# POPH90206 Assignment 2: Service Eligibility and Access Inequities

Australia's National Disability Insurance Scheme (NDIS)

Word Count: 3128

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### 1.1 NDIS Overview

The *National Disability Insurance Scheme (NDIS)* is a scheme developed by the Australian government for funding necessary and reasonable support for permanently disabled individuals under the age of 65 (Morgan et al., 2024). The scheme was first introduced in the year 2013 following the "*Make it Real*" community campaign and aims to support the disability groups (Morgan et al., 2024). It is governed by the *National Disability Insurance Scheme Act 2013* and is administered by the *National Disability Insurance Agency* as part of the *Department of Health, disability and Ageing,* and was officially launched in 2016 (Morgan et al., 2024).

The NDIS model allocates funds to an individual, with the individual, their private plan managers or guardian, purchasing services and goods from suppliers. The scheme is non-means tested and publicly funded, with the recipients not contributing to or purchasing from the scheme directly. The NDIS is independent of any state and territory disability programs and the disability support pension, even though the services provided by the NDIS might help individuals to access these supports (Lai et al., 2025). The NDIS also provides funds exclusively for disability support and non-healthcare-associated costs, which continue to remain publicly funded under the state and territory government health services and Medicare services.

*Figure 1: Categories of support budgets described within an NDIS plan (Source: Morgan et al., 2024)*

The supports that are funded by NDIS can be categorized across three distinct areas, as shown in *Figure 1- core support* (including everyday consumable items like personal care assistance, continence aids, funding for support and support with community and social participation), *capacity building* (intended for building the ability of the individual to manage their own life and acquired disability independence) and *capital support* (with that budget intended for significantly expensive assistive technology or vehicle and home modifications) (Lai et al., 2025). The information linkages and capacity-building programs focus on supporting Australians living with disability by providing financial grants to institutions for promoting community and economic involvement. This includes projects that focus on improving the accessibility of mainstream society and individual capacity (Morgan et al., 2024). The NDIS participants have also acquired support for running micro-enterprise businesses by means of the ILC program (Morgan et al., 2024).

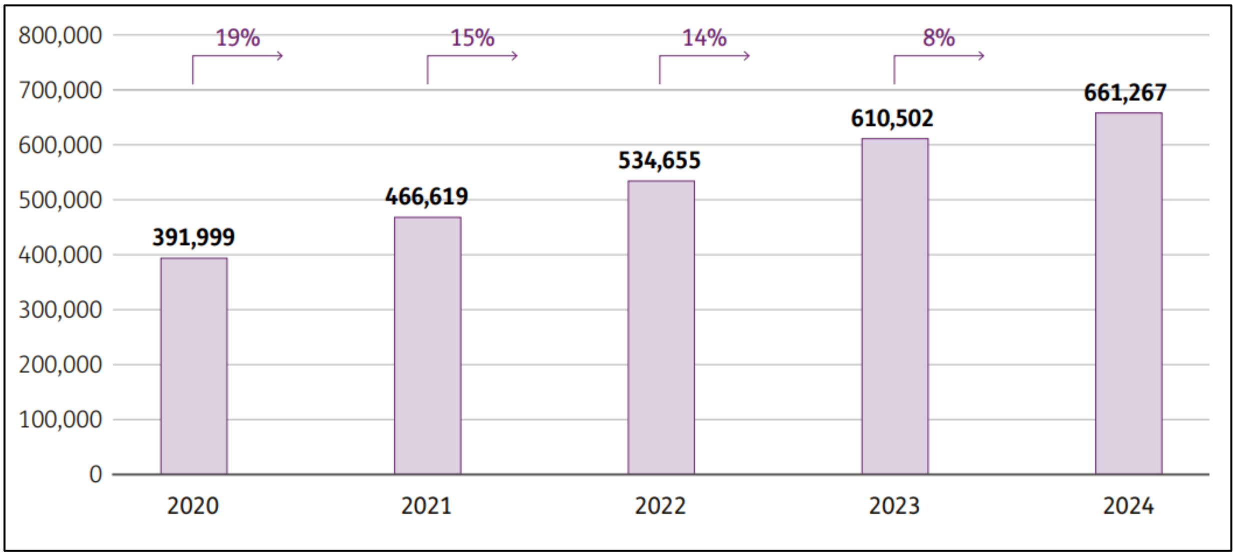

*Figure 2: Active participants with approved plans and percentage increase over time for years ending 30 June (Source: National Disability Insurance Agency, 2024)*

