel to people who require support.[14]

3.18 The Rights Information and Advocacy Centre suggested that rather than supporting a person through the process, LACs can be perceived as 'gatekeepers' to the scheme, serving as a barrier rather than a facilitator for the applicant.[15] Similarly, Outback Disability Services indicated that in their experience, some LACs:

- act as gatekeepers and effectively deny NDIS applications prior to their assessment;
- fail to make regular or any contact with applicants to discuss their application, community connections or to develop an understanding of the applicant's circumstances; and
- pick and choose conditions for NDIS recognition and act paternalistically towards clients about what is 'best' for them while being too inflexible to meet in-person to make a first-hand assessment.[16]

3.19 Ms Cristie Stewart, an Access and Support Officer based in Bendigo for Rights Information and Advocacy Centre Incorporated, observed:

> In one case, [a] LAC declined a client participation in the Scheme in connection with the disability that denies them mobility, but encouraged her to apply in relation to her mental health. This client is unable to leave her home which has led to a significant decline in her mental health and by providing support to be able to engage with community, the client's mental health could improve, so the LAC's approach showed a lack of understanding about the client's disabilities and the kinds of support that would be of most benefit to them. This client has been rejected 3 times and is currently awaiting a review.[17]

3.20 Similarly, South West Autism Network (SWAN), a peer support and advocacy organisation operating in Western Australia, provided a number of personal accounts to illustrate the difficulties that their clients face during the application process. One such person indicated that:

> I tried asking LAC & other providers to help me with understanding how to apply but was told they couldn't speak to me until I had an NDIS plan. I didn't know anyone who had NDIS and didn't understand the terminology. I was so distressed.[18]

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14 Disability Advocacy Network Australia, *Submission 72*, p. 14.

15 Rights Information and Advocacy Centre Incorporated, *Submission 102*, p. 10.

16 Outback Disability Services, *Submission 100*, p.1.

17 Rights Information and Advocacy Centre Incorporated, *Submission 102*, p. 10.

18 South West Autism Network, *Submission 86*, p.6.

3.21 To address these concerns, the committee was told that the LAC role could be better supported with more training about disabilities, cultural competency and the disability ecosystem in the RRR areas that they work in. One such submitter was Ms Anne Wilson, CEO of Emerge Australia and Deputy Chair of the Neurological Alliance of Australia. In relation to knowledge about neurological disorders and conditions, Ms Wilson advocated:

> We need the NDIA to commit to educating and training staff and contractors about the various functional impairments that arise from being diagnosed with neurological disorders and progressive, degenerative, neurological and neuromuscular conditions, including issues of stigma and social inclusion, particularly as they relate to people in rural, regional and remote settings.[19]

3.22 Others suggested the supports LACs provide participants could be improved with greater flexibility of service. For example, by enabling LACs to meet prospective or active NDIS participants in their own homes or local venues where they are more comfortable.[20] This view was also supported by the NDIA's Rural and Remote Strategy 2016–2019.[21]

3.23 It should be noted that LACs do not operate in remote or very remote communities, as these areas are directly serviced by the NDIA and RCCs, as discussed below.[22]

Remote Community Connectors

3.24 RCCs are community-based NDIA representatives that support the culturally appropriate delivery of the NDIS in remote communities.[23]

3.25 The RCC program commenced in 2017 to perform a critical role in remote and very remote communities, particularly in supporting First Nations people with disability,[24] serving as a 'conduit between the NDIA and their communities to aid communication, connection and engagement with the NDIS'.[25] According to the Department of Social Services (DSS), RCCs promote awareness, understanding and connection between NDIS participants, providers and the

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19 Ms Anne Wilson, Chief Executive Officer, Emerge Australia; and Deputy Chair, Neurological Alliance of Australia, *Official Committee Hansard*, 28 June 2024, p. 10.

20 Outback Disability Services, *Submission 100*, p. 1.

21 NDIA, *NDIA Rural and Remote Strategy 2016–2019*, p. 20.

22 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

23 NDIA, *What is a Community Connector?* ndis.gov.au/understanding/what-ndis/whos-delivering-ndis/what-community-connector (accessed 31 January 2025).

24 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

25 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

NDIS. Additionally, they have a role in promoting participant wellbeing by undertaking 'follow-ups and check-ins' with NDIS participants.[26]

3.26 At September 2024, the NDIA employed approximately 200 RCCs, covering 480 rural and remote communities in the Northern Territory, South Australia, Western Australia and Queensland.[27] RCCs are employed through local service partners, supporting Closing the Gap Priority Reform 2 (Building the Community Controlled Sector).[28]

3.27 One example of such a partnership is with the Central Australian Aboriginal Congress (Congress), an Aboriginal Community Controlled Health Organisation (ACCHO) based in Alice Springs. Congress delivers a NDIS RCC Program that supports Aboriginal clients to navigate the NDIS, including 341 NDIS participants in 2022–23.[29] Congress told the committee that its team of RCCs work with participants to navigate the complexity of the NDIS and ensure that participants are familiar with the concept of 'goal-setting', which they explained can be a difficult concept to translate across cultures.[30] Congress also explained that the RCCs provide advocacy for participants to ensure they have the services and equipment included in their NDIS plan to meet their needs.[31]

3.28 Many submitters highlighted the important work undertaken by RCCs. As a case in point, the committee heard that a 'good community connector is worth their weight in gold', particularly if they are a local person familiar with the local community and can link support people to apply to the scheme.[32]

3.29 However, the Ngaanyatjarra Pitjantatjara Yankunytjatjara Women's Council (NYP Woman's Council) suggested that the role of RCC is not always clearly understood by those appointed to the position. Furthermore, the NYP Women's Council stated that not all RCCs understand the Aboriginal languages spoken by the participants they work with. As a result, they may be unable to work productively as interpreters or cultural brokers to assist applicants with NDIS matters. However, the Council also noted that employing local people in these

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26 Department of Social Services (DSS), *Submission 1*, p. 7.

27 NDIA, *Statement on the Rural and Remote Strategy 2016–2019*, ndis.gov.au/about-us/strategies/rural-and-remote-strategy (accessed 7 February 2025).

28 DSS, *Submission 1*, p 7.

29 Central Australian Aboriginal Congress, *Submission 60*, p. 4.

30 Central Australian Aboriginal Congress, *Submission 60*, p. 4.

31 Central Australian Aboriginal Congress, *Submission 60*, pp. 2–3.

32 Mr Damian Hale, Founder, Balanced Coordination Support Services, *Official Committee Hansard*, 18 April 2024, p. 30

roles can also cause other issues, such as conflicts of interest in the work expected of them in their own community.[33]

3.30 Despite these concerns, there was broad support for the continuation of the important role RCCs play in RRR communities, and for these roles to be sufficiently supported. To this end, the NDIA advised the committee that it is in the process of expanding the RCC program and will be conducting a limited tender process to provide coverage to all First Nations communities in MMM6 and MMM7 areas later this year.[34]

Securing a diagnosis

3.31 The committee heard of significant challenges faced by people with disability in RRR communities in obtaining an initial clinical diagnosis and the relevant medical information. For some, the additional burden of having to travel, often significant distances, to obtain the necessary documentation raises other challenges including securing appropriate transport and accommodation, not to mention the costs, emotional toil and time required to travel away from home. The evidence, as shown below, suggests that these challenges often result in significant delays in the process, thereby preventing people from progressing their application to receive the necessary supports and services provided under the Scheme.

3.32 For example, several submitters informed the committee of the limited number and range of health professionals in rural and remote areas able to provide the medical evidence required for a NDIS application.[35] The AEIOU Foundation noted a general lack of diagnostic specialists in regional, rural, and remote areas. It highlighted that even where there are specialists, there are likely to be extended waitlists for appointments to receive a diagnosis, particularly in the public health system.[36] Similarly, Tandem made the point that there is often a complete absence of local specialists or clinicians to conduct the required assessments in RRR communities, and where they are available, a long wait list to obtain a diagnosis from them. Tandem continued:

> The wait time to get into a child psychiatrist or paediatrician is at least 6 months, then you have to wait many more months to get into other specialists like psychologist or OT just for basic assessments, then wait to get back into the paediatrician. It can take in excess of a year just to get the

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33 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Submission 96*, pp. 2–3.

34 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

35 See, for example: Mrs Kerri-Anne Hyde, Senior Manager Local Area Coordination, Intereach, *Official Committee Hansard*, 1 November 2024, p. 13.

36 AEIOU Foundation, *Submission 14*, p. 3.

> assessments necessary to apply to the NDIS. This is too long to leave people without vital support.[37]

3.33 Mental Health Australia submitted that where participants live significantly affects their ability to be assessed for access to the Scheme and supports:

> Getting functional assessments through core supports is impacted depending on location. There are often huge wait times and limited availability of fly-in, fly-out (FIFO) allied health professionals. It often takes a crisis situation to have people in remote communities heard.[38]

3.34 DANA raised the same concern, stating that diagnostic and specialist support services are simply not available in many RRR communities. As a case in point, there are no neuropsychological or specialist brain injury services in Central Australia, despite the area having the highest rate of brain injury and cognitive disability in the country.[39] Likewise, Vision 2020 Australia reported that an NDIS applicant with vision impairment must provide evidence of diagnosis from an ophthalmologist, which poses a significant barrier to entry for people in RRR communities, where ophthalmologists are significantly less prevalent compared to metropolitan areas, and therefore far less accessible to people in RRR areas.[40]

3.35 The point was also made to the committee that the complexity of assessments, required to access NDIS for some conditions, is a significant barrier. The Centre for Disability Research and Policy put forward the views of an NDIS participant, who stated that:

> It is problematic to use functional capacity assessments for this purpose to access the NDIS because they are such a comprehensive assessment. You know, they take a minimum of 10 hours to undertake, and complexity will add considerable hours to that. ... Functional capacity assessments do require specific qualifications of occupational therapists and they do provide quite comprehensive information down to support hours required to undertake tasks, all sorts of things. So, they are very valuable but they are not accessible to people who are trying to get into the system. It is obviously far too expensive.[41]

3.36 The NPY Women's Council observed that despite defining disability in terms of functional issues, the NDIS requires diagnosis of the impediment underlying the applicant's disability. It noted that the NDIS may not accept reports from occupational therapists and require instead, input from a doctor or specialist, which can be 'extremely difficult or impossible' to obtain in certain RRR

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37 Tandem, *Submission 71*, p. 22.

38 Mental Health Australia, *Submission 34*, p. 7.

39 Disability Advocacy Network Australia, *Submission 72*, p. 54.

40 Vision 2020 Australia, *Submission 11*, p. 4.

41 Centre for Disability Research and Policy, University of Sydney, *Submission 13*, p. 5.

communities.[42] NPY Women's Council highlighted the following example to illustrate this problem:

> … one man applied via the local Aboriginal Health provider for NDIS access. He didn't have a full functional assessment and was refused access. The provider indicated they 'didn't have the capacity' to undertake a full functional assessment in order for him to re-apply. NPYWC offered to pay for his full functional assessment through a local allied health provider but was told there would be up to a one year wait. NPYWC is now pursuing other possible occupational therapists to conduct the assessment. The point of this example is that without NPYWC offering to pay for it, this person would not be able to get a full functional assessment and therefore is blocked from requesting NDIS Access.[43]

3.37 The NPY Women's Council reiterated that obtaining initial diagnoses in the absence of specialists is problematic. In the NPY Lands of Central Australia, there are no specialists who can diagnose conditions such as autism, acquired brain injury and foetal alcohol syndrome. Therefore, visits to specialists are required which involves travelling to a regional centre or capital city, with accommodation and support required for the applicant.[44] The following case study, provided by Gidgee Healing, highlights these significant challenges.

Box 3.1 Gidgee Healing

A 24-year-old mother of three lives in Doomadgee.

Two of her children, aged six and four, have been identified by a GP as possibly having Autism Spectrum Disorder (ASD). Individuals with ASD would ordinarily be eligible for benefits under the NDIS.

In order for a formal diagnosis to be provided, the mother would be required to take the children to a tertiary hospital or private specialist paediatrician. For those people living in Doomadgee, the nearest tertiary hospital is Townsville, some 1600km away. With respect to paediatricians, visits by these specialists to remote communities are limited, and it is currently necessary for people to travel to Mt Isa, some 300km away, to seek an appointment.

Clearly, there are significant costs involved in travelling to either Townsville or Mt Isa from Doomadgee to seek to obtain to visit a specialist to obtain the diagnosis required to obtain NDIS benefits. These costs are logically far lower for metro participants of the NDIS.

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42 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *Submission 96*, p. 3.

43 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *Submission 96*, p. 3.

44 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *Submission 96*, p 3.

> In the absence of a diagnosis for her children, the support available to this mother to assist with caring for her children is limited to what the local GP and other health workers can provide locally with limited resources.[45]

3.38 The committee was told that some communities not only lack specialists but also contend with a limited number of GPs and allied health services. In other communities, there are no locally-based GPs at all, with families having to rely on visiting doctors. Strive Disability Support Services explained the consequences for applicants in these communities:

> Most GP clinics in regional and remote areas are constantly overbooked and people are unable to get in to see GP's let alone have anyone support them effectively with application processes. In a great many rural and remote areas, they don't have GP's, they need to rely on visiting GP's who only go to their area once per week, sometimes less often.[46]

3.39 Far West Community Legal Centre, which operates in regional New South Wales, also explained that the lack of medical professionals who can provide a diagnosis and supporting documentation for a NDIS application is not limited to remote communities, but also prevalent in regional areas:

> In our region, there are a lack of specialists, even in Broken Hill and to get diagnoses, people will have to travel extraordinary distances - e.g. to Mildura or even Adelaide. For individuals and families on a low income, this is very challenging. We are aware of some parents who have tried to get their child assessed for autism but have had to travel long distances for multiple appointments and are still left with lengthy wait times. Even if they are able to access funds to finance travel, it doesn't cover all out-of-pocket expenses or meet full costs of accommodation etc.[47]

3.40 Wait times for children was a particular concern raised in evidence. Professionals and Researchers in Early Childhood Intervention (PRECI), the peak body for professionals and researchers working with young children with developmental delay or disability, advised:

> The wait times for children in the regional and remote areas are considerably longer than those in the metropolitan area, often requiring travel to the capital city to participate in the assessment and diagnostic process.[48]

3.41 The often considerable upfront costs associated with obtaining a diagnosis was also raised by several submitters. Strive Disability Support Services explained

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45 Gidgee Healing, *Submission 22*, p. 3.

46 Strive Disability Support Services, *Submission 54*, p. 1.

47 National Regional, Rural, Remote and Very Remote Community Legal Network, *Submission 82*, p. 37.

48 Professionals and Researchers in Early Childhood Intervention (PRECI), *Submission 33*, p. 5.

that as a lot of people live below the Henderson poverty line, the costs of reports and diagnosis necessary to apply for the NDIS is prohibitive. It continued:

> Being in rural and remote areas, applicants have to travel to specialists or need to be able to access and understand how to use technology. Even with a travel scheme available in most states for specialist travel, this is also difficult to navigate and often relies on people having the ability to use technology or know what can be reimbursed. Another prohibitive factor is that people need to pay up front so they can be reimbursed, not everyone can do this, and it leads to delays with diagnoses and support.[49]

3.42 The AEIOU Foundation also noted that as the NDIS does not cover clinical diagnostic assessments under the current model, many families cannot afford the out-of-pocket expenses to access these services, meaning that accessing the NDIS is prohibitively expensive for them.[50]

3.43 To addresses this barrier to getting on the scheme, some organisations highlighted local initiatives that have been implemented in some communities to assist people to access medical professional and services. One such example was provided by Far North Community Services, a registered not-for-profit NDIS provider, who detailed their unique work practices in the Kimberley region of Western Australia.

3.44 Far North Community Services have established major therapy 'hubs' in Broome and Kununurra and minor hubs in Derby and Halls Creek. They have employed physiotherapists, occupational therapists and speech pathologists who then travel in teams around the Kimberley region throughout the year to provide services to remote and very remote communities. As these teams of professionals travel together, the cost of travel is shared between them. Further, the visits are carefully planned to maximise opportunities for participants to receive the services they need. As a result of their regular face-to-face service delivery over the years, Far North Community Services now supports over 350 NDIS participants across the Kimberley and have built strong connections with those communities.[51]

Navigating the application process

3.45 Even with the assistance of a LAC or Remote Community Connector and a diagnosis, the committee heard that navigating the NDIS application process in RRR communities can be challenging.

3.46 One submitter described the process as 'fraught with difficulties, including the terminology used, obtaining the right evidence, the bureaucratic and

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49 Strive Disability Support Services, *Submission 54*, p. 1.

50 AEIOU Foundation, *Submission 14*, p. 3.

51 Dr Rebecca Hunt, Therapy Manager, Far North Community Services, *Official Committee Hansard*, 18 April 2024, p. 40.

impersonal nature of the interactions with key staff'.[52] Others said that they found the process 'obstructive', 'very confusing' and 'overwhelming', to the point that their mental health was impacted, causing them to abandon their application.[53]

3.47 An Australian Federation of Disability Organisations survey of 72 participants revealed that the majority found the application process to be complex, with many requiring assistance. Of the 72 participants:

- 12.7 per cent (8) respondents indicated that they found the application process straightforward and did not require any assistance to complete the application.
- 36.5 per cent (23) respondents indicated that they found the application process somewhat complex and required assistance.
- 30.2 per cent (19) respondents indicated that the found the application process to be quite challenging.
- 34.9 per cent (22) respondents indicated that they found the application process to be confusing and stressful.[54]

3.48 Tandem shared the following case studies which describe the experiences of applicants when trying to navigate the NDIS application process:

> "We applied five times and it took many hours of rewriting all the details and producing many reports from many different allied/mental health personnel".[55]
>
> "I explained the reason for application was schizophrenia not responding to treatment. Applied with what was sent out. After a month we had not heard anything so I started making calls. No one could tell me anything. I asked for a manager after about 4 calls. She blatantly lied and said "there is a letter in the mail" that never arrived. I then sought out an NDIS advocate who told me to email. I did this and got an automatic reply. I then looked up the NDIS Act and sent an email saying which clause they were breaching in terms of timeframes. Finally we got a reply after this and he was rejected. I explained his situation and was told that he should be eligible but it did not translate well on the application form as there was nowhere to explain his particular difficulties. That is when I was told about the psychosocial assessment form! I was told to reapply with this which I did and he was approved reasonably quickly that second time but it was about 5 months from the original application and we were really struggling in that time after 3 years of illness and a dozen hospital admissions. The whole process just added to my stress

52 PRECI, *Submission 33*, p. 4.

53 Tandem, *Submission 71*, p. 16.

54 Australian Federation of Disability Organisations, *Submission 91*, p. 8.

55 Tandem, *Submission 71*, p. 16.

> load so much. The lack of support and knowledge from the general enquiry line was abysmal".[56]
>
> "The NDIS is almost impossible for poor people to access. Requiring expensive reports to be written".[57]

3.49 HR Plus Tasmania provided evidence of its experience in George Town, Tasmania (located 50 kilometres from Launceston) where it found a significant number of people eligible for the NDIS but unaware of how to connect to the Scheme. Furthermore, it noted that the lack of health professionals in rural settings placed not only significant delays and pressure on people seeking to apply for the NDIS but also a significant financial burden related to travelling to and attending medical appointments. However, HR Plus informed the committee that even some residents who had the financial means and health literacy to commence the NDIS application process 'simply gave up due to the lack of local support with navigating the application requirements'.[58]

3.50 Access to technology and the need for technology literacy, was also raised as a factor creating additional difficulties for some applying for the NDIS in RRR communities. Strive Disability Support Services contended that 'many people are told to send their receipts, assessments, applications, reports etc, online or via the use of technology. If they're unsure how to do this, they don't even have a reliable place for them to go to support them with the process'.[59] Another submitter explained:

> Even to apply for the NDIS, you have to have a reasonable level of documentation, an availability to contact the internet, use a phone and any sorts of electronic services, and those simply do not exist, for the most part, in a lot of places, or they're intermittent or inconsistent.[60]

3.51 Another said that applying for the scheme required skills and capacity that many people with disability may not have, and that applicants often had to rely on informal support from their family to assist with gathering evidence and submitting the application. For example, a parent who assisted a son to apply for the Scheme said of the experience:

> I am a plan nominee for my adult son. We had to apply twice ... If I did not have the skills for this type of work, we would probably still not be approved.[61]

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56 Tandem, *Submission 71*, p. 16.

57 Tandem, *Submission 71*, p. 16.

58 HR Plus Tasmania, *Submission 50*, p. 4.

59 Strive Disability Support Services, *Submission 54*, p. 1.

60 Ms Janet Wright, Chief Executive Officer, Integrated disAbility Action, *Official Committee Hansard*, 16 April 2024, p. 48.

