Disability and Health

Policy Position Statement

Key messages

People with disability experience poorer health than the general population, largely due to preventable and unjust differences in the social determinants of health. These health inequities are driven by systemic discrimination, barriers to accessing services, exclusion from full social participation and disadvantage across many areas of social and economic life.

The PHAA is committed to work with people with disability, disability networks, representative organisations and key non-government organisations to jointly advocate for a national, collaborative and multi-sectoral approach to improving health outcomes for people with disability.

Key policy positions:

1. People with disability and are diverse in their experience of disability, needs, and with respect to the intersection of disability with other personal characteristics.
2. A comprehensive policy approach requires addressing the drivers of poorer health outcomes for people with disability and must be aligned with the United Nations Convention on the Rights of Persons with Disabilities and underpinned by principles of human rights, equity, inclusion and intersectionality.
3. When taking action that aims to improve the health of people with disability, there must be meaningful involvement of people with disability in the development, implementation and monitoring of policy, and in decisions that affect people with disability.
4. Nationally consistent measures to collect and report population-level data disaggregated by disability will better inform government initiatives.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Diversity, Equity and Inclusion Special Interest Group

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Policy Position Statement

This position statement should be read in conjunction with the existing PHAA policies on Health Equity, Rural Health and Inclusive Practices in Healthcare Services.

PHAA affirms the following principles:

1. The PHAA recognises the diversity of people with disability and the intersectionality of disability with race, ethnicity, culture, religion, class, geographic location, gender, sexuality or other characteristics. People with disability often have strong preferences for either identity-first or person-first language and PHAA recognises the need to respect and affirm each individual person with disability's choice of language they use about themselves.[1] The PHAA is committed to inclusive language and recognises the predominant use of person-first language when referring to people with disability on the basis that people's impairment should not be unnecessarily focused on.[1] This document uses 'people with disability' in the absence of a national consensus. It is not the intention of the PHAA to exclude or disrespect those who prefer identity-first language.
2. People with disability have the right to attain the highest standard of health without discrimination on the basis of their disability, as enshrined in the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD).[2] Recognition that disability is part of human diversity is central to this right.
3. Disability is the result of interaction between people with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others.[2]
4. People with disability have inherent dignity and worth. Individual autonomy and independence for people with disability, including the freedom to make their own choices, is of critical importance.[2]
5. PHAA advocates for the 'nothing about us, without us' principle, which is the active involvement of people with disability in the planning of strategies and policies that affect them, as an avenue to achieve full participation and equalisation of opportunities for people with disability.[3]

PHAA notes the following evidence:

6. The Survey of Disability, Ageing and Carers reported that there were 5.5 million Australians with disability in 2022, representing 21.4% of the population, compared with 17.7% of Australians in 2018.[4] People with disability experience worse health than the general population and people without disability across a range of health indicators:[5, 6]
    i. Census data from 2011-2020 showed that the all-cause mortality rate of males and females with disability was 3.69 and 4.64 times higher than males and females without disability respectively.[7]
    ii. One third (31%) of adults with disability rate their health as 'excellent' or 'very good', compared with over two-thirds (68%) of adults without disability.[6]
    iii. Adults with disability are nearly three times more likely to experience a 'high' or 'very high' level of psychological distress than adults without disability (33% vs 12%).[6]

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iv. People with disability have higher rates of modifiable risk factors for chronic disease than people without disability.[6]

v. Almost half (47%) of adults with disability have experienced violence after the age of 15, and one fifth (20%) experienced abuse before the age of 15.[8]

vi. Women with disability experience higher rates of recent physical violence, sexual violence, and partner violence compared with women without disability; women with psychosocial disability or severe or profound disability experience higher rates of violence than other women with disability.[6]

7. Australia ratified the UN CRPD in 2008. Whilst Australia has made positive steps towards enacting the UN CRPD, concerns have been raised by the Committee on the Rights of Persons with Disabilities over the past decade about persistent inequities faced by people with disability in Australia.[9]

8. The National Disability Strategy 2010-2020 was developed to complement Australia's ratification of the UN CRPD and provided all levels of government with a high level framework of policy action areas to improve outcomes for people with disability. Australia's Disability Strategy 2021-2031 (ADS) builds on the 2010 Strategy; including a clearer focus on monitoring and evaluation.

9. Implemented nationally from 2016, access to the National Disability Insurance Scheme (NDIS) and benefits from available services is inequitable.[10, 11] Although focus on disability service has increased, the health of people with disability has not been fully addressed.[12]

10. The social determinants of health are key drivers of health inequities for people with disability,[13] who are often excluded from employment and from education through direct and indirect discrimination[14] and are disadvantaged with respect to almost all social determinants but particularly education, income, and employment.[4, 15] The 2024 Outcomes Framework for Australia's Disability Strategy 2021-2031 indicates that there has been little improvement in access to social determinants of health for people with disability, with many measures regressing. The exception is an improvement in participation in early education and school.