The NDIS have a direct impact on population health because by funding the assistive technology, allied health services and personal care of disabled individuals, the scheme addresses the functional and immediate population healthcare needs. The scheme also helps in supporting the mental health outcomes of the target population through enhancement in social participation, independence and reduction in career stress. NDIS supports generating feasible health benefits at the population level, which includes improvement in quality of life, reduction in hospitalization rates, moderating emergency department presentations and improvement in community integration. In the year 2024, it was estimated that NDIS made 300,000 to 500,000 payments daily, with the active participants' rates increasing steadily per year, as shown in *Figure 2.* Currently, it is considered to be the second-largest claim system under the Australian government, supporting approximately 717,001 people in Australia (NDIS, 2025).

## 1.2 Target Population

The NDIS provides funding to Australians having significant and permanent disabilities to enable them to lead ordinary lives (Morgan et al., 2024). NDIS is not a universal disability support scheme but is a targeted scheme having specific eligibility criteria. The criteria for eligibility for NDIS include the following:

- ***Age requirements***: The claimant has to be between the ages of 9 to 65 (NDIS, 2025).
- ***Residence requirements***: The claimant has to be an Australian citizen, a protected special category visa holder or a permanent resident of Australia (NDIS, 2025).
- ***Disability requirement*** - The claimant must have a permanent disability, including cognitive, intellectual, sensory, neurological, psychosocial or physical disability (NDIS, 2025).

The following report aims to provide a comprehensive review of the inequities perpetuated by NDIS, with a focus on how some groups in society experience inequalities in accessing and eligibility for the services provided by the scheme.

## 2. Literature Review: Barriers to Government Service Access

Despite the broad scope of the *National Disability Insurance Scheme (NDIS)*, the processes of acquiring eligibility and accessing the services of NDIS have been perceived to be complicated by the target population (Phuong, 2017; Mellifont et al., 2023). It is reasonable to expect that a disability funding body would make accommodations based on the needs of the participants, particularly since NDIS states that the core of its philosophy is person-centered care (Zubrinich et al. 2024). However, there are still significant barriers that prevent equitable participation across different population groups, which is a common trend that is noticeable across the majority of government services or schemes.

Access to government services is influenced by intersecting systems of disadvantage that create compounded barriers for the vulnerable population. According to the *Behavioral Model of Health Services Use* by Anderson, there are several predisposing factors (such as social structure, demographics, and beliefs), enabling factors (like community and personal resources) and need factors, which interacts with one another for determining the service utilization (Lederle et al., 2021). This model indicates that access to disability benefits or healthcare schemes is not simply related to service availability but is rather impacted by complicated interactions between structural barriers and individual characteristics that systematically advantage or disadvantage certain population groups (Lederle et al., 2021).