61 Consumer of Mental Health WA, *Submission 15*, p. 4.

3.52 The Victorian Rural Advocacy Network (VicRAN) conveyed the experience of one of its clients who lives in a remote part of East Gippsland and ultimately abandoned their application after a series of setbacks:

> They live alone and do not have family support. The closest town to the person's home is small and has limited facilities. It does not have a general practitioner or professionals of the type the person needs. The closest large commercial hub is around two and half hours' drive from the person's home. The person unsuccessfully applied to become a NDIS participant. Soon after applying our client received a confusing, poorly worded letter advising them that they had not provided sufficient evidence and that they should contact the NDIS call centre. The person contacted the call centre but found the experience so confusing and frustrating that they made no further calls and dropped their application.[62]

3.53 The committee heard that applicants who receive assistance from an advocate generally found the process much easier. For example, one applicant noted of their experience:

> It was good, but only because I had good advocacy. Other than that I was pretty much told I wouldn't qualify so I wouldn't have bothered, nor did I have the skills to apply myself.[63]

3.54 However, receiving help from an advocate is much harder for those living in RRR areas, noting 'metropolitan NDIS-based participants have better access to peer advocates and training offered on applying to the NDIS'.[64]

3.55 Ms Rhiannon Hudson, a participant who lives in the Wheatbelt area in Western Australia, provided the committee with the following account of her journey in applying for the NDIS:

Box 3.2 Account provided by Ms Rhiannon Hudson – Wheatbelt, WA

My first application for a NDIS request was back in 2020, to which I was declined. Coming from a long history of brain surgeries due to an ongoing brain tumour, which is the root cause of an acquired brain tumour, I made the assumption that with the letters from specialist stating all treatment utilised since 2006, an ABI diagnosis and several admissions into a public hospital would be sufficient.

There were no services at this time to support myself in the wheatbelt to put together the Ndis application. The outcome of this application was a decline, which stated specifically "Rhiannon Hudson's application for NDIS has been declined due to not all treatment options been used and exhausted". This was absolutely gut wrenching, when I had been through three brain surgeries since 2006, many hospital admissions and significant

62 Victorian Rural Advocacy Network (VicRAN), *Submission 19*, p. 5.

63 South West Autism Network, *Submission 86*, p. 6.

64 Mental Health Australia, *Submission* 34, p. 6.

impairments, and that this just wasn't enough to access services. My thoughts at the time, how disabled to I actually need to be? How many more brain surgeries do I need? How much more of my brain do I have to get cut out to be classified as disabled in this state? who can actually help me apply for the Ndis? All these questions running through my head resulted in a deterioration in my health and giving up on applying for the NDIS.

A couple of years later, I was starting to really battle to afford supports to function at a medium level. As I had 10 years' experience as a Social Worker at the time, a Consumer Advocate in many different fields I decided to take it upon myself to complete training through Richmond Wellbeing remotely on "how to support consumers to apply for the NDIS. " After the training was completed, I wrote down numerous notes on specific tricks on what the NDIS required for a successful NDIS application. I then contacted the Social Worker at Northam hospital, which I felt a bit funny about. I felt funny because I am a Social Worker (myself) and had been for many years. I ended up talking to the Social Worker about what I needed for a successful NDIS application, to which I had learnt from the training. The Social Worker was amazing, she was honest and upfront about the challenges regional consumers with a disability are having with regards to applying for NDIS. She was also honest in saying that their service did not have capacity to complete an NDIS application themselves, however would do their absolute best to assist myself. I explained to her exactly what wording I needed, and she agreed to allow me to write the application with her support due to my knowledge and training completion. She then assisted me to have OT and speech to complete the assessments required in the supported evidence part of the application.

During this process, I did attempt to contact the services that are "funded to support consumers to apply for NDIS" to which I was unsuccessful. I then took it upon myself to continue the process, and wanted to put the hard work into it, as emotionally I did not feel I would cope with another decline stating "You have not exhausted all treatment options". I then contacted every single hospital I had been through and went through freedom of information to access all my records to evidence all the treatment options I had used and absolutely exhausted since 2006. I then went through my current GP and Psychologist and requested letters to state 1) what treatment I had completed 2) how long I had been accessing treatment 3) all treatment options had been used and exhausted 4) my disability impacted on all aspects of my functioning.

> Thankfully, at the end of this process, I was successful. What an achievement that felt like. I am so thankful to the Social Worker and allied health team and Northam Hospital for providing this support.[65]

3.56 Many of the challenges discussed in this chapter are exacerbated for First Nations people living in RRR areas with submitters informing the committee that there is a lack of culturally appropriate services in rural and remote areas. Not only does this impact people's choice and control in relation to supports available, but can also deter them from applying for access to NDIS supports in the first instance.[66]

3.57 The committee was told the hurdles for First Nations peoples in seeking access to the NDIS were often too considerable and included not having sufficient information to navigate the NDIS, or not having information provided in a culturally appropriate way.[67]

3.58 An additional difficulty raised by many First Nations applicants, particularly in remote and very remote communities, are language and cultural barriers and the unavailability of interpreting services. The NPY Woman's Council articulated this problem with the following example:

> … the Anangu speak English as a third or fourth language. Interpreters are not available, and the use of local people is not always appropriate because of privacy concerns. Anangu not only do not understand the language used by assessors and planners but they do not understand the concepts underlying NDIS assessments, planning and operation. In addition, there are low levels of literacy in the NPY Lands. People do not value or trust paperwork, as the culture on the Lands is oral. Assessment tools are not specifically appropriate for Anangu culture, society and environment. The person performing the assessment needs to be culturally aware and informed in order to make an effective assessment. This means having specific training and support led by Anangu, and spending time in the NPY communities. Assessors need an in-depth knowledge of the local situation and relationships if they are to take these environmental factors into account in their assessment.[68]

3.59 Another challenge stems from the requirement to produce and supply certain documents as part of a NDIS application, which may be difficult for applicants who do not have the required identity documents, let alone medical documents, as explained by Ms Janet Wright, CEO of Integrated disAbility Action:

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65 Ms Rhiannon Hudson, *Submission 73*, p. 1.

66 See, for example: Queenslanders with Disability Network, *Submission 49*, p. 4.

67 Disability Advocacy Network Australia, *Submission 72*, p. 42.

68 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Submission 96*, p. 3.

> … we had a person who had a skin name, he had a name that was given to him by a whitefella, and he had two separate birthdates. Because of that system of documentation—he didn't have a birth certificate and he never did have a drivers licence. All the things that you would need to have to apply were not easily accessible to him or even understandable in any particular way.[69]

3.60 The NDIA advised that it has established a dedicated team to review access requests from people living in remote and very remote areas. The committee recognises this team is staffed with people who understand the types of information and evidence that is readily available to people living outside major cities and what is not.[70] Additionally, the NDIA advised that it is testing the use of a Trusted Referee Statement (TRS) as evidence of identity, particularly for communities where government documentation is hard to access.[71]

3.61 The Independent Review into the NDIS (NDIS Review) also considered these challenges, and recommended the application process be simplified. The NDIS Review suggested this could involve simplified access request and supporting evidence forms, as well as clear accompanying guidance materials to make the process more transparent and simpler.[72]

3.62 The NDIS Review also recommended the role of 'Navigator' be established, to support people at every stage of the scheme, including helping people understand what the NDIS is, how to make an access request and navigating the initial planning stage.[73] The NDIS Review found that this role should be delivered locally by people who have genuine local connections, knowledge and links to local services. Further, it made clear that Navigators should not be an agent of the NDIA to ensure a separation between those who set a budget and those who help a participant to use it. Additionally, the Review warned against funding for Navigators coming from individual budgets to ensure participants do not need to choose between a Navigator and other supports.[74]

3.63 The NDIA advised that it is considering the NDIS Review's recommendations about opportunities to improve participants' experience of the NDIS, including the Navigator role. The NDIS informed the committee that it is currently co-

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69 Ms Janet Wright, Chief Executive Officer, Integrated disAbility Action, *Official Committee Hansard*, 16 April 2024, p. 50.

70 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

71 NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

72 Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 6.

73 Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 37.

74 Independent Review into the National Disability Insurance Scheme, *Final Report*, pp. 101–102.

designing this potential role, including how it can better support participants in rural, regional and remote communities.[75]

3.64 As of June 2025, the NDIA had met with the relevant State and Territory departments to discuss 'the Navigators service design', with the NDIA noting that there would be ongoing significant levels of engagement with stakeholders, as Navigator functions are designed.[76]

3.65 The committee understands that NDIS Navigators have been introduced in Victorian Government specialist schools.[77] This experience in Victoria could be a valuable resource for the federal government to consider.

Advocacy and education

3.66 Other submitters advocated for the continued education and employment of local people in RRR communities to understand what the NDIS is and how to help people with their applications. Balanced Coordination Support Services highlighted the importance of educating and employing local people as its founder, Mr Damian Hale, explained:

> I'd love to see a community-by-community approach where the NDIS gets out there with local staff—and they have used our local staff to do education type activities in the last six months. I think that's the key: to get local people to go around and explain what the NDIS is and give people assistance with their access request forms and then get the technical—obviously the clinical support is paramount too, getting to the clinic and assisting people to fill in those forms and get them submitted.[78]

3.67 The Queenslanders with Disability Network recommended ongoing outreach that would provide 'targeted, tailored and ongoing engagement' to deliver outreach to potential and existing NDIS participants. The organisation suggested this could include helping people to connect to mainstream and community services, as well as identifying clients that may be eligible for the NDIS and helping them with access applications.[79] They also suggested that the government consider increasing investment in independent advocacy services to support people with disability at all stages of the NDIS process.[80]

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[75] NDIA, answers to questions on notice, 12 February 2025 (received 28 February 2025).

[76] NDIA, 'Navigator meeting co-design working group meeting 7 summary', 13 June 2025, https://www.ndis.gov.au/news/10817-navigator-meeting-co-design-working-group-meeting-7-summary (accessed 22 July 2025).

[77] Victorian Government, *School operations, NDIS Navigators*, education.vic.gov.au/pal/ndis-navigators/policy (accessed 7 February 2025).

[78] Mr Damian Hale, Founder, Balanced Coordination Support Services, *Official Committee Hansard*, 18 April 2024, p. 30

[79] Queenslanders with Disability Network, *Submission 49*, p 11.

[80] Queenslanders with Disability Network, *Submission 49*, pp. 11–12.

Initial planning

3.68 Once a person's NDIS access application has been approved, they are required to engage in an initial planning process to determine what supports and services they require. Plans can be developed by LACs or NDIA planning officers and are then approved by a NDIA delegate.[81]

3.69 DSS acknowledged that 'plans and supports for people living in remote and very remote areas require a different approach'.[82]

3.70 As at 31 December 2023, DSS advised that there were 89 Remote Planner roles across the country. Remote Planners are NDIA staff with specific knowledge of the challenges of life in remote and very remote areas, and who have skills in planning and support for NDIS participants in these areas.[83]

3.71 Despite the best efforts of these planners in RRR areas, however, some submitters advised that many of them do not live in the local community they are working with and therefore may not understand the unique circumstances of that community.[84] Others raised concerns that the individual person approach to planning taken by the NDIA does not recognise the important role of family and community to a person's support and wellbeing, which is particularly important in First Nations communities. Kiind also noted in this regard the importance of a 'whole family approach' to NDIS planning, particularly for participants under 18 years of age. The point was made that if participants are seen in isolation from family or community, plans will not provide the 'full picture of support requirements and protective factors in a family'.[85]

3.72 Similarly, the Public Health Association of Australia said:

> NDIS planning processes may hamper holistic approaches to service delivery in rural areas, or fail to account for the specific challenges faced by rural carers supporting a family member with disability. Limited discussion and negotiation time between participants and planners leads to plans that inaccurately capture the day-to-day lives of rural people with disability. As a result, support needs are not met in a way that ensures the broader family system is able to function effectively.[86]

3.73 Kiind reported that more than 60 per cent of families surveyed in the Wheatbelt, South West and Great Southern regions of Western Australia indicated that they were dissatisfied or very dissatisfied with the details and goals in their NDIS

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81 Australian National Audit Office, *Submission 3*, p. 6.

82 DSS, *Submission 1*, p. 6.

83 DSS, *Submission 1*, p. 6.

84 See, for example: National Legal Aid, *Submission 87*, p. 5; South West Autism Network, *Submission 86*, p. 16; and Health Services Union, *Submission 83*, p. 6.

85 Kiind, *Submission 78*, p. 11.

86 Public Health Association of Australia, *Submission 4*, p. 5.

plans. Reasons for this dissatisfaction related to the fact that plans either did not reflect the complex needs of their children or included goals or services that were simply not available in their region.[87]

3.74 Feedback received by South West Autism Network (SWAN) from 156 responses and 114 completed surveys also revealed significant concerns with the planning process in RRR areas. Some respondents noted that, while their planning meeting went well and they were received with support and understanding, the resulting plan itself did not adequately reflect their needs or included significant errors such as the wrong name or goals of the participant.[88]

3.75 The First Peoples Disability Network, AFDO, and SWAN also submitted that as planners and other NDIS staff often changed, participants were required to repeatedly explain their story, with AFDO noting that 'always having a different Planner means a lot of repetition and going over history that can be very traumatic to discuss'.[89]

3.76 The First Peoples Disability Network also raised concerns that some planners did not have an understanding of First Nations cultures:

> In the 8 years, I've been working within access and planning meetings. I have not come across many planners that have an understanding of [Aboriginal and Torres Strait Islander (ATSI)] people and the culture. Improving this or specifically having ATSI planners would be more appropriate.[90]

3.77 Ms Sasha Greenoff, Manager of the Youth Engagement Program, Aboriginal Legal Service of Western Australia gave the following example:

> There was a young mother who came into my office who had a young child with a disability. She couldn't read or write. She'd been given an NDIS plan and she came to me for help to explain to her what it all meant. This goes back to cultural support in explaining the language of the plan and what they need to do.[91]

3.78 In relation to the planning process, submitters urged for more local and culturally appropriate planners and coordinators to be engaged. For example, Mr Tom Poutou, a team leader with the Miwatj Health Aboriginal Corporation, confirmed that local planners are preferred, explaining that they have observed

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87 Kiind, *Submission 78*, p. 5.

88 South West Autism Network, *Submission 86*, p. 10.

89 See for example: Australian Federation of Disability Organisations, *Submission 91*, p. 10; First Peoples Disability Network, *Submission 85*, p. 13; South West Autism Network, *Submission 86*, p. 51.

90 First Peoples Disability Network, *Submission 85*, p. 13.

91 Ms Sasha Greenoff, Manager of the Youth Engagement Program, Aboriginal Legal Service of Western Australia, *Official Committee Hansard,* 18 April 2024, p. 13.

more positive outcomes from planners that are located remotely.[92] Cultural safety and the experience of First Nations NDIS participants are discussed further in Chapter 5 of the report.

3.79 The following chapter considers the next stage of the NDIS process, including plan utilisation and access to local services and supports in RRR areas.

92 Mr Tom Poutu, NDIS Team Leader, Miwatj Health Aboriginal Corporation, *Official Committee Hansard*, 16 April 2024, p. 35.

Chapter 4
Accessing services and supports

4.1 An essential principle of the National Disability Insurance Scheme (NDIS) remains that participants should be able to exercise choice and control over their services and supports. This includes choice of how participants receive supports and which service providers they use.[1] The committee has heard over several inquiries that choice and control is negatively impacted where there are limited providers and workers available to provide services and supports.

Impact of thin markets on NDIS participants

4.2 Where there are limited, or an absence of, providers in a given area, this is often described as a 'thin market'. This chapter considers the experience of NDIS participants in rural, regional and remote Australia in relation to accessing services and supports.

4.3 The Australian Federation of Disability Organisations (AFDO) explained the impact of limited services on participants' ability to exercise choice and control:

> Despite the emphasis placed by the [National Disability Insurance Agency (NDIA)] on the importance of participant choice and control, many respondents expressed feeling that their options were severely limited, and that they lacked any true agency in regard to their NDIS plans and funding. This sense of impotence is further exacerbated by frustration with arduous bureaucratic procedures, a lack of responsiveness on the part of NDIA staff and service providers, and difficulties with accessing support when needed.[2]

4.4 Dementia Australia observed that the 28 per cent of Australians who live in rural and remote areas face significant barriers to accessing a wide range of health care and support services, including medical care, allied health services, personal and specialised care, and accommodation services such as respite and residential care. It continued:

> The scarcity of resources and care options in these communities increases these obstacles, particularly affecting individuals with younger onset dementia, who already have limited specialised support options available, putting them and their carers at increased risk of reduced quality of life, functional decline, unnecessary hospitalisation, social isolation, carer burnout, and premature transition to residential aged care.[3]

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1 National Disability Insurance Agency (NDIA), *What is the NDIS responsible for?*, ndis.gov.au/understanding/what-ndis-responsible (accessed 2 February 2025).

2 Australian Federation of Disability Organisations (AFDO), *Submission 91*, p. 21.

3 Dementia Australia, *Submission 39*, p. 3.

4.5 Disability Advocacy (NSW) submitted that, in some instances, accessing disability supports and services had become more difficult, notwithstanding the implementation of the NDIS:

> There is a lack of services both in and outside of the NDIS. In this, there is also a lack of support to help people navigate and locate services within what is experienced as an overly complicated system. This can lead people with disability to disconnect completely because the help is not available and or it is too challenging to access. These individuals are not only at risk of missing out on crucial services and support, but they are at risk of not being represented in the system's data that is collected by governments to assess thin markets.[4]

4.6 The challenges associated with thin markets have been identified since the earliest days of the NDIS and raised in previous committee inquiries.

4.7 In 2018, through its inquiry into market readiness, the committee heard from a range of organisations that thin markets were 'persisting or worsening' for some groups, including participants living in rural and remote areas.[5]

4.8 At that time, the committee noted 'the lack of progress on addressing the issue of thin markets' and urged the NDIA to use its market stewardship role to proactively 'put in place strategies and intervention mechanisms to address the significant risk of market failure in some areas and for some groups'.[6]

4.9 The committee's inquiry into the NDIS workforce highlighted similar concerns. In its December 2020 interim report, the committee observed significant challenges related to access to services and supports in rural, regional and remote Australia.[7]

4.10 The committee noted some issues that contributed to these challenges were more specific to rural, regional and remote areas, such as the higher costs associated with service delivery and the time required to build trust and establish relationships with remote communities. Other issues, such as high staff turnover, high travel costs, and an inadequate variety of service providers were not necessarily specific to rural, regional and remote areas, but were nonetheless exacerbated by the additional costs and administrative burdens that increased with greater remoteness from major metropolitan areas.[8]

4.11 In its final report into the NDIS workforce, the committee observed that it had continued to receive evidence of the prevalence of thin markets in rural, regional and remote areas. Some evidence attributed the issue of thin markets to smaller

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[4] Disability Advocacy (NSW), *Submission 21*, pp. 5–6.

[5] Joint Standing Committee on the NDIS, *Market Readiness*, 20 September 2018, p. 70.

[6] Joint Standing Committee on the NDIS, *Market Readiness*, 20 September 2018, p. 73.

[7] Joint Standing Committee on the NDIS, *NDIS Workforce Interim Report*, December 2020, p. 115.

[8] Joint Standing Committee on the NDIS, *NDIS Workforce Interim Report*, December 2020, p. 115.

participant and candidate pools, and the challenges providers faced in attracting and retaining workers. While some evidence related to concerns about shortages of NDIS support workers, the preponderance of evidence related to allied health shortages in rural, regional and remote Australia.[9]

4.12 Similar evidence was received during the current inquiry, highlighting the persistence of thin markets and their impact on participants. For example, the Rights Information and Advocacy Centre (RIAC) submitted that having few options for service provision in an area exacerbates existing power differentials between providers and participants:

> Both service and client know the client is often unable to choose to go elsewhere, and may be put in a position of dependency, or be forced to put up with poor service. There is relatively less control/choice for people in regional, rural and remote areas.[10]

4.13 RIAC told the committee that many providers in RRR Australia have limited resources, and as a result, had to be careful not to overcommit them. RIAC suggested that limited resources may raise the prospect of some service providers in rural, regional and remote areas 'cherry picking' clients. Such providers may therefore decline to provide services to participants who are seen as too difficult or demanding, leaving those participants with few, or no, alternative options.[11]

4.14 The committee received evidence that having a limited number of service providers in an area can not only negatively impact the ability of participants to exercise choice, but may also reduce service quality and professionalism. Disability Advocacy (NSW) submitted that:

> Having a limited amount, or no services available can fuel a sense of desperation among people with disability who crucially need support and care. Unethical providers take advantage of this, and the lack of competition, where people with disability cannot simply take their business elsewhere and are dependent on the one service provider.[12]

4.15 Where there are limited service providers in an area, some service providers may fulfil multiple roles for a participant, leading to conflicts of interest and the risk of exploitation. Queenslanders with Disability Network told the committee that:

> There are often reports of exploitation of NDIS funds due to conflicts of interest occurring in regional areas of Queensland with limited options for service providers and thin markets. There have been reports of NDIS Coordinators who also work as Support Workers for participants, which

[9] Joint Standing Committee on the NDIS, *NDIS Workforce Interim Report*, February 2022, p. 46.