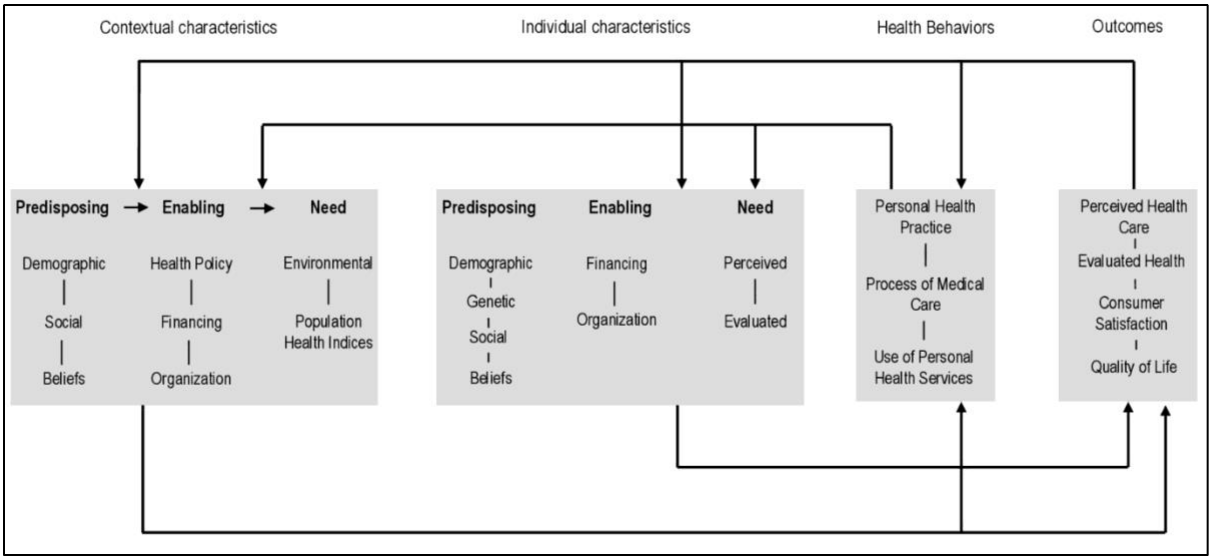

*Figure 3: Behavioral Model of Health Services Use (Source: Lederle et al., 2021)*

This is particularly noticeable in the case of NDIS services, with participants belonging to the indigenous population facing systemic barriers like geographical isolation, impacting their ability to access the benefits of the scheme.

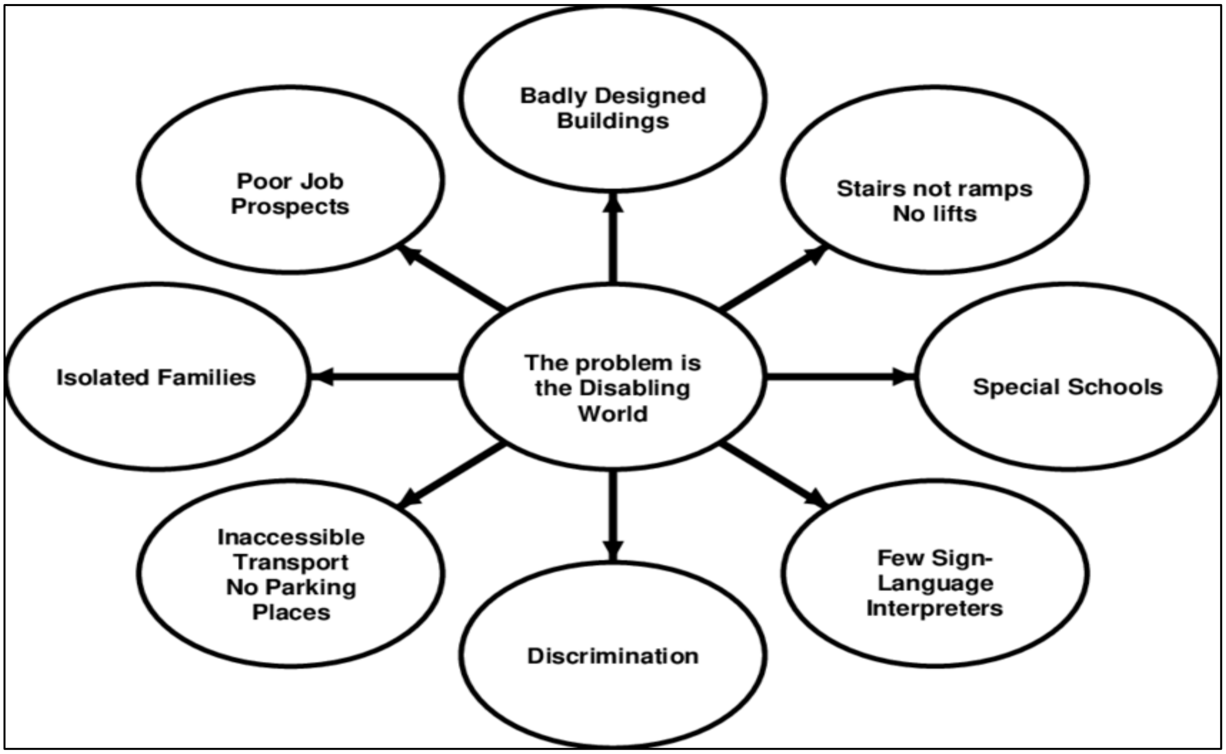

*Figure 4: Social model of disability (Source: Banerjee, 2021)*

Another major barrier to the establishment of equality in the distribution of benefits of government services or healthcare schemes is related to the lack of knowledge among healthcare workers. This gap in the knowledge of the healthcare workers can be explained by the *Social Model of Disability*, which identifies systemic barriers, social exclusion and derogatory attitudes to be the primary factors that make it difficult or impossible for disabled individuals to attain their valued functioning (Morgan, 2012).