[10] Rights Information and Advocacy Centre, *Submission 102*, p. 2.

[11] Rights Information and Advocacy Centre, *Submission 102*, p. 2.

[12] Disability Advocacy (NSW), *Submission 21*, p. 3.

> poses a potential conflict of interest. Conflicts of interest like this can compromise the ability of participants to make informed decisions and can impact a person's ability to exercise choice and control.[13]

4.16 CRANAplus observed the challenges facing NDIS participants in rural, regional and remote Australia were shared community-wide and across sectors, including disability, health, aged care and education. It was observed that these sectors 'necessarily work together in remote areas', requiring an approach 'underpinned by goodwill':

> With fewer options and multiple barriers, sharing resources, capacity, workforce, and skill development is an option. Significant and formal collaborative strategies to share knowledge, skills and resources between sectors and services at the community level are needed to meet NDIS participants' goals within their unique community context and require funding and support.[14]

4.17 Kin Disability Advocacy observed the impact of limited access to allied health professionals in rural, regional and remote areas:

> Assistive technologists (ATs), occupational therapists, and Orientation Mobility Instructors (OTs) necessitate dedicated support hours, tasks, and responsibilities. Such services are not readily accessible in remote and rural areas of Australia. As a result, essential support is limited by the number of hours available. The time frame for these sessions can span from one to four hours, excluding travel in remote and rural areas. These professionals must negotiate with the participants regarding the cost of their services.[15]

4.18 Disability Advocacy Network Australia (DANA) submitted that limited service availability may mean people are not able to access supports, even where funding is available in their plans. This can create a false perception of low demand, leading to a cycle of ever-diminishing services:

> What we are seeing is that there are very limited options for core support delivery in remote settings, so people may have things like household assistance or community access in their plan, but they are not able to use it.
>
> It becomes a vicious circle: where participants cannot access the NDIS, demand and service availability declines. Statistically, the extent of the problem is diminished and disguised, while some of the most vulnerable people in Australia are denied access to essential services.[16]

4.19 This view was supported by CatholicCare NT, who suggested an alternative approach to managing NDIS plan funding levels:

> The NDIA doesn't acknowledge the need for step up, step down supports in the remote space. When Participants are unable to fully utilise their plans,

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13 Queenslanders with Disability Network, *Submission 49*, p. 5.

14 CRANAplus, *Submission 16*, p. 4.

15 Kin Disability Advocacy, *Submission 36*, p. 8.

16 Disability Advocacy Network Australia (DANA), *Submission 72*, p. 36.

> often due to thin markets of service providers, their funding can be reduced by the NDIA or they may be required to reassess for NDIS eligibility. There is no recognition that, at times, funding is not utilised because Participants are unable to access the supports they require at that time. A step up, step down approach would enable Participants to access the supports they require as they become available.[17]

4.20 In October 2023, the NDIA published its *Thin Market Trials Final Evaluation Report*, which compiled the findings and recommendations of thin market trials. The Department of Social Services (DSS) highlighted two key findings of the report:

- coordinated funding proposals (CFPs) and direct commissioning, especially in remote and very remote locations, are promising approaches to increase participant use of NDIS supports in thin markets, more so than local government area level market facilitation; and
- most CFPs to date have focused on coordinated sourcing of one-off functional assessments. To understand the potential of CFPs, they need testing across a wider range of support types and locations.[18]

4.21 DSS also observed that the loading on price limits was higher for providers in remote and very remote locations, set at 40 per cent and 50 per cent respectively. These loadings are intended to incentivise providers to deliver services and supports in remote locations.[19]

4.22 The NDIS Review considered the issue of price caps and thin markets, and concluded that price limits should 'reflect the differences in the costs for delivering supports to participants with more complex needs and in different regions'. The NDIS Review also put forward a number of mechanisms for addressing the issue of thin markets in the NDIS, such as the utilisation of provider panel arrangements, and more active market monitoring.[20]

Mental health and psychosocial disability

4.23 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) suggested that the NDIS had created a separation between mental health services and NDIS services, and called for clearer governance and connection between these services. RANZCP called for improved support for people with complex mental health challenges and comorbidities living in rural, regional and remote areas:

> Acknowledging the intersections between mental health and disability, however, is imperative in improving the experience of people with

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17 CatholicCare NT, *Submission 42*, [p. 2].

18 Department of Social Services, *Submission 1*, pp. 8–9.

19 Department of Social Services, *Submission 1*, p. 9.

20 Independent Review into the NDIS, *Final Report*, October 2023, pp. 169 & 183.

> disabilities. As highlighted by the Productivity Commission, clearer governance is needed between these services, as well as more seamless connections, care pathways and triangulation of services. A more cohesive model of care needs to ensure NDIS participants receive the full range of mental health and physical health supports, with providers having a shared understanding of what services are being provided. This would help ensure an appropriate range and level of supports for the participant. There also needs to be greater triangulation between the NDIS, service providers and participants to improve shared planning and reduce the burden on participants.[21]

4.24 Tandem observed that systemic and structural disadvantages experienced by people with psychosocial disability were exacerbated in regional and rural areas:

> People with psychosocial disability and their families, carers and supporters often face a myriad of compounding systemic and structural disadvantages and other difficulties that are particular to, or exacerbated within, regional and rural areas. Lack of health and other services, long distances from the services that do exist, socioeconomic disadvantage, mental health stigma, lack of transport and access to technology, and natural disasters ramify one another, to the great detriment of people who already face the inherent challenges of psychosocial disability.[22]

Travel costs

4.25 Where there are few, or no, options for accessing service providers within a participant's local community, services are often provided by workers who live outside those areas. In these cases, either participants must travel to see service providers, or service providers must travel to participants. Either way, the costs of such travel are often drawn from the participant's plan.

4.26 The committee received substantial evidence regarding the impact of travel costs on participants and providers.[23]

4.27 RIAC submitted that often the only way for participants to access the professional services identified in their NDIS plans, such as occupational therapy, physiotherapy, specialists and psychologists, is through time-consuming and expensive travel. The costs of getting to service providers may include paying for support workers to assist with mobility, as well as accommodation for participants and support workers. These costs can quickly

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21 Royal Australian and New Zealand College of Psychiatrists, *Submission 59*, p. 3.

22 Tandem, *Submission 71*, p. 21.

23 See, for example, Vision Australia, *Submission 20*, [p. 2]; MS Australia, *Submission 89*, p. 11; South West Autism Network, *Submission 86*, p. 45; Health Services Union, *Submission 83*, p. 11.

deplete NDIS plan budgets, or may even mean that participants 'cannot afford to access the services their plan theoretically provides for'.[24]

4.28 Kiind observed that NDIS participants in remote and very remote areas were 'at a distinct disadvantage' due to the impact of travel costs:

> Many families use more than 50% of their NDIS funding to pay for specialist travel, especially where there are no providers in the local area and they need to utilise Fly-In-Fly-Out (FIFO) services or make regular trips to larger regional centres or Perth to access treatment. This results in reduced plan effectiveness and inequitable access – families have less funding for interventions as proportionately more of their funding is paid for provider travel than their metropolitan counterparts.[25]

4.29 Vision Australia submitted that, although it endeavours to provide services to people regardless of where they live, this may not be sustainable in the long term:

> The current funding environment will not, however, allow us to continue delivering services to the extent and on the terms we have historically provided them. Workforce pressures, along with the impacts associated with unfunded NDIS travel costs, will make it increasingly difficult to provide a comprehensive range of services in rural and remote areas.[26]

4.30 Rare Voices Australia (RVA) expressed a similar view, noting that travel costs could make in-home supports and allied health services unsustainable within the funding allocated to participants' plans. It noted that in many cases, services were not accessible at all outside metropolitan areas as they are considered uneconomical or financially unattractive for providers.[27]

4.31 RVA also observed that even where NDIS plans provided some funds for travel costs of therapists and NDIA staff, they did not include funding for participants and their carers to travel for appointments, meetings with medical practitioners to gather necessary information for planning purposes or accommodation costs when traveling distances that require an overnight stay. RVA suggested that:

> For rural Australians it would be much easier if there were a bucket of funding we could apply for in certain situations to have our own support worker travel with us to specialist appointments, hospital visits, and therapies that would not necessarily be taken from our budget. To find accommodation for the support worker on top of our needs is prohibitively expensive but to have a random stranger provide support in the city is just not workable. We are left with no choice but to struggle on our own.[28]

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24 Rights Information and Advocacy Centre, *Submission 102*, pp. 2–3.

25 Kiind, *Submission 78*, p. 9.

26 Vision Australia, *Submission 20*, [p. 2].

27 Rare Voices Australia, *Submission 23*, p. 7.

28 Rare Voices Australia, *Submission 23*, p. 10.

4.32 The Victorian Rural Advocacy Network (VicRAN) submitted that the additional costs faced by participants in rural, regional and remote Australia could present intimidating barriers to access to the Scheme:

> NDIS applicants often need to submit specialist medical assessments with their applications that can't be obtained via the health professionals located in their local communities. For rural, regional and remote applicants, this often requires them to have to travel for several hours (with limited transport options), organise overnight accommodation and pay specialists thousands of dollars for their assessments. For a person with disability that can't drive, has limited public transport options, and possibly is unable to work, this is an extremely daunting and expensive process, with no guarantee of a successful outcome.[29]

4.33 Lifely observed that inadequate travel funding in NDIS plans can create significant obstacles for participants in RRR areas and for the financial sustainability of service provision in those areas:

> Current funding does not reflect the absence of public transport, the lengthy distances to access services, or the costs of providers visiting remote communities. Many rural participants rely solely on private or community transport to reach essential services, with some unable to travel to regional hubs for specialist support due to physical or financial constraints, isolating them from vital care.
>
> Furthermore, the need for service providers to travel to remote areas is often overlooked, and without compensation, many providers find it financially unsustainable to serve these regions. This limits participants' access to consistent support and essential services.[30]

4.34 The Australian Psychological Society supported this view, and suggested that the government needed to appropriately reimburse providers for their travel costs in RRR areas:

> … to overcome barriers associated with travel, it is essential for the NDIS Price Arrangements and Price Limits to recognise and appropriately remunerate providers for both travel costs and their time to ensure that they can provide the right support at the right location to meet the needs of participants.[31]

4.35 The issue of travel costs is particularly salient where services are provided by FIFO or drive-in, drive-out (DIDO) workers.

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29 Victorian Rural Advocacy Network, *Submission 19*, [p. 5].

30 Lifely, *Submission 103*, p. 23.

31 Australian Psychological Society, *Submission 31*, p. 3.

Fly-in, fly-out and drive-in, drive-out providers

4.36 The use of FIFO and DIDO workers is common in RRR areas. The committee received evidence that these service models enable providers to serve communities that would otherwise go without.[32]

4.37 The Northern Territory Government submitted that participants in remote communities rely on FIFO workers to provide therapy services. The use of FIFO workers can result in infrequent and costly visits that quickly draw down participants' plans. They also found that FIFO models of care did not support engagement with community members and local organisations, and often did not meet participants' needs.[33]

4.38 The committee also received evidence that FIFO and DIDO services can impact on relationship building and continuity of care. Neurological Australia commented on the prevalence of these models of service provision:

> Both models have challenges due to the high cost of delivery, their infrequent and time-limited nature and typically high staff turnover. Although the disability services workforce has increased in size with the advent of the NDIS, in regional, rural and remote regions it still predominately operates on a FIFO/DIDO model.[34]

4.39 Mental Health Australia submitted that:

> A range of FIFO allied health professionals are not understanding of the environment and culture of the distant location. This lack of continuity and turnover means that speaking with different health professionals about their story often retraumatises NDIS participants with psychosocial disability, impeding their chances to move ahead in one's recovery. Trust is vital between workers and NDIS participants in their recovery, which takes time to build.[35]

4.40 First Peoples Disability Network, agreed with that perspective, and indicated that a reliance on FIFO workers to make assessments could also present a barrier for access to the scheme:

> Due to a severe lack of specialists and services in the regions for example, participants spoke about having to travel extremely long distances to access diagnostic assessments. While most of the communities were visited by General Practitioners (GPs) on a fly in, fly out (FIFO) basis, the GPs were often different each time, and therefore lacked the medical 'history' knowledge required to make accurate diagnostic assessments.[36]

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32 Mr Jonathan Craig, Vision 2020 Australia, *Official Committee Hansard*, 28 June 2024, p. 5.

33 Northern Territory Government, *Submission 2*, pp. 11 and 13.

34 Neurological Alliance Australia, *Submission 46*, p. 6.

35 Mental Health Australia, *Submission 34*, p. 8.

36 First Peoples Disability Network, *Submission 85*, p. 10.

4.41 Carers WA informed the committee about the use of FIFO workers for participants in the Kimberley and Goldfields regions, including:

> … doctors needing to be flown in from New Zealand in FIFO arrangements; and where allied health services have been flown in, reports of these costs being added to the cost of the appointment for families.[37]

Telehealth

4.42 Evidence to the committee suggested that telehealth was a useful way of supplementing NDIS services to isolated participants and communities and addressing the issue of travel costs. However, several submitters noted some shortcomings and suggested an appropriate balance would need to be struck if the practice was more widely adopted.

4.43 The Australian Psychological Society submitted that, while telehealth was not a replacement for in-person consultations, psychologists in larger geographical centres would provide telehealth assessments and other supports for NDIS participants in rural, regional, and remote locations when there was no viable in-person alternative, or where telehealth services were more appropriate for the participant.[38]

4.44 The Royal Australian College of General Practitioners called for expanded funding to include telehealth consultations to better support patients with disability who have difficulties travelling and people in rural and remote areas.[39] They also acknowledged that telehealth was often not a viable option for rural patients due to a 'lack of appropriate infrastructure including unstable phone and internet services'.[40]

4.45 The committee notes the federal government, alongside the Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts is introducing the Universal Outdoor Mobile Obligation (UOMO) to expand basic voice and SMS access across Australia. Consultation on the draft UOMO legislation closed on 19 October 2025 and is now being considered by government.[41]

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[37] Carers WA, *Submission 35*, p. 8.

[38] Australian Psychological Society, *Submission 31*, p. 2.

[39] Royal Australian College of General Practitioners, *Submission 18*, p. 5.

[40] Royal Australian College of General Practitioners, *Submission 18*, pp. 5 and 7.

[41] Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts, 'Consultation on Universal Outdoor Mobile Obligation (UOMO) draft legislation', https://www.infrastructure.gov.au/have-your-say/consultation-universal-outdoor-mobile-obligation-uomo-draft-legislation (accessed 13 October 2025).

4.46 The Royal Flying Doctor Service (RFDS) suggested a 'potential opportunity' to use telehealth services to enhance the implementation of the NDIS, noting current trends across many health disciplines:

> Where these services are successfully operating, this is cost effective for patients, with reduced travel time to access care, and the potential for additional care to be provided. It is also valuable for rurally isolated health professionals, and provides opportunities for coordinated care between patients, rural clinicians and specialists.[42]

4.47 The RFDS observed, however, that there had been 'poorer uptake' of telehealth by both patients and clinicians in rural and remote areas. This was attributed to deficiencies in the quality, accessibility of telecommunications infrastructure in those areas:

> These include, for example, insufficient bandwidth allocated for healthcare – often resulting in frozen screens, lagging, and dropouts – or the unaffordability of necessary infrastructure or available services. It must be ensured that internet connections throughout rural and remote areas are sufficient, reliable and affordable enough to enable these populations to access the benefits of comprehensive telehealth services, and not be left behind. There also remains the need for continued development of technology including reliable videoconferencing systems that ensure the privacy and security of personal data. These systems need to be affordable, adaptable and easy to use, particularly for those with low digital literacy. Further, telehealth services will only be successful where they are well integrated into the full service model, supporting face to face to face services.[43]

4.48 HR Plus Tasmania expressed a similar view, noting that reliance on technology for accessing NDIS and telehealth services can be more difficult for people in rural communities, due to lower literacy rates, limited access to the internet, and poor IT infrastructure.[44] It also observed that, while telehealth can reduce costs for participants, it can result in diminished service outcomes. HR Plus Tasmania explained that for one participant:

> … this is far from ideal with his limited capacity to remain engaged without the physical presence of a therapist. Without this access and without the therapeutic interventions needed, his behaviours rapidly escalate, resulting in the need for 2:1 support for safety.[45]

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42 Royal Flying Doctor Service, *Submission 77*, p. 8.

43 Royal Flying Doctor Service, *Submission 77*, p. 8.

44 HR Plus Tasmania, *Submission 50*, p. 5.

45 HR Plus Tasmania, *Submission 50*, p. 11.

4.49 Disability Rights Advocacy Service SA submitted that telehealth was not an option for intensive assessments which required in-person assessment, or if medical practitioners were reluctant to offer telehealth for a first appointment.[46]

4.50 Kimberley Therapy Services suggested that telehealth services may not be considered culturally safe for some First Nations participants:

> In the remote locations we have a lot of telehealth—a lot of phones, a lot of Teams. Again, as we've just heard, technology is not always something that we can get in remote areas. And then, with relationships, what I've found in working in the Kimberley for the past 20 years is that to get cultural safety with family members you have to be face to face; you have to show up regularly. If you don't have that, they're sometimes not going to listen, or you don't get buy-in. Why would they listen when it's just so overwhelming and so confusing? It's having someone that they can go and see.[47]

4.51 The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPY Women's Council) suggested that some participants may require funded support to engage with telehealth services:

> … families who might benefit from access to therapists via telehealth do not have the capacity to utilise telehealth without assistance, lacking access to Wi-Fi and not having the confidence to deal with allied health professionals without support. They would have a vastly increased potential for benefitting their children if funding for support workers was available. These factors need to be considered in plan design.[48]

Box 4.1 NPY region

The NPY Women's Council observed that telehealth is not always a suitable way of addressing a lack of services in the NPY region:

> A woman on the Ngaanyatjarra Lands recently had her funding for psychology cut due to her not engaging in a mental health care plan. This participant lives in the small community of Blackstone. No psychologist visits her community, let alone one that bulk bills. This participant is often without a phone, and has no access to emails so she can not engage with a psychologist through a Mental Health Care Plan via phone or telehealth.[49]

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46 Disability Rights Advocacy Service SA, *Submission 38*, [p. 4].

47 Ms Brooke Lowry, General Manager, Kimberley Therapy Services, *Committee Hansard*, 18 April 2024, p. 50.

48 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Submission 96*, p. 6.

49 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Submission 96*, p. 10.

4.52 Public Health Association of Australia and Familycare observed that:

> Digital health and telehealth approaches could be used to supplement in person services to increase accessibility, but building a fit for purpose rural health, social and disability workforce remains paramount.[50]

Building a local workforce

4.53 Several submitters raised the importance of building a locally-based NDIS workforce in rural, regional and remote areas. They suggested that ongoing relationships between participants and locally based service providers were preferable to the more transient relationships developed with FIFO and DIDO service providers.[51]

4.54 The committee received evidence about the difficulties providers experience in attracting and retaining allied health and disability support workers. Some submitters suggested a range of incentives for providers to attract and retain workers, while other suggested that incentives be provided to workers directly. It was also suggested that migration incentives may form part of a solution.

Difficulties in attracting and retaining workers in RRR areas

4.55 Disability support providers report pervasive problems with recruiting and retaining workers, especially in rural, regional and remote Australia. According to National Disability Services, the peak body representing disability service providers:

> Barriers to recruitment include a tight labour market, lack of qualified staff, competition from other sectors, pay expectations, job security concerns, and challenges in accommodation availability, especially in regional areas. Facilitators of recruitment include positive word of mouth, organisational reputation, relationships with educational institutions, and fair pay.[52]

4.56 A University of Sydney consultation with the disability sector described the challenges of attracting and retaining NDIS workers in RRR areas. It found that NDIS providers compete with aged care providers and government agencies for good staff and that both pay higher wages. [53]

4.57 The Health Services Union (HSU) observed that participant choice was limited in rural, regional and remote areas due to limited supply and rapid turnover of workers, with just 15 per cent of their members expressing a belief that participants could find workers that suited their needs or that they could expect

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50 Public Health Association of Australia and Familycare, *Submission 4*, p. 7.

51 See, for example, CatholicCare NT, *Submission 42*, [p. 2]; National Indigenous Australians Agency, *Submission 70*, p. 16; Mrs Denise Kay, Senior Disability Advocate, Great Southern Community Legal Services, *Official Committee Hansard*, 16 April 2024, p. 15.

52 National Disability Services, *Submission 32*, p. 8.

53 Centre for Disability Research and Policy, *Submission 13*, p. 13.

a consistent quality of service. The HSU attributed the problem to a lack of investment in regional workforce development pushing support workers out of regional centres and rural towns towards major cities, and continually restrictive funding preventing regional and remote providers from offering workers incentives to relocate.[54]

4.58 The HSU suggested this had created:

> ... a vicious cycle where poor working conditions leads to shortages, which worsens those conditions through lower supervision, less training, fewer staffing and increased workloads.[55]

4.59 In relation to the shortage of allied health professionals, DSS advised that the government has progressed work with state and territory counterparts to develop a National Allied Health Workforce Strategy. This strategy will consider how to address the problem of a shortage of allied health professionals in Australia. Public consultation on the draft strategy has now closed, with the expectation that the strategy will be completed in 2025, subject to endorsement from the relevant federal, state and territory officials.[56]

Provider incentives

4.60 National Disability Services recommended that pricing and payments frameworks be reformed to improve incentives for providers to 'promote the delivery of efficient and quality supports and continuity of supply':

> This reform is particularly important for regional, rural and remote disability service providers under the NDIS that often face unique challenges such as higher service delivery costs, workforce shortages, and limited market competition. By implementing reforms that improve incentives for providers to deliver quality supports, these regions can benefit from more sustainable and efficient service delivery.[57]

4.61 HSU proposed that the NDIS provide a relocation allowance for regional and remote workers for a fixed period, especially for allied health workers, as part of a broader workforce attraction and retention strategy. This was framed as an investment in rural, regional and remote areas, as workers moving to more distant areas would relieve pressure on the allied health system, reduce travel costs billed to the NDIS, and increase plan utilisation. It was also suggested that workers who were supported to stay in rural, regional and remote areas would bring their families with them, broadening the revenue base from which schools

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[54] Health Services Union, *Submission 83*, p. 5.

[55] Health Services Union, *Submission 83*, p. 5.

[56] DSS, answers to questions on notice, 12 February 2025 (received 3 March 2025); Department of Health, Disability and Ageing, 'National Allied Health Workforce Strategy', 6 June 2025, https://www.health.gov.au/our-work/national-allied-health-workforce-strategy (accessed 22 July 2025).

[57] National Disability Services, *Submission 32*, pp. 28–29.

and health facilities could be expanded. The HSU observed that relocation and retention allowances could be integrated with preferred provider panel arrangements for regional supports, fixed-term employment guarantees to ensure continuity of supports and housing options that place workers close to participants they support.[58]

4.62 Queenslanders with Disability Network suggested that the government support place-based workforce strategies in rural, regional and remote areas to identify models of service delivery that ensure equitable access to services and supports:

> Workforce strategies should prioritise disability awareness training, quality standards in service delivery, cultural awareness training, skills development and strategies to attract, recruit and retain quality staff including incentives for working in remote and rural areas.[59]

4.63 Lifely proposed the introduction of higher travel rates for providers serving areas beyond regional hubs to cover additional time and expenses undertaken. They suggested that appropriate incentives could encourage consistent services in remote areas and promote continuity of care.[60]

4.64 As previously noted, DSS submitted that providers could already claim remote loadings to price limits for NDIS services. The remote and very remote loadings are 40 per cent and 50 per cent respectively, and are designed to incentivise providers to deliver supports in remote areas.[61]

4.65 However, Disability Advocacy (NSW) submitted that even when there are incentives that may attract skilled disability and health professionals to RRR areas, it is difficult to retain them for long periods:

> Attracting professionals to these areas has been a longstanding issue. Many workers prefer to stay closer to cities where there is more support and potential for career progression. Thus, an inherent problem within thin markets is a short supply of skilled professionals who deliver good quality health and disability care. As a result, positions can remain vacant for considerable amounts of time.[62]

Training incentives

4.66 Mental Health Australia indicated that, where local people in rural, regional and remote areas want to become support workers, they must leave their communities for extended periods of time to obtain the necessary qualifications:

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58 Health Services Union, *Submission 83*, p. 15.

59 Queenslanders with Disability Network, *Submission 49*, p. 12.

60 Lifely, *Submission 103*, p. 25.

61 DSS, *Submission 1*, p. 9.

62 Disability Advocacy (NSW), *Submission 21*, p. 15.

> Community members seeking to be trained up as support workers have expressed disappointment and concern that their placement cannot be done locally and therefore requires travel to the service providers that sit away from the community, which impacts local recruitment.[63]

4.67 HSU suggested that workers in regional areas had less access to training, as regional areas could not achieve the economies of scale that were possible in metropolitan areas. HSU saw benefit in increasing access for workers to NDIS training in regional areas, including through on-job placements and increased access to paid training opportunities.[64]

4.68 Speech Pathology Australia proposed a range of interventions targeted at building the disability workforce in rural, regional and remote Australia, including:

- support for universities to establish programs in rural and regional areas, with students from these areas to be given priority access;
- support for potential students to attend university while remaining in their communities;
- giving disability practitioners access to housing that has been previously established for the public health workforce;
- incentives for rural, regional and remote practitioners to provide clinical placements for students;
- extending existing allied health scholarship programs within the health system to include positions within disability services and organisations; and
- extending existing workforce incentive programs, with a specific pathway for allied health providers.[65]

4.69 South West Autism Network (SWAN) called for a:

> … significant increase in university places for Allied Health courses is urgently needed, with improved access for prospective students living in regional and remote Australia – without the requirement and additional cost to relocate to capital cities. These courses must also be amended to include codesigned disability content.[66]

4.70 Disability Advocacy (NSW) suggested the Commonwealth, state and territory governments invest in upskilling the labour market in RRR areas. As an example, Disability Advocacy (NSW) proposed that TAFE courses on basic levels of disability care be provided to RRR communities, with subsidies to

63 Mental Health Australia, *Submission 34*, p. 8.

64 Health Services Union, *Submission 83*, p. 14.

65 Speech Pathology Australia, *Submission 76*, p. 7.

66 South West Autism Network, *Submission 86*, pp. 52–53.

assist with fees and associated costs of living and studying in a RRR area, as well as online programs for students who could not relocate or travel to study.[67]

4.71 The committee was also informed of the Bonded Medical Program, which helps to address the shortage of medical professionals in rural, regional and remote areas of Australia. The Bonded Medical Program provides a Commonwealth Supported Place in a medical course at an Australian university. In return, bonded participants have a 'return of service obligation' where they commit to work in an eligible regional, rural and remote area for three years after they complete their course.[68]

Migration incentives

4.72 The NDIS Review recommended that the Australian Government develop targeted and flexible migration pathways for care and support workers, including consideration of an industry labour agreement targeted at workers who would not otherwise qualify for skilled migration.[69]

4.73 The AEIOU Foundation submitted that the Australian Government could further address workforce shortages in RRR areas by collaborating with relevant professional associations to expedite the recognition of foreign qualifications held by skilled migrants in the allied health professional field. This would enable them to register with their respective professional bodies more quickly and contribute to improving access to quality disability support.[70]

Alternative approaches

4.74 The committee received considerable evidence recommending that alternative approaches to standard NDIS systems and processes should be considered and implemented to address the challenges faced by NDIS participants in rural, regional and remote Australia. Some of these approaches are described as 'alternative commissioning' and include a variety of measures to ensure that NDIS participants can access the services and supports in their plans, regardless of where they live.

Alternative commissioning

4.75 As described by the NDIS Review, alternative commissioning involves partnering with communities to pilot alternative approaches to improve access to NDIS supports in remote and First Nations communities. It is thought that this approach will enable more NDIS participants to access services under their

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67 Disability Advocacy (NSW), *Submission 21*, p. 17.

68 Department of Health, Disability and Ageing, *Bonded Medical Program*, health.gov.au/our-work/bonded-medical-program, 22 July 2025 (accessed 22 July 2025).

69 Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 198.

70 AEIOU Foundation, *Submission 14*, [p. 5].

plans, that would otherwise be unavailable or too costly for them to access where they live. This approach differs from the individualised market-driven approach to NDIS supports and services and is believed to be necessary when a particular market has failed to meet the demand. [71]

4.76 Alternative commissioning approaches enable a flexible approach to addressing a community's specific needs. For example, the committee heard what an arrangement under this approach could look like and achieve:

> In a lot of remote communities we have large numbers of providers offering services, which means that individual participants are all going off to different providers. No-one gets a critical mass that lets them deliver a viable service there. When we use alternative commissioning approaches and we have participants who want to pool their funding and go to one provider, that gives them a more consistent service. So instead of having someone who comes in once a year—and then you don't see them—you can have an organisation that comes in once a month, and a number of people get services from that organisation once a month. Over time, as we build local capacity, we can have more of those services delivered locally, rather than fly in, fly out.[72]

4.77 While this approach has been discussed and recommended in several previous reports and reviews, recently the NDIS Review considered alternative commissioning in some detail. The final report of the NDIS Review observed that there is limited access to supports for remote and First Nations participants, finding that for all participants living in remote communities who have been in the Scheme for at least one year:

- around two in five participants are not getting daily activity supports; and
- over one in three participants are not getting therapy services.[73]

4.78 To address this issue, the NDIS Review recommended that alternative commissioning arrangements be utilised to improve access to supports for First Nations participants across Australia and for all participants in remote communities.[74] These arrangements should involve the NDIA, First Nations communities, remote communities, other Australian Government agencies and state and territory governments working together to 'commission' supports for people in a community. This would require taking a 'whole-of-community' approach and could integrate funding for different supports and community

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[71] Independent Review into the National Disability Insurance Scheme, *Alternative commissioning for remote and First Nations communities*, June 2023 (accessed 2 February 2025).

[72] Ms Fleur Hill, General Manager, SA, WA, NT and Remote Services, National Disability Insurance Agency, *Official Committee Hansard*, 28 June 2024, p. 53.

[73] Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 186.

[74] Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 190.

initiatives across government programs.[75] Not only could this approach help fill the current gaps in the market to access certain supports but would also minimise the duplication of services and reduce the overall cost to individual participants (for example, by sharing the travel costs for a service provider with other members of the community).

4.79 In recommending this approach, the NDIS Review was clear that alternative commission does not mean returning to the previous system of 'block funding'. Rather, it can include a range of design choices, including place-based and community-driven approaches, designed in partnership with the community. The approach does, however, require governments to play a more active and flexible role as 'stewards' of the NDIS market.[76]

4.80 In order to implement alternative commissioning, the NDIS Review proposed that the NDIA, in genuine partnership with First Nations representatives, communities, participants and relevant government agencies should progressively roll-out alternative commissioning arrangements for both First Nations communities and remote communities, starting as soon as possible, ensuring that the approach taken:

- is underpinned by an understanding of, and builds on, community strengths and preferences;
- explores and designs commissioning on a case-by-case basis with communities - this could include models of direct and community-led commissioning approaches as well as integrated commissioning (where a provider is commissioned to provide supports across multiple service types); and
- is culturally appropriate, outcome-based, and uses practical and community-driven processes to collect data and evaluate outcomes.[77]

4.81 The NDIS Review also cautioned against implementing this approach too quickly:

> Expanding too far, too fast is a significant risk. Time is needed to build commissioning capability and roll out alternative commissioning approaches across both remote and First Nations communities. Piloting approaches will help to understand what works and allow time to develop and strengthen community partnerships.[78]

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[75] Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 187.

[76] Independent Review into the National Disability Insurance Scheme, *Alternative commissioning for remote and First Nations communities*, June 2023, p. 2.

[77] Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 190.

[78] Independent Review into the National Disability Insurance Scheme, *Alternative commissioning for remote and First Nations communities*, June 2023, p. 8.

4.82 DSS acknowledged that plans and supports for people living in remote and very remote areas do require a different approach, and informed the committee that alternative commissioning is an initiative being considered for 'further review and development'.[79]

4.83 Many submitters to the inquiry expressed strong support for the use of alternative commissioning in remote communities, including state and territory governments, peak bodies, advocacy organisations and service providers.[80]

4.84 The Western Australian Government submitted that place-based and collaborative approaches, including alternative commissioning models, have been shown to achieve better outcomes, especially for Aboriginal people, whose cultural needs can vary significantly between communities.[81] They advised that these approaches are 'the best option to ensure equitable and culturally safe access to services in regional and remote areas' and to effectively address shortfalls in the market for certain services.[82]

4.85 The Northern Territory Government explained that remote and very remote communities in the Territory have long faced the challenge of thin markets resulting in limited or no access to disability supports and services.[83] It explained that:

> The Northern Territory is a small, culturally diverse, dispersed population over a large remote geographic footprint, and has a unique remote service delivery operating context. As a result, the Northern Territory and Commonwealth Governments have agreed that the Northern Territory's approach to the NDIS will be guided by the principles that recognise the importance of placed-based, tailored solutions to planning, market development and service access, while supporting risk management and coordinated and culturally competent engagement and service responses.[84]

4.86 As a result of these unique conditions, the Northern Territory Government advised that it welcomed the selection of Maningrida as the first trial site for the Commonwealth's alternative commissioning pilot program.[85] This trial is ongoing and discussed further in this chapter.

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79 DSS, *Submission 1*, p. 11.

80 See, for example, Northern Territory Government, *Submission 2*, p. 14; National Disability Services, *Submission 32*, p. 29; First Peoples Disability Network, *Submission 85*, p. 18; Queenslanders with Disability Network, *Submission 38*, p. 10.

81 Western Australian Government, *Submission 88*, p. 10.

82 Western Australian Government, *Submission 88*, p. 10.

83 Northern Territory Government, *Submission 2*, p. 4.

84 Northern Territory Government, *Submission 2*, p. 6.

85 Northern Territory Government, *Submission 2*, p. 15.

4.87 National Disability Services (NDS) supported these arrangements, advising that alternative commissioning can be used to strengthen market monitoring and improve access to supports, particularly for First Nations participants across Australia and for all participants in remote communities. The NDS submitted that:

> The Australian Government should engage in more active, evidence-driven market monitoring to identify issues with access to quality supports early and take timely and appropriate action. Concurrently, the NDIA should progressively implement provider panel arrangements for allied health supports in small and medium rural towns or areas where participants face persistent supply gaps. Additionally, the NDIA, in collaboration with First Nations representatives, communities, participants, and relevant government agencies, should commence the gradual rollout of alternative commissioning arrangements for both First Nations communities and remote communities, starting as soon as possible.[86]

4.88 This view was shared by the Central Australian Aboriginal Congress, an Aboriginal Community Controlled Health Organisation (ACCHO) based in Alice Springs. They asserted that alternative commissioning is needed in remote communities, particularly in areas classified as MMM6 and MMM7 under the Modified Monash Model of remoteness, citing that currently, less than 50 per cent of NDIS plans in remote locations are being drawn on.[87] However, additional grant funding is needed to support this approach.[88]

4.89 Likewise, the First Peoples Disability Network (FPDN) submitted that it is 'very supportive' of alternative commissioning in regional, rural and remote settings, stating that this approach could deliver more sustainable, efficient and appropriate support for First Nations communities.[89] In providing their support for alternative commissioning, the FPDN stressed the importance of undertaking the design, implementation, and evaluation of this approach in line with the National Agreement of Closing the Gap.[90] This includes:

- forming place-based partnerships with communities and the community controlled sector, including FPDN as the peak body;
- strengthening of the community controlled and non-Indigenous disability sector to build a localised culturally safe, inclusive and disability rights informed sector;
- ensuring that all approaches are evaluated with First Nations disability evaluation principles, and in line with the Cultural Model of Inclusion

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86 National Disability Services, *Submission 32*, p. 29.

87 Central Australian Aboriginal Congress, *Submission 60*, [p. 1].

88 Central Australian Aboriginal Congress, *Submission 60*, [p. 2].

89 First Peoples Disability Network, *Submission 85*, p. 18.

90 First Peoples Disability Network, *Submission 85*, p. 18.

Framework will ensure that the measures of success for First Nations people with disability living in regional, rural; and

- remote locations guide the alternative commissioning approaches, as well as identify opportunities for upscaling.[91]

4.90 In a similar vein, numerous organisations including Tandem, Vision 2020 Australia, Carers WA and MS Australia provided their support for the NDIS Review's recommendation to roll out alternative commissioning arrangements where appropriate.[92] Tandem went further to recommend that the approach should be considered more broadly across the regions, rather than limited to remote communities, noting that alternative commissioning can build social capital, foster community inclusion and improve access to culturally safe services.[93]

Maningrida pilot program

4.91 In August 2023, the Hon Bill Shorten MP, then Minister for the NDIS, announced Maningrida in the Northern Territory as the first alternative commissioning trial site. This included the allocation of $7.6 million to pilot an approach to improve NDIS service gaps in First Nations, remote and very remote communities.[94] The trial is being developed and piloted in partnership with First Nations representatives and remote communities to ensure the pilot is culturally appropriate and underpinned by an understanding of community strengths and preferences.[95] The goal of the pilot is to ensure the solutions are co-designed from the beginning through collaboration with community.[96]

4.92 Maningrida is an Aboriginal community in the heart of the Arnhem Land region of the Northern Territory, 500 kilometres east of Darwin. It has a population of 2956 (2021 census) and at least five language groups, including Ndjebbana, Kunwinjku, Maung, Djambarrpuyngu, and Kriol.

4.93 At the time that Maningrida was being considered for the trial, there were 75 NDIS participants living in the area.[97] This number has now grown to 101 active participants in the area.[98] Of the original 75 participants, 93 per cent identified

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[91] First Peoples Disability Network, *Submission 85*, p. 18.

[92] See, for example: Tandem, *Submission 71*, p. 34; Vision 2020 Australia, *Submission 11*, p. 7; Carers WA, *Submission 35*, p. 2; and MS Australia, *Submission 89*, [p. 13].

[93] Tandem, *Submission 71*, p. 34.

[94] National Indigenous Australians Agency, *Submission 70*, p. 16.

[95] National Indigenous Australians Agency, *Submission 70*, p. 16.

[96] National Indigenous Australians Agency, *Submission 70*, p. 16.

[97] Northern Territory Government, *Submission 2*, p. 9

[98] DSS, answers to questions on notice, 12 February 2025 (received 28 February 2025).

as Indigenous/First Nations, and 63 per cent identified as Culturally and Linguistically Diverse. The average annual NDIS plan was $56,086, with the usage of these funds being only 36.5 per cent.[99]

4.94 Minister for Disabilities in the Northern Territory Legislative Assembly, then Minister Ngaree Ah Kit, provided further detail, explaining that Maningrida has around forty-eight service providers and around $4 million worth of NDIS packages. The committee understands that there are now fifty-five providers.[100] When the trial began, around $1 million was being drawn down. Additionally, the then Minister explained:

> What we need to do is understand that Maningrida is not like any other community. It is completely unique. So going out and working with the people and hearing from them firsthand was a focal point and a starting point and really important.
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> …
>
> It is a large community that has a fluctuation of between 2½ thousand and 3½ thousand people. It is very, very big. That was our baseline: how do we ensure that we work with community, the providers and the NDIA to help local residents on a package draw down more support to live their best life?[101]

4.95 While this trial is still in progress, the committee heard that the initial effects have been positive, particularly in relation to increased community engagement with NDIS supports and services. Ms Fleur Hill, General Manager, SA, WA, NT and Remote Services, of the NDIA commented:

> We're seeing, when we go in and talk to community in those terms, that they're very engaged. They've asked us to be a signatory to their local decision-making agreement, which we've done, because we're giving that signal that we're not just about this transactional piece of work—we're interested in the broader environment and we want to help you build that.[102]

4.96 The committee was informed that a new trial began in August 2024 in Katanning and surrounding areas in Western Australia.[103] The former minister, the Hon Bill Shorten MP, explained the importance of the trail for NDIS participants in Katanning:

> … there's 61 NDIS participants in the Shire of Katanning. Their average plan size is $25K, so it's not like a king's ransom. But the average usage of the

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99 Northern Territory Government, *Submission 2*, p. 9.

100 DSS, answers to questions on notice, 12 February 2025 (received 3 March 2025).

101 The Hon Ngaree Ah Kit, Minister for Disabilities, Northern Territory Legislative Assembly, *Committee Hansard*, 16 April 2024, pp. 2–3.

102 Ms Fleur Hill, General Manager, SA, WA, NT and Remote Services, NDIA, *Committee Hansard*, 28 June 2024, p. 49.

103 DSS, answers to questions on notice, 12 February 2025 (received 28 February 2025).

> plans in the last six months was only 45%. So, they've got a plan but they're not able to use it.[104]

4.97 People with disability living in RRR areas face significant challenges in accessing NDIS services and supports, including thin markets and travel costs. Providers also face challenges in building local disability workforces in RRR areas. The committee welcomes the recommendations of the Disability Royal Commission and the NDIS Review that address these challenges. Initial government and NDIA responses to those recommendations appear promising. The committee will continue to monitor the implementation of these responses as part of its ongoing oversight role.

[104] Ministers for the Department of Social Services, *Minister Shorten interview on 6RP Radio Perth*, 30 July 2024, https://ministers.dss.gov.au/transcripts/15461 (accessed 13 March 2025).