The model highlights how the barriers to disability schemes for individuals with psychosocial and intellectual disability can be classified as systemic and societal failures rather than individual deficits (Islam & Cojocaru, 2015). Even though sensory, physical, psychological and intellectual variations might result in individual functional differences, these should necessarily lead to disability unless society fails to include or take into account people intentionally concerning their individual needs (Miles, 2011).

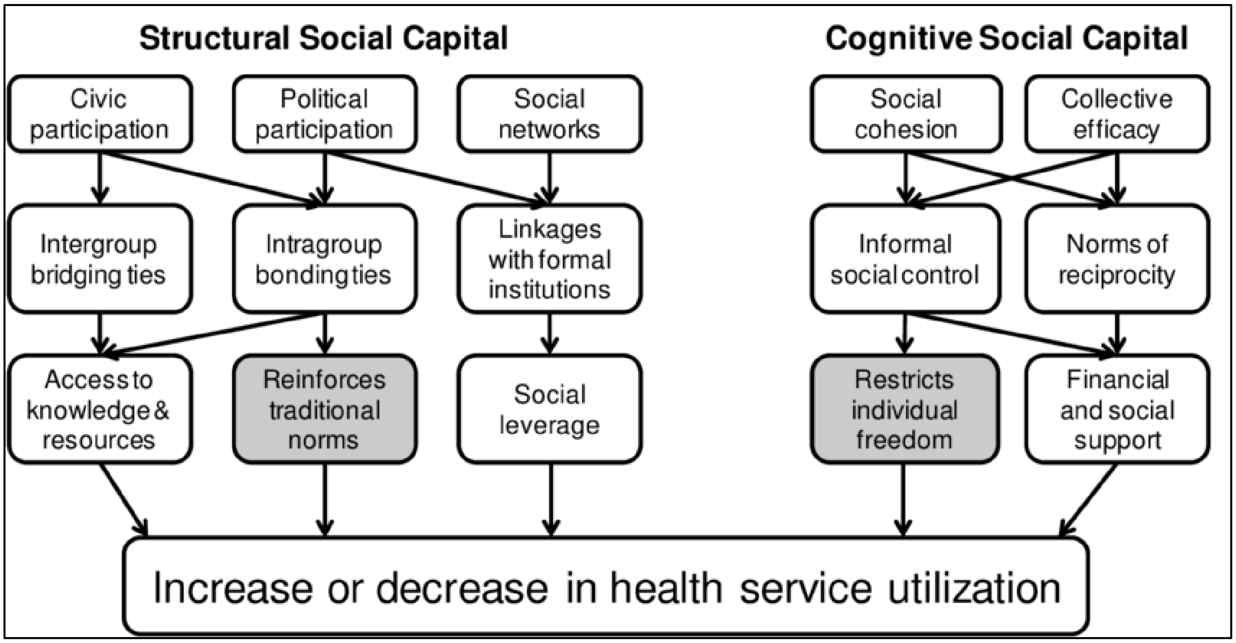

*Figure 5: Conceptual framework for the relationship between social capital and health service utilization (Source: Story, 2013)*

The *Theory of Social Capital* also provides information regarding how economic, cultural and social resources impact service accessibility (*Figure 5*). Individuals with greater social capital have the knowledge, skills and networks that are required for understanding the comprehensive and complicated bureaucratic systems, while those who do not have these resources face systematic disadvantage (Laporte et al., 2008). This theoretical framework indicates how seemingly neutral application processes might induce existing inequalities by making it necessary to have cultural capital that is not equally distributed across the population. This is particularly evident in the form of geographic isolation to government service access, particularly impacting the remote and rural population. Research has consistently highlighted that distance from the service centers correlates with the reduction in service utilization across different government programs, including the NDIS (Triffitt, n.d.). Rural populations face accessibility barriers like travel costs, physical distance and time constraints, which introduce inequities in the healthcare system (Triffitt, n.d.).