Chapter 5
Cultural safety and communication

5.1 A culturally safe environment is one where people feel safe, respected, understood and included. This chapter considers the importance of culturally safe practices and services for First Nations and Culturally and Linguistically Diverse (CALD) NDIS participants.

Cultural safety in the NDIS context

5.2 This section will discuss definitions of cultural safety for First Nations and CALD people with disability. It will also examine the extent to which cultural safety practices are, and should be, implemented by the NDIA and by NDIS service providers.

Cultural safety for First Nations people with disability

5.3 The National Agreement on Closing the Gap provides a definition of cultural safety for First Nations people focused on the person, their identity, and their right to determine what is culturally safe for themselves:

> Cultural safety is about overcoming the power imbalances of places, people and policies that occur between the majority non-Indigenous position and the minority Aboriginal and Torres Strait Islander person so that there is no assault, challenge or denial of the Aboriginal and Torres Strait Islander person's identity, of who they are and what they need. Cultural safety is met through actions from the majority position which recognise, respect, and nurture the unique cultural identity of Aboriginal and Torres Strait Islander people. Only the Aboriginal and Torres Strait Islander person who is recipient of a service or interaction can determine whether it is culturally safe.[1]

5.4 On 17 January 2025, the Australian Government announced a new *NDIS First Nations Strategy 2025-2030* (First Nations Strategy), designed to provide First Nations people with disability with culturally safe and accessible supports through the NDIS.[2]

5.5 Former Minister the Hon Bill Shorten MP said that the First Nations Strategy represented the government's commitment to:

> … meaningful action to address systemic barriers and challenges for First Nations people who are already on the Scheme, and for those who need

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[1] Coalition of Aboriginal and Torres Strait Islander Peak Organisations and the Council of Australian Governments, *National Agreement on Closing the Gap*, July 2020, p. 52, closingthegap.gov.au/national-agreement (accessed 22 January 2025).

[2] National Disability Insurance Agency, *First Nations Strategy*, ndis.gov.au/about-us/strategies/first-nations-strategy, 15 April 2025 (accessed 20 January 2025).

> supports but may not yet have them. It's also a key step in responding to both the Disability Royal Commission and the NDIS Review, while also delivering on our stated commitment to the National Agreement on Closing the Gap and working across government to Close the Gap between Indigenous and non-Indigenous Australians.[3]

5.6 The First Nations Strategy was co-developed with a First Nations Strategy Working Group that comprised First Nations NDIS participants, carers, providers, partners, peak bodies, non-government organisations, academics and advocates. The former NDIA First Nations Advisory Council also played an important role.[4]

5.7 The First Nations Strategy highlights that a culturally safe environment is created when First Nations people define and decide what is culturally safe for them, and can report that:

- their experiences are believed and validated;
- their cultures are centred and valued in policy development, research, evaluation, and service design and delivery;
- they feel welcomed and respected in policy, research, evaluation and service environments;
- they see other Aboriginal and Torres Strait Islander people working in the policy, research, evaluation or service context; and
- they do not experience any form of racism in policy, research, evaluation and service contexts or processes.[5]

5.8 In the First Nations Strategy, Dr Janine Mohamed, NDIA's Deputy CEO, First Nations Group, explained that cultural safety creates environments where First Nations people feel understood, respected and valued, and where their needs and aspirations are taken seriously and prioritised. The Deputy CEO also emphasised the importance of self-determination and reconciliation:

> Cultural safety honours and embeds First Nations ways of knowing, being and doing into our systems, policies, services and supports. It's about sharing power with First Nations people, honouring historical truth telling and committing to never repeating the wrongs of the past. It's about meeting First Nations people where they are at and providing services commensurate with need.
>
> Cultural safety will always be determined by First Nations people, but requires allyship by non-Indigenous people. Allies of First Nations people

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3 The Hon Bill Shorten MP, Minister for the National Disability Insurance Scheme (NDIS), 'First Nations Strategy to ensure better outcomes for First Nations people living with disability', *Media Release*, 17 January 2025, ministers.dss.gov.au/media-releases/17356 (accessed 20 January 2025).

4 National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, p. 11, ndis.gov.au/media/7416/download?attachment (accessed 20 January 2025).

5 National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, p. 40.

are critical to advocating for equity, promoting anti-racism, accountability, and sharing power and the workload at all levels.[6]

Cultural safety for CALD people with disability

5.9 On 30 April 2024, the Australian Government announced its *NDIS Cultural and Linguistic Diversity Strategy 2024-2028* (CALD Strategy), developed through co-design with the National Ethnic Disability Alliance (NEDA) and an Expert Advisory Group of 32 organisations.[7]

5.10 In the NDIS context, the CALD Strategy seeks to realise the following aims:

- increase access to and participation in the NDIS for CALD communities;
- increase use of NDIS plans by CALD participants; and
- improve experiences with the NDIS, including its processes, systems and staff, for CALD participants and communities.[8]

5.11 Key actions to be taken through the CALD Strategy include:

- providing better guidance to planners to improve their understanding of the supports and needs of CALD participants, and to make sure planning processes are culturally appropriate;
- reviewing and updating processes for NDIS meetings with interpreters (including Auslan) to improve communication approaches such as options for longer meetings, preferred or required interpreters, and in-person interpreting services;
- working with the NDIS Quality and Safeguards Commission to enable more culturally appropriate services;
- identifying, developing and supporting activities from community organisations that promote awareness of the NDIS (including eligibility) and reduce stigma around disability in CALD communities; and
- researching, identifying and publishing new data on participants from CALD backgrounds to enable better evidence-based decision making by NDIS staff, partners and the sector.[9]

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[6] National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, p. 10.

[7] The Hon Bill Shorten MP, Minister for the NDIS, 'CALD community co-design new NDIS CALD Strategy', *Media Release*, 30 April 2024, formerministers.dss.gov.au/20349/cald-community-co-design-new-ndis-cald-strategy/ (accessed 23 January 2025).

[8] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, p. 6, ndis.gov.au/media/6944/download?attachment (accessed 8 January 2025).

[9] The Hon Bill Shorten MP, Minister for the NDIS, 'CALD community co-design new NDIS CALD Strategy', *Media Release*, 30 April 2024.

Impacts of deficiencies in cultural safety

5.12 According to the Aboriginal and Torres Strait Islander Health Performance Framework, rates of disability among First Nations people are almost twice as high as among non-Indigenous Australians.[10]

5.13 The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability observed that exclusion of First Nations people with disability from culturally safe and inclusive services and supports resulted in continued neglect:

> We consider this exclusion amounts to the systemic neglect of First Nations people with disability by governments, institutions and organisations responsible for providing services. While this systemic neglect is a problem in itself, we also consider it creates environments more likely to encourage violence, abuse and exploitation of First Nations people with disability.[11]

5.14 Similarly, the 2023 Independent Review into the NDIS (NDIS Review) found that, despite rates of disability for First Nations people being higher than the general population, and national commitments under the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the National Agreement on Closing the Gap, First Nations issues were not given adequate attention and commitment under existing disability governance arrangements:

> For First Nations people with disability, this represents a critical gap in a commitment by all Australian governments under the National Agreement on Closing the Gap. Not enough has been done to identify, develop or strengthen independent accountability mechanisms that work with government to identify and eliminate racism, embed and practice meaningful cultural safety, monitor progress, listen and respond to concerns about mainstream institutions and agencies, and report publicly on transformation.[12]

5.15 Disability Advocacy Network Australia (DANA) described the effects of historical and contemporary government actions and attitudes on First Nations NDIS participants:

> Given the profound history of mistreatment, racism and colonial violence, many First Nations people with disability feel distrust and suspicion when interacting with government agencies and disability services. Many advocates speak about the NDIA displaying a lack of cultural safety and poor cultural responsiveness in NDIS processes including access and planning. This can compound the disadvantage created by the additional

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[10] Australian Institute of Health and Welfare & National Indigenous Australians Agency, *Aboriginal and Torres Strait Islander Health Performance Framework: 1.14 Disability*, indigenoushpf.gov.au/measures/1-14-disability (accessed 29 January 2025).

[11] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report, Volume 9: First Nations people with disability*, p. 56 (accessed 8 January 2025).

[12] NDIS Review, *Final Report: Working together to deliver the NDIS*, December 2023, pp. 236–237.

barriers that are faced by Aboriginal and Torres Strait Islander people interacting with and seeking support from government systems.[13]

Box 5.1 North Queensland

Disability Advocacy Network Australia submitted that:

> Aboriginal & Torres Strait Islander participants are concerned they must relocate to regional or urban areas to get NDIS supports to meet their specific disability support needs. This creates anxiety and fear of being dispossessed, reliving the intergenerational trauma of historical forced removal of children & young people (stolen generation), loss of culture, lore, and connection to country.[14]

5.16 First Peoples Disability Network (FPDN) held the view that the NDIS had 'failed' First Nations communities in rural, regional and remote Australia:

> It's still the case in 2024, 11 years after the scheme was rolled out, that the scheme's assessors and plan managers don't understand us. They stereotype us, degrade us, traumatise us and facilitate our removal from country. They ignore our concerns or even worse our goals and ambitions for the future—and that is if you can access them in the first place. When we do, of course, the data shows that our plan utilisation rates are lower than those of non-Indigenous Australians, which means that, no matter how good your plan is, the scheme is just not working for our people.[15]

5.17 FPDN attributed this in part to a lack of recognition of the number of First Nations people with disability who experience poverty:

> Poverty of access and opportunity, as well as financial and economic poverty, impact every aspect of our lives and, therefore, every aspect of the scheme. For example, how effective is NDIS self-care or home-modification support if you don't have a home? How effective can social participation be if the person facilitating it doesn't understand your social or cultural life? How effective can therapies be if the approach being employed holds no cultural significance or value to you, let alone if you haven't had secure access to water, food or housing for the last six months? These conditions and concerns, while some are considered out of scope or not a matter for the NDIS, are the lived realities of many First Nations people with disability across rural, regional and remote Australia.[16]

5.18 The Western Australian Government observed that First Nations people were 'disproportionately impacted by disability and under-represented in the uptake

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[13] Disability Advocacy Network Australia, *Submission 72*, p. 19.

[14] Disability Advocacy Network Australia, *Submission 72*, p. 41.

[15] Ms Tahlia-Rose Vanissum, National Policy and Systemic Advocacy Manager, First Peoples Disability Network, *Official Committee Hansard*, 28 June 2024, p. 39.

[16] Ms Tahlia-Rose Vanissum, National Policy and Systemic Advocacy Manager, First Peoples Disability Network, *Official Committee Hansard*, 28 June 2024, p. 39.

of disability services', and that First Nations participants in regional Western Australia faced challenges including:

- lack of cultural and place-based consideration in plan development that can result in inappropriate, impractical and underfunded plans;
- limited service choice and availability, impacted by thin markets/market failure;
- limited or no availability of Aboriginal community controlled health organisations;
- the need for extensive travel and transportation;
- lack of suitable accommodation options;
- lack of culturally appropriate service options;
- lack of specialist disability expertise, noting the challenges to recruiting, training and retaining professionals in these areas; and
- issues with service quality including cultural appropriateness and safety.[17]

5.19 Gidgee Healing submitted that the community members they serve experienced a lack of available, accessible and culturally appropriate services, while also being affected by intersectional disadvantages:

> Aboriginal and Torres Strait Islander people with a disability sit at an intersection of profound disadvantage when compared with non-indigenous people with disability. For example, they are more likely to have greater levels of need for care and support due to more severe disability; and they live in remote areas of 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. Finally, personal and community experience of trauma impacts the uptake of services.[18]

5.20 The National Indigenous Australians Agency (NIAA) gave evidence that, when services do not demonstrate culturally safe practices, there are risks that First Nations people will disengage from the NDIS, or that there will be barriers to using plans and receiving supports:

> Services that do not, or are yet to develop cultural safety practices, are at risk of indirectly discriminating against First Nations Australians by placing cultural barriers in the way of accessing the same services as other Australians. This is critical for rural, regional and remote locations where culture is strong and often discrimination is common. Lack of safety can incite fear and produce and provoke trauma. Unsafe practices can re-traumatise peoples and lead them to not to seek available supports.[19]

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17 Western Australian Government, *Submission 88*, p. 8.

18 Gidgee Healing, *Submission 22*, p. 2.

19 National Indigenous Australians Agency, *Submission 70*, p. 11.

5.21 The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council observed that limited service provision in rural, regional and remote areas can impinge on cultural safety for First Nations participants:

Box 5.2 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council

The lack of services creates a situation where there is no choice available for participants. A number of young men with disability on the NPY Lands refuse to engage with the NDIS because of shame around having a disability. They are unwilling to talk or work with female providers – both Coordinators of Supports and therapists as this is perceived as culturally 'wrong way'. Limited service provision is unable to cater for this element of traditional culture.[20]

5.22 Griffith University research found that First Nations people, regardless of the remoteness of the area in which they lived, experienced challenges not only where services were difficult or impossible to access, but also as a result of engaging with culturally unsafe services. First Nations participants described:

> … NDIS planners who tried to force them to accept services they did not want or need, coordinators who harassed them to relinquish control of their NDIS funds in a way that was not reported by 'white folks', and service providers who abused them based on race or failed to respect cultural needs even when specifically requested. This distinction between First Peoples and non-Indigenous participants was pervasive and consistent throughout the sample, the latter experiencing errors of omission and neglect, but the former also experiencing actively ignorant treatment or deliberate harm associated with discrimination.[21]

5.23 First Nations and CALD communities in rural, regional and remote Australia are distinct, each with their own experiences and historical contexts. Nevertheless, people from First Nations and CALD communities often share similar challenges in accessing culturally safe and appropriate disability supports and services. For example, Kin Disability Advocacy submitted that some staff at the NDIA and some service providers may lack the cultural understanding necessary to provide culturally safe services to both First Nations and CALD people with disability:

> The staff at NDIA lack a comprehensive understanding of the local context with delivering services to individuals with disabilities from culturally and linguistically diverse backgrounds, as well as Aboriginal and Torres Strait Islander people with disabilities. Clients in remote regional areas may encounter cultural safety issues when accessing services from certain

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20 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Submission 96*, p. 8.

21 Griffith University, *Submission 74*, p. 24.

> providers. The traditional service delivery model may not always suit our clients and can lead to family confusion and conflicts.[22]

5.24 Strive Disability Support Services observed that many First Nations and CALD participants prefer face-to-face, in-home and in-community support settings, and do not access or use services that are run from offices, over the phone or telehealth. Strive submitted that service providers would need to be willing to go to people's homes to check in on people who were not willing or able to visit offices or communicate via phone or email. Strive suggested that, despite the NDIA's expressed intention that culturally safe supports be provided, participants' plans were rarely funded in order to do so.[23]

5.25 Cultural safety for First Nations and CALD people with disability can be equally impacted when staff are not sensitive or accepting of LGBTQI+ people, as described by Griffith University:

> Personal safety did not appear to be a consideration for people who identified as LGBTQI+. Instead, they were encouraged to remain silent, which meant their needs were unlikely to be expressed and met. As one participant noted, the most significant challenge was finding 'staff [who] are safe to engage with when you are CALD and LGBTQI+'. A First Peoples participant described how a female support worker refused to keep working with him when she learned of his LGBTQI+ status.[24]

5.26 The NDIA's CALD Strategy identified several challenges faced by CALD people with disability. While these challenges are also present in metropolitan areas, they are more acute in rural, regional and remote Australia:

- NDIS policies, procedures and systems do not reflect the cultural and language needs of all participants;
- NDIS systems and processes do not recognise the cultures, traditions, understanding of disability and family roles that exist in CALD communities;
- CALD participants, and their nominees, families and carers do not have access to NDIS and partner staff who understand their cultural needs or deliver services in an effective and safe and meaningful way;
- the ways in which NDIS staff and partners communicate with applicants and participants does not always reflect the ways CALD communities need to be engaged with, or the ways they would like to be engaged with;
- CALD participants are not supported to identify and choose services;
- service providers are not supported to promote culturally specific, responsive and safe supports and services;

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22 Kin Disability Advocacy, *Submission 36*, p. 8.

23 Strive Disability Support Services, *Submission 54*, [p. 3].

24 Griffith University, *Submission 74*, p. 26.

- the definition of CALD used by the NDIS is not broad enough to properly identify people from CALD backgrounds, as it does not fully capture cultural and language characteristics;
- stakeholders are not aware of publicly available NDIS data about CALD participants, and how to use this data;
- many people with disability from CALD backgrounds are not provided with information to enable them to understand NDIS eligibility and the application process. They also experience barriers in accessing information;
- many people with disability from CALD backgrounds have different understandings of disability and when it might be the right time to get support; and
- there is limited access to resources (including in-language content) to support people with disability from CALD backgrounds to understand the NDIS.[25]

5.27 The National Rural Health Alliance and the Office of the National Rural Health Commissioner submitted that the need for disability services that are tailored to the specific requirements of CALD people and groups, including the provision of resources and care in the appropriate language, was well recognised. They observed, however, that as the numbers of people from a CALD background were smaller outside major cities, provision of such specialised services was less likely in rural, regional and remote areas, with a consequential impact on the accessibility of disability supports and services.[26]

5.28 Dementia Australia outlined some of the barriers faced by people from CALD backgrounds when accessing the NDIS, including inadequate interpreter services, lack of preparedness and access to essential documents by Local Area Coordinators (LACs), inefficient communication and process management, leading to unnecessary stress, delays in receiving support, and confusion during the planning process. Dementia Australia continued that:

> These issues are particularly pronounced in regional, rural, and remote areas due to fewer service providers and specialists in these areas and fewer options for culturally appropriate support. Additionally, increased distance from service centres makes it harder to access in-person meetings, requiring reliance on potentially unreliable communication methods. The availability of interpreters, especially for less commonly spoken languages, is likely to be even more limited outside of metropolitan areas. Potential limitations in internet access and digital literacy can hinder online application processes and virtual meetings. There may be a greater gap in awareness and

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[25] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, pp. 16–17.

[26] National Rural Health Alliance and the Office of the National Rural Health Commissioner, *Submission 90*, p. 13.

understanding of the NDIS process among both potential applicants and local service providers in regional areas.[27]

Box 5.3 Access to advocacy

DANA observed that people with disability from CALD communities had limited access to culturally appropriate supports even in major metropolitan areas, with choices even more narrow in rural, regional and remote areas. Culturally appropriate advocacy services were similarly limited outside metropolitan areas.[28] DANA submission provided the following example:

> … in [our area], it's a very multicultural area and we come across people with disabilities and their families that are not connected to services, don't even understand, never heard of advocacy. We've met somebody recently who's 45 years old, intellectual disability, not on the NDIS, being cared for by his 95-year-old mother from a CALD background that is no longer able to look after this person. So I think the Government needs to - and even advocacy organisations maybe have a little bit more funding to go to have more of an impact on people from cultural and linguistic backgrounds in a point of view from providing information, basic information, as to what services are out there and how to access advocacy organisations.[29]

Language barriers

5.29 Mental Health Australia submitted that, when information about the NDIS is not provided in First Nations or community languages, it was difficult for people to access and utilise the Scheme:

> There is no accommodation for language issues, especially with First Nations and Culturally and Linguistically Diverse (CALD) communities. There are structural limitations for these communities in understanding NDIS documents, as, unlike Centrelink, there is no requirement for the NDIS to translate their documentation.[30]

5.30 Disability Rights Advocacy Service (DRAS) observed that the NDIA's current CALD Strategy identified a lack of interpreters and translated material, as well as a lack of culturally appropriate services in all areas, but severely so in rural, regional and remote areas.[31]

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27 Dementia Australia, *Submission 39*, p. 7.

28 Disability Advocacy Network Australia, *Submission 72*, p. 21.

29 Disability Advocacy Network Australia, *Submission 72*, p. 44.

30 Mental Health Australia, *Submission 34*, p. 8.

31 Disability Rights Advocacy Service, *Submission 38,* [p. 8].

5.31 Danila Dilba Health Service also told the committee about the impacts of language differences impacting cultural safety for First Nations participants:

> In supporting clients through this NDIS process, the most obvious barrier to clients accessing and engaging with the NDIS is the cultural safety of the process and services being engaged. There is often an obvious lack of cultural understanding and awareness among staff within the system. An example of this is when an LAC, local area coordinator, was talking to a client. The client didn't understand. The LAC began raising their voice at the client as if they were not hearing or were incapable. The client walked out on this discussion and reported feeling upset and not wanting to engage any more in the process. English was not this client's first language or second or third. The client didn't understand due to the language barrier and for no other reason.
>
> This lack of awareness around language differences creates many barriers within the NDIS. These language barriers are not considered during assessment and access to the NDIS. Clients are unable to use their NDIS funding to access language interpretation services. They can only use funds to support disability related communication barriers. This creates multiple barriers and disempowers individuals to access the support they need with complete comprehension.[32]

5.32 Community Bridging Services (CBS) observed that a lack of NDIS education and resources disproportionately affected people with disability from First Nations and CALD backgrounds. CBS suggested that the NDIA facilitate community education programs in rural, regional and remote areas.[33]

Workforce

5.33 Recent initiatives by the NDIA to improve staff capability through its CALD Strategy and First Nations Strategy contain goals of improving cultural safety for participants and promoting representation among NDIA staff.[34]

5.34 Increasing the numbers of people from First Nations and CALD backgrounds working for the NDIA and for service providers would significantly benefit the sector and participants.[35]

5.35 The Joint Council on Closing the Gap's *Disability Sector Strengthening Plan* described a range of challenges in increasing the number of First Nations people working within the disability sector, including:

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32 Ms Julie Brown, NDIS Support Officer, Danila Dilba Health Service, *Official Committee Hansard*, 16 April 2024, p. 22.