Moreover, the digital capital accessibility also increases the barriers brought by the geographic isolation, with remote and rural areas often having lower digital literacy rates and limited internet connectivity. Government services are dependent on digital communication and online platforms, which creates additional barriers for the population who are already disadvantaged because of geographic isolation (Correa & Pavez, 2016). While digitalization helps in improving efficiency, it inadvertently causes disproportionate impact on older adults, socioeconomically disadvantaged populations and Indigenous communities (Correa & Pavez, 2016). Indigenous communities face specific geographic barriers, with many communities located in areas having limited service available and transport infrastructure, something that is also noted in the case of NDIS accessibility (Triffitt, n.d.).

Moreover, cultural competency in service delivery also has an extensive impact on the accessibility of the service benefits for the linguistically and culturally diverse population. According to the Multicultural Counselling Framework, services are designed for the dominant cultural groups, which often fail to meet the needs of the minority population, inadvertently creating systematic exclusion (Jaladin et al., 2021).

Language barrier is a primary accessibility issue, with individuals having limited English proficiency acquiring reduced government services in service benefits across multiple domains (Jaladin et al., 2021). For the indigenous population and the population belonging to the lower socio-economic strata, the cultural barriers extend beyond the language issues, comprising different conceptual frameworks for understanding disability, health and social support (Cerna et al., 2021).

Particular groups are often unfairly treated because of the prejudice in the way legal procedures, policies and practices are developed and designed. Factors such as ethnicity, education and gender lead to institutional discrimination. Eligibility criteria also serve as a way to prevent people from getting equal health service benefits. Requirements for eligibility may appear to be neutral on the surface, but they usually create differences among various population groups (Bohren et al., 2022).

In 1989, Crenshaw introduced the intersectionality theory, which explains how several kinds of marginalization collectively affect some individuals (Losleben & Musubika, 2023). Indigenous people in remote areas, women with disabilities, and elderly individuals having non-English speaking backgrounds face unique combinations of barriers that cannot be comprehended by analyzing a single characteristic in isolation. The cumulative impact of these different barriers creates capability deprivation by systematically reducing the abilities of individuals to achieve valued functioning because of structural constraints rather than personal choices.

## 3. Structured Analysis: NDIS-Specific Barriers

### 3.1 Eligibility Assessment Barriers

NDIS eligibility requires meeting three criteria: age (9-65 years), Australian residency (citizen, permanent resident, or protected visa holder), and permanent disability (cognitive, intellectual, sensory, neurological, psychosocial, or physical). There are more than 4.3 million Australians having disabilities, but NDIS applicants only range to 700,000 individuals (Super Claim Assist, n.d.).People who can benefit from NDIS are systematically excluded.

A large portion of this significant gap between the actual disability population and the total help provided by NDIS can be associated with the eligibility cutoffs of NDIS. NDIS provides funds to only those individuals who suffer from "permanent" disability (Mellifont et al., 2023). This criterion makes it difficult for individuals with psychosocial disability or intellectual disability to apply for NDIS. This is because psychosocial disability or intellectual disabilities are often episodic, making it difficult to meet the permanent impairment criteria (Soldatic et al., 2014). On top of this, discrimination and stigma also impact both the ongoing support and application process, which further deters individuals with psychosocial disabilities from applying for NDIS.

A similar trend has been noted in individuals who suffer from chronic diseases, like musculoskeletal disorders, arthritis, tendinitis, chronic obstructive pulmonary disease, multiple sclerosis, epilepsy, and back pain, which lead to temporary disability or paralysis (Fisher et al., 2024). Even though these individuals face significant problems with they are daily lives because of frequent impairment in their ability to function normally, the temporary nature of their disability cuts them off from the eligibility criteria for accessing NDIS benefits (Fisher et al., 2024).