33 Community Bridging Services, *Submission 67*, p. 3.

34 See, for example, National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, pp. 20–21; National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, p. 10.

35 See, for example, Disability Advocacy Network Australia, *Submission 72*, p. 19; National Indigenous Australians Agency, *Submission 70*, p. 15; AEIOU Foundation, *Submission 14*, [p. 6].

- workforce attraction and retention to meet growth and demand, including non-competitive remuneration;
- limited recognition, opportunities and/or support for the development of local First Nations workforce and their cultural knowledge, community connection and skills and the long-term commitment to supporting their communities;
- in regional and remote communities, reliance on an external workforce, with a need for transportation into and between remote communities, difficulty recruiting, training and retaining staff, lack of accommodation options for staff and limited support for staff; and
- First Nations people also experience further barriers in obtaining requisite qualifications.[36]

5.36 The South Australian Health & Medical Research Institute (SAHMRI) called for investment in engagement, training, mentorship and retention of the First Nations NDIS provider workforce, and recognition of the importance of the First Nations NDIS workforce in providing culturally safe and responsive care.[37]

NDIA Inclusion Plans

5.37 The NDIA explained that its commitment to engaging and retaining First Nations peoples is articulated in the NDIA First Nations Employment and Inclusion Plan 2022–25. This plan includes the following initiatives:

- Cultural and National Aboriginal and Islanders Day Observance Committee (NAIDOC) leave that acknowledges the cultural needs of First Nations peoples, and which are included in the Agency's Enterprise Agreement;
- Staff working at the NDIA who identify as First Nations are supported through a First Nations Employee Network;
- Affirmative Measures recruitment practices are used to fill some roles, including in the Agency's First Nations group;
- Having a dedicated First Nations Champion and a First Nations Allyship Champion whose role is to advocate on behalf of First Nations staff, promote awareness of First Nations matters, guide Agency strategy activities and direction, and raise the profile and influence of First Nations peoples and community;
- The NDIA's Reconciliation Action Plan which supports attraction and retention of First Nations staff to the NDIA; and
- actively seeking First Nations peoples to participate in the NDIA Graduate Program and a commitment to participation in Services Australia's

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36 Joint Council on Closing the Gap, *Disability Sector Strengthening Plan*, August 2022, p. 26 (accessed 9 January 2025).

37 South Australian Health & Medical Research Institute, *Submission 68*, p. 1.

Indigenous Apprenticeship Program as a key mechanism for increasing the percentage of First Nations peoples coming to work at the Agency.[38]

5.38 In relation to CALD staff, the NDIA explained that its Culturally and Linguistically Diverse Inclusion Plan 2024–27 includes initiatives to attract and retain CALD staff members, through measures such as:

- implementing and maintaining a recruitment target for CALD staff at executive and senior levels;
- improving the CALD recruitment approach to elevate the NDIA's presence in the CALD community as an employer of choice;
- encouraging CALD candidates to disclose their heritage for recruitment data collection explaining why the information is being collected; and
- reviewing recruitment processes to identify and remove any potential barriers to inclusive recruitment for CALD applicants.[39]

5.39 Further, the NDIA stated that it has already completed a number of deliverables under the Inclusion Plan, including providing additional training and resources to staff, and targeted cultural sensitivity training to relevant staff members.[40]

Developing culturally safe practices

5.40 The Victorian Rural Advocacy Network outlined the characteristics of cultural safety for both First Nations and CALD people with disability, and steps to implement culturally safe practices:

> The culture and identity of all Aboriginal and Torres Strait Islander people and all CALD communities must be respected and celebrated. Communication in language is one key for each NDIS plan to be designed and implemented in a way that embraces culture and community. All LAC's and Planners must have an in-depth knowledge and be culturally informed. Every discussion must be done with the person, their family and other informal and formal supports. Everyone must be aware, and in agreement, of the person's goals now and into the future.[41]

5.41 The Royal Australian College of General Practitioners (RACGP) observed a need for recognition of First Nations values and understandings of disability:

> In many cases, Western-led models of care that focus on remediating individual pathology have been found to conflict with Indigenous understandings of disability, resulting in Aboriginal and Torres Strait

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[38] National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

[39] National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

[40] National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

[41] Victorian Rural Advocacy Network, *Submission 19*, [p. 13].

> Islander consumers feeling stigmatised. A culturally safe workforce is imperative to ensure health equity is attainable. To be successful these interventions must encompass Aboriginal and Torres Strait Islander values and social practices. Providing community-based care may also be essential in lowering the instances of preventable hospitalisations. For example, there is a strong preference for Aboriginal and Torres Strait Islander people to work with disability workers who are embedded in the community.[42]

5.42 The RACGP recommended that the government consider further investment in developing culturally safe, informed and appropriate practices through co-design with local communities:

> To ensure that the service provision of the NDIS is truly meeting the needs of the Aboriginal and Torres Strait Islander community, the Australian government must consider further investment in providing culturally safe, community-led interventions for rural and remote people living with disabilities. This must include extensive community involvement in governance and development, and research into co-design and community-controlled approaches.[43]

5.43 The National Rural Health Alliance and the Office of the National Rural Health Commissioner observed that the NDIS Review recommended there be improved integration between the NDIS and other services accessed by people with disability.[44] However, they noted that it did not specifically identify the central role of primary healthcare as an interface with other services in rural and remote communities:

> Creating a system where NDIS providers connect with a multidisciplinary team that traverses the disability and health sectors is key to improving the participant experience and related outcomes and is particularly important in rural and remote areas. Such sustainable rural and remote multidisciplinary health teams are also key to the recruitment and retention of the high quality, culturally safe workforce required to serve these regions.[45]

5.44 Griffith University submitted that the NDIA could improve cultural safety for participants by working to increase the numbers of First Nations people employed not only within the Agency, but also within NDIS-funded services, liaison agencies helping with NDIS applications, and the government in general. Griffith University suggested that the NDIA could implement a range of initiatives, ideally in partnership with First Nations people, such as:

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42 Royal Australian College of General Practitioners, *Submission 18*, p. 12.

43 Royal Australian College of General Practitioners, *Submission 18*, p. 12.

44 2023 Independent Review into the National Disability Insurance Scheme, *Final Report*, p. 5.

45 National Rural Health Alliance and the Office of the National Rural Health Commissioner, *Submission 90*, p. 12.

- information sessions specific to First Nations people, to describe the NDIS and what it does;
- more creative pathways for First Nations people, including family members, to become NDIS service providers; and
- cultural and social awareness training and on Country immersion programs for NDIA staff.[46]

5.45 Danila Dilba Health Service told the committee that cultural safety could be improved through better community outreach, and meeting participants in settings where they were most comfortable:

> Many clients from Danila Dilba often speak about feeling uncomfortable in confined, clean, white spaces. However, these are often the spaces where conversations with NDIS services occur. If more cultural awareness was embedded in the system, services and organisations might be more likely to yarn with clients in community settings outside or even in someone's front yard.[47]

5.46 DRAS submitted that the NDIA and NDIS service providers should conduct 'meet and greet' sessions in culturally safe spaces in regional areas, to meet First Nations people where they live, break down barriers and build rapport.[48]

5.47 CatholicCare NT emphasised that place-based providers in remote communities, in contrast to those providing fly-in, fly-out services, are able to provide daily services and supports while maintaining higher levels of knowledge and understanding of the appropriate cultural requirements for each community. It was suggested that place-based services were better able to build relationships, providing participants with increased transparency, continuity and connection. CatholicCare NT observed that place-based providers face additional costs that were not directly recoverable through NDIS payments, such as infrastructure, housing and staffing. It was suggested that a block funded model of NDIS delivery in remote areas was critical to the sustainability of place-based services.[49]

5.48 FPDN told the committee that the market-based approach of the NDIS was an 'absolute nonsense' to many First Nations communities, and that community-based care was preferable:

> Community based models of care, capacity building and supports that integrate our care workforces and recognise the inherent value of our cultural responsibilities to care for our people are needed to make any significant change. We believe that meaningful reform of the NDIS for First

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46 Griffith University, *Submission 74*, p. 24.

47 Ms Julie Brown, NDIS Support Officer, Danila Dilba Health Service, *Official Committee Hansard*, 16 April 2024, p. 22.

48 Disability Rights Advocacy Service, *Submission 38*, [p. 8].

49 CatholicCare NT, *Submission 42*, pp. 3–4.

> Nations people with disability is achievable; however, this can only occur through a genuine shared decision-making partnership that both informs design and serves as an accountability mechanism for effective and culturally responsive, safe and inclusive implementation.[50]

5.49 SAHMRI observed that recognising and promoting the rights of First Nations people required applying principles of First Nations leadership 'in designing and implementing programs and services and actively addressing racism'. SAHMRI observed that using this approach had ensured that disability programs were culturally responsive and appropriate, had First Nations people's strengths, perspectives, needs and challenges at their centre, and adhered to the principle of shared decision-making.[51]

5.50 AEIOU Foundation observed that it had made a number of suggestions to the NDIA through the Agency's consultation on its CALD Strategy in 2023, including:

- tailoring specific systems, policies, procedures, and processes to the needs of CALD people;
- employing CALD planner delegates and giving staff access to training modules that acknowledge culture in individual support plans;
- improving accessibility of communications, including implementing feedback surveys; and
- investing in collaboration with organisations that serve CALD participants.[52]

Role of Aboriginal Community Controlled Health Organisations

5.51 The National Agreement on Closing the Gap recognises the following four Priority Reforms targeted at changing the way that governments work with First Nations people:

- formal partnerships and shared decision-making;
- building the community-controlled sector;
- transforming government organisations; and
- shared access to data and information at a regional level.[53]

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50 Ms Tahlia-Rose Vanissum, National Policy and Systemic Advocacy Manager, First Peoples Disability Network, *Official Committee Hansard*, 28 June 2024, p. 40.

51 South Australian Health & Medical Research Institute, *Submission 68*, p. 5.

52 AEIOU Foundation, *Submission 14*, [p. 6].

53 Coalition of Aboriginal and Torres Strait Islander Peak Organisations and the Council of Australian Governments, *National Agreement on Closing the Gap*, July 2020, pp. 5–15 (accessed 22 January 2025).

5.52 Building the community-controlled sector is one way of improving outcomes for First Nations people with disability.[54]

5.53 The National Agreement on Closing the Gap acknowledged that community-controlled services are better for First Nations people, achieve better results, employ more First Nations people and are often preferred over mainstream services.[55]

5.54 The parties to the Agreement recognise that a strong community-controlled sector is one where:

- there is sustained capacity building and investment in First Nations community-controlled organisations which deliver services and address issues through clearly defined standards or requirements, such as an agreed model of care;
- there is a dedicated and identified First Nations workforce, that complements a range of other professions and expertise, where people working in community-controlled sectors have wage parity based on workforce modelling commensurate with need;
- organisations are supported by a peak body, governed by a majority First Nations board, which has strong governance and policy development and influencing capacity;
- organisations have a dedicated, reliable and consistent funding model designed to suit the types of services required by communities, responsive to the needs of those receiving the services, and is developed in consultation with the relevant peak body.[56]

5.55 The committee received evidence that Aboriginal Community Controlled Health Organisations (ACCHOs) would generally be well-placed to provide culturally safe disability services to First Nations NDIS participants, if funded appropriately to do so.

5.56 The National Aboriginal Community Controlled Health Organisation (NACCHO) represents 145 ACCHOs and assists other Aboriginal Community Controlled Organisations (ACCOs). NACCHO submitted that, consistent with the National Agreement on Closing the Gap, there should be an 'ongoing,

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54 See, for example, First Peoples Disability Network, *Submission 85*, p. 16; the Hon Ngaree Ah Kit, Minister for Disability, Northern Territory Legislative Assembly, *Official Committee Hansard*, 16 April 2024, p. 2; National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, pp. 14 and 25.

55 Coalition of Aboriginal and Torres Strait Islander Peak Organisations and the Council of Australian Governments, *National Agreement on Closing the Gap*, July 2020, p. 8.

56 Coalition of Aboriginal and Torres Strait Islander Peak Organisations and the Council of Australian Governments, *National Agreement on Closing the Gap*, July 2020, p. 8.

concerted effort to build the capacity of the community-controlled sector to deliver NDIS services' through:

- a long-term, stable block funding agreement with the Commonwealth, state and territory governments to ensure that the ACCHO sector can build its capacity to deliver NDIS services in thin markets and other markets in which culturally safe services are thin or non-existent;
- funding for ACCHOs and ACCOs to deliver navigation services, including Remote Community Connectors, assistance with evidence of disability and access to the scheme, and coordination of Planning Officers and Aboriginal Disability Liaison Officers, with national coordination of these programs transferred from the NDIA to NACCHO; and
- funding for support coordination to be provided by default in NDIS plans for all First Nations participants, including funds for Return to Country.[57]

5.57 The Aboriginal Health & Medical Research Council of NSW (AHMRC) submitted that it was crucial to recognise the leading role that ACCHOs play in providing health services and regular patient care to First Nations people. The AHMRC noted the efforts of the NDIA to include ACCHOs in its First Nations Strategy, however, questioned whether this was being adequately implemented:

> Rural, regional, and remote Indigenous communities often miss out on accessing support due to culturally inappropriate mainstream services or ACCHOs simply not receiving funding to provide critical support.[58]

5.58 This view was supported by the Central Australian Aboriginal Congress, who emphasised the effectiveness of ACCHOs in delivering services, despite not always being funded to do so:

> Evidence has shown that ACCHOs are more effective in delivering outcomes than mainstream services, achieving comparable outcomes but with a more complex case load. It's for these reasons that Aboriginal organisations, especially community controlled health services, should be formally recognised as the preferred providers for services under the NDIS for Aboriginal people. Our clinicians also act as advocates for NDIS participants in this region, and we're often asked to write detailed reports to support initial access to the scheme. This is unfunded work.[59]

5.59 The Department of Social Services (DSS) submitted that the NDIA was working to grow the existing Remote Community Connector network, through affirmative measures recruitment, in First Nations communities to ensure a place-based presence and perspective, and supplementing this with a Local

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57 National Aboriginal Community Controlled Health Organisation, *Submission 92*, p. 3.

58 Aboriginal Health & Medical Research Council of NSW, *Submission 8*, [p. 5].

59 Mr Andrew Jolly, Central Australian Aboriginal Congress, *Official Committee Hansard*, 28 June 2024, p. 38.

Community Connector role in non-partnered regional centres to ensure there is a Partners in the Community equivalent.[60]

Recent initiatives

5.60 The committee noted that the NDIA and the NDIS Quality and Safeguards Commission have implemented a range of initiatives to improve cultural safety for First Nations and CALD people with disability. The committee welcomes these initiatives and believes they represent steps in the right direction towards improving cultural safety for First Nations and CALD people with disability.

Indigenous and Remote Operations team

5.61 DSS noted that the NDIS Quality and Safeguards Commission had recently established an Indigenous and Remote Operations team (IRO) 'dedicated to quality and safeguarding in Indigenous and remote communities'. The purposes of the team include:

- building strong community relationships;
- implementing strategies to address risks impacting quality of services; and
- safeguarding of First Nations people with disability and people with disability living in remote communities.[61]

5.62 The NDIS Quality and Safeguards Commission explained that the IRO team is a dedicated unit that delivers culturally appropriate engagement activities with participants and providers in the Top End of Queensland, Northern Territory, Western Australia and the APY lands. These activities are dependent on the needs of each community and can include drop-in sessions, provider forums, participant sessions, stakeholder and community engagement and compliance monitoring site visits.[62]

5.63 As of February 2025, the IRO team had been operating for the last 18 months and had provided the commission with 'important insights … relating to its role and the needs of people with disability in regional and remote areas' which would be used to drive improvement in how they operate in these areas.[63]

First Nations Advisory Council

5.64 DSS observed that the NDIA had established a First Nations Advisory Council (FNAC) in collaboration with FPDN. At its first meeting, the FNAC discussed principles including:

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60 Department of Social Services, *Submission 1*, p. 6.

61 Department of Social Services, *Submission 1*, p. 9.

62 NDIS Quality and Safeguards Commission, answers to questions on notice, 12 February 2025 (received 28 February 2025).

63 NDIS Quality and Safeguards Commission, answers to questions on notice, 12 February 2025 (received 28 February 2025).

- valuing the diversity, cultures and intersectionality of all First Nations peoples;
- embedding culturally sensitive and trauma-informed ways of working;
- elevating the voices of Elders, young people and future generations;
- empowering family-centred ways of living and working;
- moving away from deficit language and models of disability to describe First Nations people with disability;
- building respectful relationships across sectors; and
- addressing power imbalances between government and First Nations communities.[64]

5.65 The FNAC operated from March 2023 to August 2024 to provide First Nations-led strategic advice and guidance to the NDIA. In August 2024, the FNAC moved to establish an NDIA Independent Advisory Council (IAC) First Nations Reference Group to assume the functions of the FNAC.[65]

5.66 The IAC First Nations Reference Group is to be based on First Nations disability sovereignty and aligned with the Disability Royal Commission and NDIS Review recommendations, as well as Closing the Gap priority reforms. It is intended to offer an elevated and strengthened First Nations voice within the NDIA. Its first priority was to co-design the First Nations Strategy with the Agency and advise on Scheme reform and policy issues as they affect First Nations people with disability.[66]

Independent Advisory Council First Nations Reference Group

5.67 On 1 October 2024, the NDIA IAC sought expressions of interest from First Nations people with disability to join the new IAC First Nations Reference Group. At the time, it was anticipated that the First Nations Reference Group would meet at least four times a year to advise the NDIA on issues facing First Nations people with disability.[67]

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64 National Disability Insurance Agency, *First Nations Advisory Council 6 June meeting*, ndis.gov.au/news/9379-first-nations-advisory-council-6-june-meeting (accessed 3 February 2025).

65 Department of Social Services, *Submission 1*, p. 13; National Disability Insurance Agency, *First Nations Advisory Council*, ndis.gov.au/about-us/reference-group-updates/first-nations-advisory-council (accessed 23 January 2025).

66 National Disability Insurance Agency, *First Nations Advisory Council August 2024 meeting*, ndis.gov.au/news/10331-first-nations-advisory-council-august-2024-meeting (accessed 3 February 2025).

67 National Disability Insurance Agency, *The Independent Advisory Council is seeking Expressions of Interest from First Nations people with disability*, ndis.gov.au/news/10426-independent-advisory-council-seeking-expressions-interest-first-nations-people-disability (accessed 23 January 2025).

5.68 Minister Shorten said that the Reference Group, which held its first meeting in February 2025, would play a vital role in strengthening strategic advice to the NDIA Board on policies and services affecting First Nations people.[68]

5.69 The Reference Group met for the second time in June 2025, to provide feedback from communities, and to discuss the Reference Group's Work Plan, the work of the NDIA's First Nations Group and the NDIA's rural and remote strategy.[69]

First Nations Strategy 2025–2030

5.70 The First Nations Strategy identified four key priority areas for action:

- Strategic priority 1: Fair and equitable access and support – this focuses on the experiences of First Nations people with disability, their families, communities and advocates, as they apply for the NDIS, navigate the NDIS pathway and choose service providers and services.
- Strategic priority 2: NDIS 'our way' – transformation for power-sharing – this is about the decisions the NDIA takes about policy, programs and quality standards, and the way the NDIA co-designs and funds culturally safe and effective services for First Nations participants.
- Strategic priority 3: Working together well within and across sectors – this focuses on better systems within the NDIS and stronger collaboration between services and sectors at the national, regional and local levels that support a smoother NDIS journey for First Nations participants.
- Strategic priority 4: Gathering, sharing and revisiting knowledge about meaningful change – this priority is about how the NDIA is accountable for tracking change over time in the experiences of and outcomes for First Nations participants, their families, communities and advocates, and then using the learnings for ongoing improvement.[70]

5.71 The NDIA anticipates codesigning a First Nations Strategy Implementation Plan during 2025, in partnership with First Nations participants and the wider First Nations disability community, including families, carers, providers, peak bodies and government and non-government organisations.[71]

5.72 The NDIA advised that in response to the Strategy, it has received informal feedback from government stakeholders, First Nations non-government organisations and First Nations NDIS participants. This feedback indicated that the Strategy was seen as an important step for the NDIA to implement the

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68 The Hon Bill Shorten MP, Minister for the National Disability Insurance Scheme, 'First Nations Strategy to ensure better outcomes for First Nations people living with disability', *Media Release*, 17 January 2025, ministers.dss.gov.au/media-releases/17356 (accessed 20 January 2025).

69 Independent Advisory Council to the NDIS, 'First Nations Reference Group meeting bulletin, 11-12 June 2025, https://www.ndis-iac.com.au/first-nations-reference-group-meeting-bulletin-11-12-june-2025 (accessed 22 July 2025).

70 National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, p. 10.

71 National Disability Insurance Agency, *NDIS First Nations Strategy 2025–2030*, p. 15.

National Agreement on Closing the Gap and respond to the findings of the Disability Royal Commission and the NDIS Review.[72] Additionally, the feedback was focussed on ensuring the NDIA implements the Strategy, including 'in partnership with the First Nations disability sector and in alignment with concurrent policies and programs'.[73]

Cultural and Linguistic Diversity (CALD) Strategy 2024-2028

5.73 The CALD Strategy identifies six priority areas in which outcomes for CALD are to be improved:

- infrastructure;
- staff capability;
- accessible communications;
- markets;
- data; and
- outreach.[74]

5.74 Improvements to infrastructure are designed to embed responses to cultural and language needs into the systems, policies and procedures of the NDIS and its partners, including:

- co-designing definitions of 'cultural safety' and 'culturally appropriate and responsive service' with CALD disability communities, partners, providers and the NDIS Quality and Safeguards Commission;
- reviewing and updating NDIS policies, procedures and systems to enable equitable access to the NDIS and use of plans for people with disability from CALD backgrounds; and
- ensuring that NDIS communication processes with CALD communities and participants are culturally appropriate, are effective and transparent, and promote trust.[75]

5.75 The CALD Strategy's staff capability goals include improving the ability of NDIA staff and partners to understand and respond to the cultural and language needs of participants and how these needs may affect their disability supports. This is to be implemented through an ongoing education program, as

72 National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

73 National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

74 National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, p. 17.

75 National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, pp. 18–19.

well as by supporting employment opportunities for people from CALD backgrounds to improve representation.[76]

5.76 Staff capability is also to be improved through education and training on cultural safety, anti-racism and trauma-informed practice. A CALD inclusion program is to be developed, to promote a culturally safe and inclusive workplace for NDIS staff.[77]

5.77 The NDIA intends to improve the accessibility of its communications across a range of channels, including video, audio and print. The NDIS website, participant portal, and other online resources are to be updated to improve accessibility for CALD participants, including by using information in-language and accessing help when in-language information is not available. The Strategy also has a goal of promoting awareness and accessibility of translation and interpreting services.[78]

5.78 The CALD Strategy's goals on markets are intended to improve the accessibility and supply of culturally safe and linguistically appropriate NDIS services, and to provide better support to CALD participants to find providers that offer those services.[79]

5.79 The Strategy's data goals include working with CALD communities and government agencies to develop a more inclusive definition of CALD. This is intended to inform additional research and data-gathering on participants from CALD backgrounds to enable better evidence-based decision making by NDIS staff, partners and the sector.[80]

5.80 Improvements in outreach are intended to promote greater awareness and understanding of the NDIS and disability in CALD communities. This includes NDIS eligibility, the application process and the potential cultural stigma around disability as a barrier to accessing the NDIS.

5.81 The NDIA's first quarterly report of 2024-25 notes that the Agency has 'begun implementing improvements to enhance the experiences of CALD participants in the NDIS'. The report also identifies staff capability as a key priority in the CALD action plan, to be addressed through the implementation of the NDIA CALD Inclusion Plan 2024–2027. The inclusion plan is designed to improve the capability of the NDIA in four key areas:

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[76] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, p. 20.

[77] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, p. 21.

[78] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, pp. 22–23.

[79] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, p. 24.

[80] National Disability Insurance Agency, *Cultural and Linguistic Diversity Strategy 2024–2028*, p. 26.

- cultural competence and leadership;
- inclusive culture;
- inclusive polity and practice; and
- career development and advancement.[81]

5.82 The NDIA's third-quarter report for 2024-25 indicates that the NDIA 'continues to implement the NDIS CALD Strategy'. The report notes that the NDIA has progressed the Strategy by:

> … improving recruitment practices and training frontline staff. The NDIA's Office of Accessibility and Inclusion continues to engage with and give confidence to candidates from a CALD background who are considering working at the NDIA, by having dedicated information on the NDIS website that explains why the NDIA is an inclusive place to work for CALD people.[82]

5.83 Since the CALD Strategy was published, the NDIA has received feedback from the External Advisory Group established to support the co-design of the Strategy, as well as participants, families and carers. The feedback received emphasises what CALD communities need from the NDIS, including:

- information provided in languages other than English, and alternative formats such as audio and Easy Read;
- access to quality interpreter services;
- transparent reporting on progress against the Strategy; and
- more information about the role of NDIS supports in building independence and capacity, reforms and participant rights.[83]

5.84 The NDIA's third quarter report for 2024-25 notes that it continues to work with the CALD External Advisory Group 'to support and monitor implementation of the strategy'. The Advisory Group was provided with a mid-year progress report, which put forward the following outcomes:

> … the release of the internal NDIA CALD Inclusion Plan, appointment of an SES CALD Champion, establishment of a staff network, and development of a CALD data dashboard.[84]

5.85 The 2024-25 third quarter report concluded that:

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81 National Disability Insurance Agency, *NDIS Quarterly Report to Disability Ministers, Q1 2024-25*, September 2024, p. 22, ndis.gov.au/media/7320/download?attachment (accessed 29 January 2025).

82 National Disability Insurance Agency, *NDIS Quarterly Report to Disability Ministers, Q3 2024-25*, March 2025, p. 23, https://www.ndis.gov.au/media/7685/download?attachment (accessed 22 July 2025).

83 National Disability Insurance Agency, answers to questions on notice, 12 February 2025 (received 28 February 2025).

84 National Disability Insurance Agency, *NDIS Quarterly Report to Disability Ministers, Q3 2024-25*, March 2025, p. 23, https://www.ndis.gov.au/media/7685/download?attachment (accessed 22 July 2025).

> The ongoing implementation of the CALD Strategy and action plan will in part be delivered through or alongside the implementation of NDIS reforms, including the introduction of the new planning framework outlined in the NDIS Act.[85]

5.86 The committee welcomes recent initiatives to ensure that NDIS provides culturally safe services and supports for First Nations and CALD people with disability. The First Nations Strategy and CALD Strategy provide clear plans of action in these areas. The committee will provide ongoing oversight of the implementation of these important reforms.

[85] National Disability Insurance Agency, *NDIS Quarterly Report to Disability Ministers, Q3 2024-25,* March 2025, p. 23, https://www.ndis.gov.au/media/7685/download?attachment (accessed 22 July 2025).

Chapter 6
Committee views and recommendations

6.1 During this inquiry, the committee travelled around the country to hear from NDIS applicants and participants in rural, regional and remote (RRR) areas of Australia to better understand their experience with the NDIS. Throughout the inquiry, the committee heard about the life changing impact the NDIS can have on people with disability. However, the committee also received considerable evidence from applicants, participants, family members and advocacy organisations in RRR areas, describing the challenges and barriers they face in relation to the NDIS.

6.2 This report follows the experiences of people with disability in RRR communities at each stage of the NDIS process, from applying for access to the Scheme, through to developing an NDIS plan, to accessing services and supports under their plan. After hearing directly from communities in RRR areas about these matters and what they require, the committee makes the following recommendations which should help address many of these challenges.

Accessing the NDIS

6.3 The committee received significant evidence about the challenges experienced by people with disability in RRR areas in accessing the NDIS in the first instance. This includes challenges in obtaining information about the Scheme, completing the relevant forms and obtaining the required supporting documentation. The committee heard that meeting these requirements is a daunting and complicated process for many applicants. These challenges, coupled with unstable internet connections, poor digital literacy, and scarcity of resources in many RRR areas, has made the task of accessing the NDIS a significant and overwhelming hurdle.

6.4 The committee heard from many submitters that they would like to see the application process simplified so that it does not present a barrier to the Scheme. The committee acknowledges that this matter was also canvassed in the 2023 Independent Review into the National Disability Insurance Scheme (NDIS Review) and welcomes the implementation of the recommendations proposed by that process, including a simplification of the application process and the language used.

Recommendation 1

6.5 The committee recommends that the National Disability Insurance Agency develop and implement a plan to further simplify and streamline the National Disability Insurance Scheme (NDIS) application process and create and publish accessible guidance materials for rural, regional and remote communities, consistent with the recommendations of the NDIS Review and the evidence received by the committee.

6.6 The committee appreciates that the work of NDIS staff and contractors, including Local Area Coordinators (LACs), can be complex and challenging. Evidence to the inquiry revealed the critical role that LACs in particular play in guiding people through the NDIS process. However, acknowledging the accounts provided in evidence to the inquiry, it is apparent to the committee that there remains significant challenges for NDIS applicants and participants in obtaining support to apply for and navigate the Scheme. To better assist people in these important roles in RRR communities, the committee recommends that LACs be provided with more targeted training and better supports.

6.7 The committee recommends additional training for NDIS staff and contractors including LACs working in RRR communities with a focus on building cultural awareness and competency, as well as a greater understanding of disabilities and working with the disability community in RRR areas. The committee takes the view that this additional training, and the capability that it will provide people in these positions, will better enable them to exercise greater flexibility to ensure they best meet the needs of individual NDIS participants and their communities. It is also the committee's view that this additional training would streamline processes and improve productivity in the long-term.

Recommendation 2

6.8 The committee recommends that the Department of Health, Disability and Ageing and the National Disability Insurance Agency, through co-design with disability communities in rural, regional and remote Australia, develop a training and cultural awareness program for National Disability Insurance Scheme staff and contractors operating in rural, regional and remote (RRR) communities, focusing on:

- **building knowledge and understanding of disability;**
- **developing cultural awareness and competency;**
- **understanding and responding to the challenges for people with disability in RRR communities;**
- **greater flexibility in delivering services to meet the needs of people with disability; and**
- **more access to interpreters in RRR communities.**

6.9 In addition to the challenges faced by people with disability in RRR areas in securing information and support to apply for the NDIS, the committee heard that it can be difficult to get a diagnosis of disability, which is required to access the Scheme. Throughout the inquiry, the committee heard about the limited availability and high costs associated with accessing medical and allied health professionals in RRR areas. The committee was told that this requirement alone was insurmountable for some to continue with their applications to the Scheme. To combat this issue, evidence was received about several effective local initiatives whereby medical professionals travel to RRR communities on a regular basis, for example, the practices highlighted by Far North Community Services in the Kimberly region of Western Australia.

6.10 Such initiatives, which make it easier for applicants to receive a diagnosis without having to travel often significant distances themselves, have community support. These initiatives, and particularly where a range of medical practitioners visit communities together on a regular basis, also provide greater opportunity for people with disability to access the medical and allied health services they require. Therefore, the committee recommends that the Department of Health, Disability and Ageing (DHDA) work with the medical profession and RRR communities to implement similar practices or identify alternative local options to ensure that medical services are accessible to people with disability in RRR communities.

Recommendation 3

6.11 The committee recommends that the Department of Health, Disability and Ageing, in consultation with the National Disability Insurance Agency, work with the medical profession and communities in rural, regional and remote areas to explore practices and initiatives to ensure that people with disability in rural, regional and remote communities obtain timely access to medical and allied health services.

Access to local services and supports

6.12 Throughout the inquiry, the committee received evidence of the value of local place-based services and supports to NDIS participants. Evidence provided revealed that the concept of choice and control, which underpins the NDIS, is significantly undermined when services and supports are not locally available. Unfortunately, access to local services in many communities is limited as thin markets are still prevalent in RRR areas. The committee considered the following options for addressing this ongoing difficulty.

Building a local workforce

6.13 Building and retaining a local workforce is a challenge for providers across rural, regional and remote Australia. Providers told the committee that it can be

difficult to attract and retain workers in RRR areas due to issues of distance and cost of living.

6.14 The committee observes that fly-in, fly-out (FIFO), drive-in, drive-out (DIDO) and telehealth services have an important role to play in providing supports to participants in rural, regional and remote Australia. However, the committee notes a strong preference for local services and supports, delivered by organisations with strong connections to local communities. The committee notes participants spoke of the benefit of a consistent and ongoing workforce that builds trust and rapport within RRR communities.

6.15 The committee received evidence recommending a range of initiatives to help increase the supply of medical professionals, allied health professionals, and NDIS workers in RRR Australia.

6.16 Drawing on this evidence, the committee recognises the need for DHDA to work with the medical profession and NDIS workers and in consultation with disability communities in RRR Australia to consider initiatives to address these shortages.

Recommendation 4

6.17 The committee recommends the Department of Health, Disability and Ageing work with the medical profession, the National Disability Insurance Agency and disability communities in rural, regional and remote (RRR) areas to explore initiatives that could help address shortages of medical professionals, allied health professionals and National Disability Insurance Scheme (NDIS) workers in RRR areas of Australia, including:

- **incentives for NDIS service providers to attract and retain workers based in rural, regional and remote areas;**
- **incentives for medical professionals, allied health professionals and NDIS workers to live and work in rural, regional and remote areas;**
- **incentives and supports for people living in rural, regional and remote areas to undertake local education and training towards medical, allied health or NDIS worker qualifications;**
- **initiatives to attract qualified workers in Australia and overseas to live and work in rural, regional and remote areas; and**
- **working with state and territory skills departments to build capacity and encourage attainment of accreditation in First Nations language interpreting, which builds workforce capacity in rural, regional and remote communities.**

Travel costs

6.18 The committee understands that travel costs represent a significant financial burden on NDIS participants in rural, regional and remote Australia. The committee recognises that price loadings for remote and very remote areas go

some of the way to defraying these expenses. However, the bulk of the evidence to the committee indicates that the costs of travel involved in accessing services can quickly deplete participants' plans. For this reason, this inquiry had a strong focus on investigating initiatives that bring medical professionals, allied health professionals, and NDIS providers to RRR communities in a coordinated manner.

6.19 Remoteness loadings are currently available for services performed in remote communities, but not for services provided in non-remote regional centres for participants who have to travel from remote communities.

6.20 Therefore, the committee recognises the need for the NDIA to consider ways to better coordinate travel of NDIS participants in remote and very remote communities to access the services they require.

Recommendation 5

6.21 The committee recommends that the National Disability Insurance Agency incorporate greater flexibility to facilitate travel for National Disability Insurance Scheme participants who live in remote and very remote areas.

Cultural safety

6.22 The committee recognises the importance of cultural safety for First Nations people and CALD people with disability. Actions to address cultural safety issues are an important part of the national response to both the Disability Royal Commission and the NDIS Review, as well as fulfilling commitments made under the National Agreement on Closing the Gap.

6.23 Evidence to the committee indicates a need for ongoing cultural safety training of staff within the NDIA and within all organisations providing services and supports to NDIS participants from First Nations and CALD backgrounds.

6.24 Consistent with Recommendation 2, the committee holds the view that cultural safety training is fundamentally important.

Recommendation 6

6.25 The committee recommends that the National Disability Insurance Agency develop and publish plans to implement additional First Nations and Culturally and Linguistically Diverse cultural safety training for its staff and partners.

Role of First Nations community-controlled organisations

6.26 Throughout this inquiry, the committee received a significant body of evidence recommending an increased role for First Nations community-controlled organisations in providing culturally safe NDIS services and supports for First Nations people with disability. It was also suggested that, where services can be provided by Aboriginal Community Controlled Health Organisations,

Aboriginal Community Controlled Organisations and Aboriginal Medical Services, this could be a more cost-effective approach than FIFO and DIDO services.

6.27 The committee welcomes the NDIA's commitment in the NDIS First Nations Strategy, underpinned by the National Agreement on Closing the Gap, to engage community-controlled organisations to deliver sustainable, adequately funded, culturally safe and effective disability programs and services for First Nations people with disability and their families and communities.

6.28 Informed by the evidence, the committee is therefore of the view that community-controlled organisations should be given preference in providing NDIS services and supports for First Nations participants for reasons of cultural safety and cost-effectiveness.

Recommendation 7

6.29 The committee recommends that the Department of Health, Disability and Ageing and the National Disability Insurance Agency work with First Nations community-controlled organisations to deliver culturally safe National Disability Insurance Scheme services to First Nations participants as preferred providers.

First Nations languages

6.30 The committee also heard that it is important for information about the NDIS to be made available in First Nations languages, especially in remote and very remote communities.

6.31 The committee welcomes the NDIA's commitment in the First Nations Strategy, to focus on using more straightforward, plain language. However, the Strategy does not appear to specifically address provision of information in First Nations languages. Therefore, the committee recommends that the NDIA take steps to develop materials about the NDIS in First Nations languages, and work with First Nations community-controlled organisations to create opportunities and capacity for First Nations people to undertake interpreter training courses with the aim of working in local RRR communities.

Recommendation 8

6.32 The committee recommends that the National Disability Insurance Agency work in partnership with First Nations community-controlled organisations to develop communications strategies and materials to deliver information about the National Disability Insurance Scheme in First Nations languages, and work with First Nations community-controlled organisations to create opportunities for First Nations people to undertake interpreter training courses.

Cultural safety for CALD people with disability

6.33 The committee heard that cultural safety is also important for CALD people with disability, as identified by the Disability Royal Commission and the NDIS Review.

6.34 Accessibility of information about the NDIS in the participant's own language, as well as services and supports from providers who speak that language, is an important aspect of cultural safety. The committee welcomes the NDIA's intent, as expressed in the CALD Strategy and associated implementation plan, to improve cultural safety for CALD people with disability, and calls for the development of more materials in community languages.

Recommendation 9

6.35 The committee recommends that the National Disability Insurance Agency collaborate with Culturally and Linguistically Diverse peak organisations to:

- **improve communications strategies and materials to deliver information about the National Disability Insurance Scheme in community languages; and**
- **improve accessibility and diversity of services from Culturally and Linguistically Diverse providers in rural, regional and remote Australia.**

Alternative Commissioning

6.36 As discussed in Chapter 4 of this report, alternative commissioning enables a flexible, place-based and culturally safe approach to delivering the NDIS that addresses a community's specific needs. It is widely believed that alternative commissioning will enable more NDIS participants to access services under their plans that would otherwise be unavailable or too costly for them to access where they live.

6.37 Many submitters to the inquiry expressed strong support for the use of alternative commissioning in remote and First Nations communities, including state and territory governments, peak bodies, advocacy organisations and service providers. Similarly, the NDIS Review recommended alternative commissioning arrangements be rolled out for First Nations participants across Australia and for all participants in remote communities, in partnership with First Nations representatives, communities, participants and relevant government agencies. The committee is aware of the alternative commissioning trials taking place in Maningrida in the Northern Territory, and Katanning in Western Australia, which are believed to have increased community engagement with NDIS supports and services.

Recommendation 10

6.38 The committee recommends that the Department of Health, Disability and Ageing and the National Disability Insurance Agency conduct a review of the current alternative commissioning trials, including drawing on the Maningrida and Katanning experience, with a view to understanding best practice before expanding these arrangements to other remote and First Nations communities, in partnership with First Nations representatives and communities.

Ms Libby Coker MP
Chair
Member for Corangamite

Coalition's Additional Comments

1.1 The Coalition expresses their appreciation to all witnesses who gave evidence at public hearings, and to the individuals and organisations who provided submissions to this inquiry.

1.2 Many organisations and individuals who provided evidence to the inquiry raised significant concerns about travel costs and the potential for poorly designed or hastily implemented transport pricing arrangements to create barriers to accessing the Scheme.

1.3 The Coalition remains critical of the Government's decision to announce major changes under the Pricing Arrangements and Price Limits for 2025-26 with only two weeks' notice to participants and providers.

1.4 It is unreasonable to expect NDIS providers and participants to make the necessary adjustments to service delivery within such a compressed timeframe, particularly given that many affected providers are small businesses.

1.5 The NDIA has effectively acknowledged that the notice period was insufficient and will adjust the Annual Pricing Review timeframe to ensure more effective implementation and earlier advice to the sector.

1.6 The Coalition remains particularly concerned about the scope and impact of the changes relating to the claiming of transport costs.

1.7 In response to these concerns, the Shadow Minister for Disability and the NDIS and the Shadow Assistant Minister for the NDIS wrote to the Minister for Disability and the NDIS, the Hon Mark Butler MP, urging the Government to defer the changes for at least three months. This would have allowed for proper consultation and planning regarding the consequential adjustments to service delivery, which could be substantial. The Government, however, chose to ignore this request.

1.8 While the Coalition acknowledges and welcomes that no changes have been made to transport pricing arrangements for providers operating in remote and very remote areas, we note with concern that providers in regional areas remain subject to the new transport pricing changes.