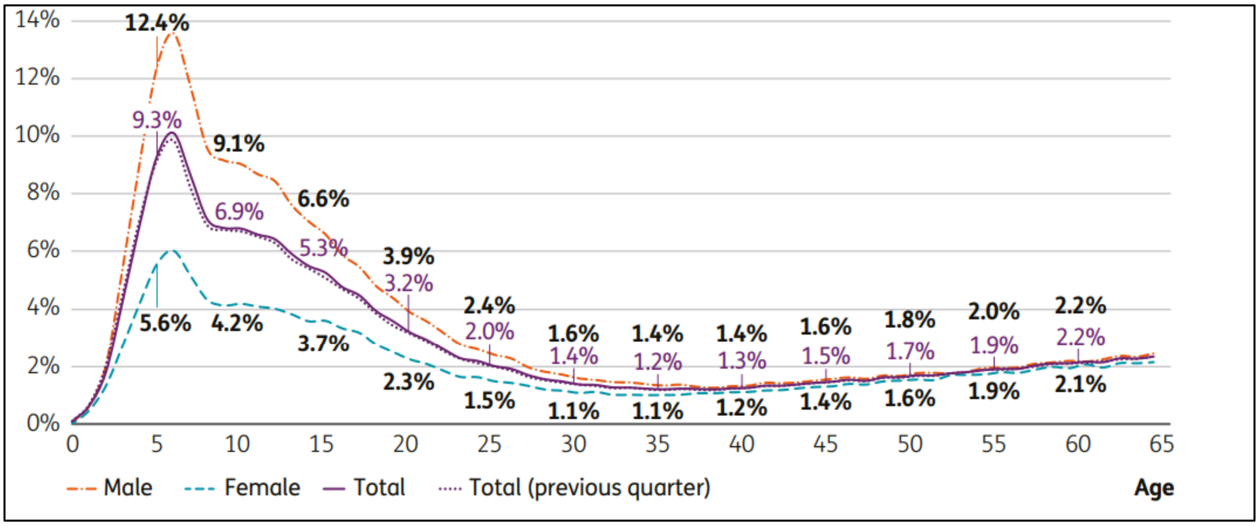

*Figure 6: NDIS Participation Rates (Source: National Disability Insurance Agency, 2024)*

Another major eligibility cut-off of NDIS is the age group, with NDIS providing support to individuals who fall between the ages of 9 and 65. Individuals below the age of 9 and above the age of 65 are not able to apply for the NDIS, even if they suffer from permanent disability and are not capable of financially supporting their wellbeing (Soldatic et al., 2014). This introduces inequities in the eligibility criteria of NDIS.

As indicated by National Disability Insurance Agency (2024), the number of NDIS participants aa a proportion of the Australian population peaks at the age of 5 and 7, with approximately 13% of 5 to 7 years old males and 6% of 5 to 7 year old females being the NDIS participants, receiving benefits only after the age of 9. There is a sharp decline in participation after the age of 20, with the participation falling below 2.1% at the age of 60, as shown in *Figure 5*, which highlights the inequities in the criterion cut-offs.

### 3.2 Population-Specific Access Inequities

Researchers have found that there are several challenges for indigenous people, such as a lack of trust in government services and diverse views on disability, leading to general exclusion from the NDIS (O’Flaherty et al., 2024). It has been found that isolation caused by geographic location is a main obstacle faced by the indigenous community. (Reddihough et al., 2016).

*Figure 7: Regional and Remote Areas of Queensland (Source: Triffitt, n.d.)*

As shown in *Figure 6*, a large portion of Queensland (a populated location in Australia) is considered to be remote or regional, with 37.2% of individuals living in remote and regional areas and approximately 14.5% of these individuals belonging to the First Nation or Indigenous population (Triffitt, n.d.). Because of the remoteness of these areas, there is an extensive lack of physical NDIS offices in these areas. Families of individuals with disabilities who live in these areas or often required to travel significant distances to access a NDIS provider. These families might not have the financial ability or the reliable transport to travel to these offices (Triffitt, n.d.).

While NDIS advises these families to acquire services by completing the application process online or calling for NDIS support,  this advice is inadequate for many families who do not have regular access to a telephone or internet, whose primary language might not be English or who might not be digitally literate (Triffitt, n.d.). These acute barriers cause inequalities for the indigenous population to access disability benefits from NDIS, even though disability prevalence is higher among this population.

### 3.3 Eligibility Cut-Offs and Consequences of Design Failures

The approach of person-centred design in NDIS is a primary barrier for the target population. According to Zubrinich et al. (2024), Australians with psychosocial disability faced substantial barriers with the eligibility and application processes of NDIS. Adults with intellectual disability often feel unsure of the processes of NDIS and are unprepared for the planning meetings. Zubrinich et al. (2024) stated that the adults with intellectual disability described that they faced significant difficulties in employing the appropriate language that is expected for describing their abilities and needs, understanding how to utilize the funding and navigating the general bureaucracy that is associated with the NDIS. These highlight how the design of the application process fails to respond to the needs of people suffering from psychosocial disability (Zubrinich et al., 2024).

Perry et al. (2019) noted that some members of staff may think that individuals with psychosocial or intellectual disabilities are not capable of understanding the NDIS process, as a result of which they may receive unequal treatment. Bigby (2020) found that there were problems in the NDIS system that resulted from some NDIS workers lacking the necessary knowledge about meeting the needs of people with intellectual disability. Families and carers also express concerns regarding difficulties of preparing for the first meeting, understanding the expectations and criteria, and the information that they should absorb (Bigby, 2020). According to Zubrinich et al. (2024), 16 out of 19 parents having children with intellectual disability felt that they were inadequately prepared for the initial NDIS meeting, which introduced inequities in accessing the benefits provided by the scheme, even though they technically fell under the criteria reserved for NDIS.

Conversely, some families of children with disabilities also indicated that the planners expected an increase in independence once the children with disabilities turned eighteen, thereby denying them NSIC claims, without recognizing the impact that intellectual disability might have on the transition of children to adulthood (Russo, 2021). Planners lacked a realistic understanding of the capabilities of the service users and the specific challenges that they experience as they approach adulthood (Russo, 2021). These inequities and gaps in the NDIS can be attributed to the improper design of the scheme, which lacks a consistent point of contact with the NDIS, insufficient allocation of funds for operating the services and difficulties in implementing plans efficiently (Zubrinich et al. 2024).

## 4. Priority Action to Close Access Inequities

Based on the literature review and analysis of the systemic barriers, the priority action for mitigating the NDIS is the *Responsive NDIS Navigator program.*

The *Responsive NDIS Navigator program* will be created to fit the needs of both the indigenous and the culturally and linguistically diverse (CALD) groups living in remote and regional areas. It will help to reduce the influence of problems such as cultural gaps, remote locations, discrimination and digital literacy

The key components of the recommended Navigator Program would involve the following:

| Strategy | Description | Barrier Addressed |
|---|---|---|
| **Community-Based Approach** | Indigenous and CALD navigators would work directly within their own communities. This local presence means families no longer have to travel long distances to access NDIS services. | Tackles the geographic barriers faced by 37.2% of Queenslanders living in regional and remote areas. |
| **Cultural and Linguistic Competency** | Navigators would offer support in the family's preferred language and with an understanding of their cultural values. Services would be tailored to reflect diverse cultural understandings of disability. | Helps families with limited English or unfamiliarity with mainstream disability concepts feel understood and respected, instead of excluded. |
| **Simplified Application Support** | Navigators would guide families step-by-step through complex paperwork and processes, making sure nothing gets lost in translation or misunderstood. Especially helpful for those with intellectual or psychosocial challenges. | Responds to evidence showing 16 out of 19 parents felt unprepared for their first NDIS meetings, often overwhelmed by the bureaucratic nature of the process. |
| **Digital Bridge Services** | In areas with poor internet access, navigators could assist with online forms and digital communication, using | Addresses the digital divide that adds another layer of difficulty for isolated or low-tech |

| | | |
|---|---|---|
| | their own devices or local hubs to connect people to NDIS services. | communities trying to access support. |
| **Systemic Advocacy** | Navigators would not only help individuals but also act as a voice for their communities, feeding back to NDIS about what is not working and pushing for more culturally appropriate and inclusive policies. | Ensures long-term improvement by highlighting structural issues and encouraging the NDIS to adapt to the needs of all communities, not just those who fit the dominant model. |

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