1.9 The Coalition will continue to closely monitor the effects of removing the remote and very remote loadings for plan managers; loadings originally designed to address barriers in thin markets. Although some services can be delivered virtually, in-person service delivery remains the gold standard for effective coordination and high-quality care. No NDIS participant should be disadvantaged simply because of where they live.

Recommendation 1

1.10 The National Disability Insurance Agency should ensure that any future pricing changes are announced with a minimum of three months' notice prior to their commencement date.

Senator Maria Kovacic
Deputy Chair
Liberal Senator for New South Wales

Appendix 1
Submissions and additional information

1 Department of Social Services
2 Northern Territory Government
3 Australian National Audit Office
4 Public Health Association of Australia and Familycare
5 Miwatj Health Aboriginal Corporation
6 Dr David Walker, Dr Archana Pradhan and Dr Silvana Bettiol
7 Australian Psychosocial Disability Collective
- 7.1 Supplementary to submission 7

8 Aboriginal Health & Medical Research Council of NSW
9 Uniting WA
10 Services for Australian Rural and Remote Allied Health
11 Vision 2020 Australia
12 Centre for Excellence in Child and Family Welfare
13 Centre for Disability Research and Policy, University of Sydney
- Attachment 1

14 AEIOU Foundation
15 Consumers Of Mental Health WA
16 CRANAplus
17 Women With Disabilities Australia
18 Royal Australian College of General Practitioners (RACGP)
19 Victorian Rural Advocacy Network (VicRAN)
20 Vision Australia
21 Disability Advocacy (NSW)
22 Gidgee Healing
23 Rare Voices Australia
24 PCC Alliance
25 Vertaview Group
26 Summer Foundation
27 Deaf Australia
28 Grampians disAbility Advocacy
29 Australian Lawyers Alliance
30 Lived Experience Australia
31 Australian Psychological Society
32 National Disability Services
33 PRECI - Professionals and Researchers in Early Childhood Intervention
34 Mental Health Australia
35 Carers WA
36 Kin Disability Advocacy Inc

37 BAM Disability Services
38 Disability Rights Advocacy Service
39 Dementia Australia
40 Mental Health Carers NSW
41 Commonwealth Ombudsman
42 CatholicCare NT
43 Darwin Community Legal service
44 Lavender Co
45 Blind Citizens Australia
46 Neurological Alliance Australia
47 Limbs 4 Life Incorporated
48 Australian Services Union
49 Queenslanders with Disability Network (QDN)
50 HR Plus Tasmania
51 Assistive Technology Suppliers Australia
52 Community Living Australia
53 Royal Far West
54 Strive Disability Support Services
55 Serendipity Support Services
56 Mable Technologies
57 Challenge Community Services
58 University of Adelaide
59 Royal Australian and New Zealand College of Psychiatrists
60 Central Australian Aboriginal Congress

- Attachment 1

61 Children's Tumour Foundation
62 Empowrd Pty Ltd
63 Advocacy WA

- Attachment 1

64 Office of the Public Advocate Victoria
65 Tasmanian Government
66 Australian Association of Psychologists Incorporated
67 Community Bridging Services (CBS) Inc.
68 South Australian Health & Medical Research Institute
69 Carers NSW
70 National Indigenous Australians Agency

- Attachment 1

71 Tandem

- 71.1 Supplementary to submission 71

72 Disability Advocacy Network Australia
73 Ms Rhiannon Hudson
74 Griffith University

75 National Rural Women's Coalition
76 Speech Pathology Australia
77 Royal Flying Doctor Service of Australia
78 Kiind
79 Bankwest Curtin Economics Centre (BCEC)
- Attachment 1
- Attachment 2

80 Outback Independent Living
81 Marathon Health
82 National Regional, Rural, Remote and Very Remote Community Legal Network
83 Health Services Union (HSU)
84 Monash Business School
85 First Peoples Disability Network (FPDN)
- Attachment 1
- Attachment 2
- Attachment 3

86 South West Autism Network
87 National Legal Aid
88 Western Australian Government
89 MS Australia
90 National Rural Health Alliance and Office of the National Rural Health Commissioner
91 Australia Federation of Disability Organisations (AFDO)
92 National Aboriginal Community Controlled Health Organisation (NACCHO)
93 People With Disabilities WA
94 Name Withheld
95 Name Withheld
96 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council
97 Name Withheld
98 Mala'la Health Service
99 Ms Cat Walker
100 Outback Disability Services
101 Deafblind Australia
102 Rights Information and Advocacy Centre Incorporated
103 Lifely

Additional Information

1 Table linking themes and recommendations in Darwin Community Legal Service (DCLS) submission to the inquiry's Terms of Reference, Darwin, 16 April 2024.

2 Organisations endorsing the submission of the National Regional, Rural, Remote and Very Remote Community Legal Network (4Rs Network), Darwin, 16 April 2024.

3 Submission in response to NDIS Thin Markets Project Discussion Paper prepared by Aboriginal Medical Services Alliance Northern Territory (AMSANT) Aboriginal Corporation, Darwin, 16 April 2024.

4 Statement prepared by Ms Helen and Ms Christina Pachos, Darwin, 16 April 2024.

5 Opening statement prepared by National Disability Services (NDS), Canberra, 28 June 2024.

Answers to Questions on Notice

1 Danila Dilba Health Service - Answers to questions taken on notice at a public hearing on 16 April 2024, Darwin (received 22 April 2024)

2 National Regional, Rural, Remote and Very Remote (4Rs) Network - Answers to questions taken on notice at a public hearing on 16 April 2024, Darwin (received 15 May 2024)

3 Aboriginal Medical Services Alliance Northern Territory - Answers to questions taken on notice at a public hearing on 16 April 2024, Darwin (received 15 May 2024)

4 CatholicCare NT - Answers to questions taken on notice at a public hearing on 16 April 2024, Darwin (received 17 May 2024)

5 Northern Territory Government - Answers to questions taken on notice at a public hearing on 16 April 2024, Darwin (received 20 June 2024)

6 Far North Community Services - Answers to questions taken on notice at public hearing on 18 April 2024, Broome (received 17 May 2024)

7 Government of Western Australia - Answers to questions taken on notice at a public hearing on 18 April 2024, Broome (received 20 May 2024)

8 Government of Western Australia - Answers to questions taken on notice at a public hearing on 18 April 2024, Broome (received 20 May 2024)

9 Speech Pathology Australia - Answers to questions taken on notice at a public hearing on 28 June 2024, Canberra (received 17 July 2024)

10 Emerge Australia - Answers to questions taken on notice at a public hearing on 28 June 2024, Canberra (received 18 July 2024)

11 National Disability Insurance Agency - Answers to questions taken on notice at a public hearing on 28 June 2024, Canberra (received 19 July 2024)

12 National Disability Insurance Agency - Answers to questions taken on notice at a public hearing on 28 June 2024, Canberra (received 19 July 2024)

13 First Peoples Disability Network - Answers to questions taken on notice at a public hearing on 28 June 2024, Canberra (received 30 July 2024)

14 NSW Health - Answers to questions taken on notice at a public hearing on 17 October 2024, Dubbo (received 4 November 2024)

15 Department of Social Services - Answers to questions taken on notice (received 28 February 2025)

16 National Disability Insurance Agency - Answers to questions taken on notice (received 28 February 2025)

17 NDIS Quality and Safeguards Commission - Answers to questions taken on notice (received 28 February 2025)

Media Releases

1 Public hearing in Darwin, 16 April 2024

2 Public hearing in Broome, 18 April 2024

3 Public hearing in Canberra, 28 June 2024

4 Public hearings in Dubbo, 17 October 2024 and Bendigo, 1 November 2024

Tabled Documents

1 Overview, key issues and case studies prepared by Mount Alexander Shire Council, Bendigo, 1 November 2024

2 Speaking notes prepared by Bendigo Community Health Services, Bendigo, 1 November 2024

Appendix 2
Public Hearings and witnesses

Tuesday 16 April 2024
Hilton Darwin
32 Mitchell Street, Darwin

Northern Territory Government
- The Hon Ngaree Ah Kit, Minister for Disability
- Ms Samantha Livesley, General Manager, Community Participation, Department of Territory Families, Housing and Communities
- Ms Bryony Bree, Executive Director, Social Inclusion, Department of Territory Families, Housing and Communities

Darwin Community Legal Service
- Ms Ros Harrison, Managing Solicitor
- Ms Anne McKinstray, Senior Disability Advocate

National Regional, Rural, Remote & Very Remote Community Legal Network
- Ms Judy Harrison, Co-Convenor
- Ms Cheryl Rosales, Solicitor Disability Advocacy Service, Uniting Communities Law Centre, South Australia
- Mr Brodie Lewis, Business Manager, Great Southern Community Legal Services
- Ms Denise Kay, Senior Disability Advocate, Great Southern Community Legal Services

Aboriginal Medical Services Alliance Northern Territory
- Dr John Paterson, Chief Executive Officer
- Dr Jenny Summerville, Policy, Research & Advocacy Manager

Danila Dilba Health Service
- Ms Kate Finegan, Senior Manager - Chronic Disease
- Ms Julie Brown, NDIS Support Officer

Miwatj Health Aboriginal Corporation
- Mr Steve Rossingh, Chief Executive Officer
- Mr Tom Poutu, NDIS Team Leader

Mala'la Health Service Aboriginal Corporation
- Ms Lesley Woolf, Executive Health Manager
- Ms Diane Soloman, NDIS Coordinator

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council

- Ms Kim McRae, Tjungu Team Manager

CatholicCare NT

- Ms Judy Davis, General Manager Corporate Services

Outback Disability Services

- Ms Mandinyara Munamati, Clinical Manager

Disability Advocacy Service

- Ms Merrilee Cox, General Manager

Integrated disAbility Action

- Ms Janet Wright, Chief Executive Officer
- Mr Lachlan Rowe, Advocate

Statements from people with lived experience of disability and the NDIS

- Ms Helen Pachos and Ms Christina Pachos

Thursday 18 April 2024

Oaks Broome Hotel
99 Robinson Street, Broome

Western Australian Government

- Ms Sheila-Anne Macleod, Director, Disability Practice Support

Aboriginal Legal Service of Western Australia

- Mr Paul Tobin, Managing Lawyer
- Ms Sasha Greenoff, Manager, Youth Engagement Program
- Mr Mark Panaia, Team Leader, Bail Support Service

Kimberley Aboriginal Medical Services and Kimberley Supports Consortium

- Mr Oskar Stenseke, Kimberley Supports Senior Manager

Broome Regional Aboriginal Medical Service

- Ms Melanie Prewett, NDIS Manager

Balanced Coordination Support Services

- Mr Damian Hale, Founder

Community Statement

- Mr Victor Patrick

Far North Community Services

- Ms Kathy Hough, Chief Executive Officer
- Dr Rebecca Hunt, Therapy Manager

Nirrumbuk Environmental Health and Services

- Mr Ray Christophers, Chief Executive Officer
- Ms Rhondda Chappell, Quality and Compliance

Kin Disability Advocacy

- Ms Cheryl Ozies, Regional Advocacy Officer
- Ms Christine Grace, Advocacy Services Manager

Kimberley Therapy Services

- Ms Brooke Lowry, General Manager
- Ms Yasmin Ralph, Specialist Support Coordination

Friday 28 June 2024

Committee Room 2S1
Parliament House Canberra

Blind Citizens Australia

- Dr Corey Crawford, National Policy Officer
- Mr Mark Warrington, National Policy Committee member
- Mr Ross Hurford, National Policy Committee member

Vision 2020 Australia

- Mr Jonathan Craig, Policy Advisor

Rare Voices Australia

- Ms Fiona Lawton, Disability Advocacy Manager
- Ms Louise Healy, Education and Advocacy Manager

Neurological Alliance Australia

- Ms Anne Wilson, CEO, Emerge Australia and Deputy Chair, Neurological Alliance Australia
- Ms Sue Donaldson, Team Leader, MND NSW

MS Australia

- Ms Katie Snell, National Policy Manager

Limbs 4 Life Incorporated

- Ms Melissa Noonan, CEO

National Disability Services

- Ms Emily Forrest, Deputy CEO
- Mr Benjamin Keast, CEO, Arc Disability Services, Inc.

Speech Pathology Australia

- Ms Jodie Long, Chief Executive Officer
- Ms Erin West, Senior Policy Officer

Australian Psychosocial Disability Collective

- Ms Kristin Gillespie, Member
- Ms Zoe Mithen, Member

National Mental Health Consumer & Carer Forum

- Ms Jordan Frith, Deputy Consumer Co-Chair
- Mr Ebenezer Swan, Senior Policy and Project Officer

Tandem

- Ms Marie Piu, Chief Executive Officer
- Ms Sarah Irving, Manager Policy and Advocacy
- Ms Amaya Alvarez, Manager Research
- Ms Renee Leary, Research Officer
- Ms Joanna Pankhurst, Senior Policy and Project Officer

Lived Experience Australia

- Professor Sharon Lawn, Executive Director
- Ms Krysti-Lee Patterson, Chair

Central Australian Aboriginal Congress

- Ms Melanie Churchill, NDIS Allied Health Services Manager / Occupational Therapist, Allied Health
- Mr Andrew Jolly, Manager, Allied Health
- Mr Frank Curtis

First Peoples Disability Network (FPDN)

- Mr Damian Griffis, Chief Executive Officer
- Ms Tahlia-Rose Vanissum, National Policy & Systemic Advocacy Manager

Aboriginal Health & Medical Research Council of NSW

- Ms Nicole Turner, Chief Executive Officer

National Disability Insurance Agency

- Ms Fleur Hill, A/g Deputy CEO Service Delivery
- Ms Tanya Malthouse, Branch Manager, First Nations
- Mr Mark Wiggins, Branch Manager, Market Stewardship

Thursday 17 October 2024

Savannah Function Centre
Taronga Western Plains Zoo
Obley Road, Dubbo

Western NSW Local Health District

- Mr Mark Spittal, Chief Executive

NSW Ageing and Disability Commission

- Ms Kathryn McKenzie, Acting Commissioner

Gilgandra Shire Council

- Mr David Neeves, General Manager
- Ms Donna Dobson, Director of Aged Care and Disabilities

Parkes Shire Council

- Mayor Neil Westcott
- Cr Doug Pout, Councillor

Bamara

- Ms Simone Deveigne, NDIS Operations Manager

Regional Medical Specialists Association

- Assoc Prof Steve Flecknoe-Brown, President

Social Futures

- Mr Tony Davies, Chief Executive Officer
- Miss Shayne Toussaint, General Manager Disability Inclusion
- Ms Linda Walsh, Senior Manager of Western Service Area

Friday 1 November 2024

Quality Hotel Lakeside
286 Napier Street, Bendigo

Mount Alexander Shire Council

- Ms Rosalie Rogers, Manager Community Wellbeing
- Ms Philippa Calwell, Access and Support Officer

Intereach

- Ms Jessica Dodd, Senior Manager Early Childhood
- Ms Kerri-Anne Hyde, Senior Manager Local Area Coordination

Bendigo and District Aboriginal Cooperative

- Mr Josh Hercus, Aged Care Team Leader

Bendigo Community Health Services

- Ms Mandy Hutchinson, Chief Executive Officer

Rights Information and Advocacy Centre

- Dr Sandy Ross, Chief Executive Officer
- Ms Alex Riemers, Member, Lived Experience Advisory Committee
- Dr Anna Fry, Senior Advocate/Team Leader
- Ms Christie Stewart, Access and Support Officer and ILC Project Officer
- Ms Loretta O'Neill, First Nations Advocate

Golden City Support Services

- Ms Natasha Williams, Chief Executive Officer

Lifely

- Ms Janette Martin, Chief Executive Officer

Appendix 3
Participants by remoteness

1.1 The data in the following tables was sourced from National Disability Insurance Agency's *Explore Data* tool.[1]

Figure 3.1 NDIS participants by remoteness – National

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	All Australia	Major Cities	507,128
Q4 FY24/25	All Australia	Population > 50,000	80,197
Q4 FY24/25	All Australia	Population between 15,000 and 50,000	60,500
Q4 FY24/25	All Australia	Population between 5,000 and 15,000	32,770
Q4 FY24/25	All Australia	Population less than 5,000	47,237
Q4 FY24/25	All Australia	Remote	6,784
Q4 FY24/25	All Australia	Very Remote	4,436
Q4 FY24/25	All Australia	Missing	361

Figure 3.2 NDIS participants by remoteness – NSW

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	NSW	Major Cities	153,116
Q4 FY24/25	NSW	Population > 50,000	6,717
Q4 FY24/25	NSW	Population between 15,000 and 50,000	29,010
Q4 FY24/25	NSW	Population between 5,000 and 15,000	12,884
Q4 FY24/25	NSW	Population less than 5,000	15,350
Q4 FY24/25	NSW	Remote	733
Q4 FY24/25	NSW	Very Remote	92
Q4 FY24/25	NSW	Missing	< 11

[1] National Disability Insurance Agency, *Explore Data*, dataresearch.ndis.gov.au/explore-data (accessed 28 October 2025). Data provided from Quarter 4, 2024/25.

Figure 3.3 NDIS participants by remoteness – VIC

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	VIC	Major Cities	144,859
Q4 FY24/25	VIC	Population > 50,000	19,473
Q4 FY24/25	VIC	Population between 15,000 and 50,000	13,091
Q4 FY24/25	VIC	Population between 5,000 and 15,000	10,597
Q4 FY24/25	VIC	Population less than 5,000	11,479
Q4 FY24/25	VIC	Remote	70
Q4 FY24/25	VIC	Very Remote	0
Q4 FY24/25	VIC	Missing	< 11

Figure 3.4 NDIS participants by remoteness – QLD

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	QLD	Major Cities	98,653
Q4 FY24/25	QLD	Population > 50,000	35,284
Q4 FY24/25	QLD	Population between 15,000 and 50,000	5,860
Q4 FY24/25	QLD	Population between 5,000 and 15,000	6,347
Q4 FY24/25	QLD	Population less than 5,000	10,346
Q4 FY24/25	QLD	Remote	1,447
Q4 FY24/25	QLD	Very Remote	1,314
Q4 FY24/25	QLD	Missing	< 11

Figure 3.5 NDIS participants by remoteness – WA

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	WA	Major Cities	51,330
Q4 FY24/25	WA	Population > 50,000	3,343
Q4 FY24/25	WA	Population between 15,000 and 50,000	3,898
Q4 FY24/25	WA	Population between 5,000 and 15,000	< 738
Q4 FY24/25	WA	Population less than 5,000	2,803
Q4 FY24/25	WA	Remote	1,839
Q4 FY24/25	WA	Very Remote	< 1072
Q4 FY24/25	WA	Missing	< 11

Figure 3.6 NDIS participants by remoteness – SA

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	SA	Major Cities	47,140
Q4 FY24/25	SA	Population > 50,000	1,268
Q4 FY24/25	SA	Population between 15,000 and 50,000	5,800
Q4 FY24/25	SA	Population between 5,000 and 15,000	2,139
Q4 FY24/25	SA	Population less than 5,000	4,830
Q4 FY24/25	SA	Remote	1,135
Q4 FY24/25	SA	Very Remote	522
Q4 FY24/25	SA	Missing	< 11

Figure 3.7 NDIS participants by remoteness – TAS

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	TAS	Major Cities	0
Q4 FY24/25	TAS	Population > 50,000	10,382
Q4 FY24/25	TAS	Population between 15,000 and 50,000	2,841
Q4 FY24/25	TAS	Population between 5,000 and 15,000	< 73
Q4 FY24/25	TAS	Population less than 5,000	2,345
Q4 FY24/25	TAS	Remote	158
Q4 FY24/25	TAS	Very Remote	< 42
Q4 FY24/25	TAS	Missing	0

Figure 3.8 NDIS participants by remoteness – ACT

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	ACT	Major Cities	12,030
Q4 FY24/25	ACT	Population > 50,000	< 11
Q4 FY24/25	ACT	Population between 15,000 and 50,000	0
Q4 FY24/25	ACT	Population between 5,000 and 15,000	0
Q4 FY24/25	ACT	Population less than 5,000	0
Q4 FY24/25	ACT	Remote	0
Q4 FY24/25	ACT	Very Remote	0
Q4 FY24/25	ACT	Missing	< 11

Figure 3.9 NDIS participants by remoteness - NT

Period	State/Territory	Remoteness Rating	Active participants
Q4 FY24/25	NT	Major Cities	0
Q4 FY24/25	NT	Population > 50,000	3,719
Q4 FY24/25	NT	Population between 15,000 and 50,000	0
Q4 FY24/25	NT	Population between 5,000 and 15,000	0
Q4 FY24/25	NT	Population less than 5,000	< 87
Q4 FY24/25	NT	Remote	1,402
Q4 FY24/25	NT	Very Remote	< 1332
Q4 FY24/25	NT	Missing	< 11