11. People with disability continue to face barriers, stigmatization, and discrimination when accessing health and health-related services.[16] One in ten Australian people with disability reported they had experienced discrimination because of their disability[4] and in 2020-21, 43% of all complaints to the Human Rights Commission in 2023-24 were lodged under the Disability Discrimination Act.[17]

12. Disability is most often viewed as an outcome to be prevented, and often conflated with poor health.[12] However, poor health outcomes are not always caused or explained by disability alone, but by barriers to accessing healthcare services (costs, untrained workforce, lack of community care); other factors such as the lack of culturally appropriate information and support; and the drivers and barriers discussed above.[5]

13. The National Safety and Quality Health Service (NSQHS) Standards has *Partnering With Consumers* joining *Clinical Governance* as an underpinning Standard and should ensure that 1) consumers [are] partners in planning, design, delivery, measurement and evaluation of systems and services, and 2) Patients [are] partners in their own care, to the extent that they choose. These statements will, in best practice, assume equitable access, communication and empowerment for people with disability as partners in their own care, addressing the added imbalance of power that can occur for people with disability in health service settings.

14. Specific populations in Australia have a higher prevalence of disability, including Aboriginal and Torres Strait Islander people,[18] people who are incarcerated,[19] refugees and asylum seekers,[20] and people living in

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socioeconomic disadvantaged conditions.[21] Specific populations of people with disability also experience additional disadvantage with respect to service access or utilisation, including: older people;[22] women and girls;[23] LGBTQI+ people;[24, 25] people from culturally and racially marginalised backgrounds;[26] Aboriginal and Torres Strait Islander people;[27] people living in rural and remote areas;[28] people who experience homelessness;[29] refugees and asylum seekers;[20] people in contact with the criminal justice system;[30] people living in socio-economic disadvantaged areas or conditions;[10] and people with psychosocial disability.[28]

15. In 2022, there were 3 million unpaid informal carers of people with disability and older people.[4] Two-thirds of primary carers were female.[4] Adult carers have poorer health and wellbeing than other Australians,[31] and over one third (38.6%) of primary carers have disability themselves.[4]
16. Inconsistent definitions of disability, and a lack of identifying mechanisms across data sources, limit the understanding of the experience of people with disability and their engagement with mainstream services.[32] The National Disability Data Asset (NDDA) launched in 2024 could provide a more complete picture regarding program and service utilisation, and provide data on disability, social services, health and key social determinants of health to improve opportunities and outcomes for people with disability.[33]
17. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3 – Good Health and Wellbeing and Goal 10 – Reduced Inequalities.

PHAA seeks the following actions:

18. Address the drivers of poorer outcomes to improve the health of people with disability including all social determinants, barriers in accessing healthcare, and discrimination on the basis of disability through multisectoral action with the involvement of people with disability.
    i. *Responsibility: all levels of government, health services, education sector, non-government organisations.*
19. Advocate for meaningful application of 'nothing about us, without us' in the development, decisions, implementation and monitoring of policy that affect people with disability.
    i. *Responsibility: all levels of government, healthcare services, non-government organisations.*
20. Advocate for the continual learning of disability health for public health professionals to reduce the burden and onus on people living with disabilities to educate and inform others.
    i. *Responsibility: health services, federal government, education sector.*
21. Address action areas in ADS 2021-2031 and National Aboriginal and Torres Strait Islander Health Plan 2021-2031 that act as social determinants of health, particularly improving meaningful employment and income for people with disability who are employed in addition to providing meaningful opportunities for employment for people with disability who are able to work.
    i. *Responsibility for action: state and federal government*
22. Develop nationally consistent measures to collect and report population-level data disaggregated by disability which can be advanced in part through further development of the NDDA.
    i. Responsibility for action: federal government and health services.
23. Ensure that the full intent of the NSQHS *Partnering with Consumers Standard,* is supported by rigorous health services practices to safeguard equity through policies, procedures, staff training, communication protocols and

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other measures that support and empower people with disability to be active partners in planning, design, delivery, measurement and evaluation of systems and services and as partners in their own care.

i. Responsibility for action: Health services, health service accreditation and regulatory bodies.

Address concerns raised by the Committee on the Rights of Persons with Disabilities[9] and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability[15] and encourage relevant action, including:

24. Make health services and equipment accessible and affordable for all people with disability, particularly the specific populations that face additional disadvantage, including those previously specified (see point 14).
25. Improve cultural safety of disability services and supports, including trauma-informed services. Health, care and social service systems are required to recognise that Aboriginal and Torres Strait Islander people with disability face unique barriers in accessing services and recognise the importance of self-determination.
26. Amend the NDIS accessibility and assessment process to provide equal opportunities for underserved groups, adopt the human rights model of disability, and make more resources available and accessible.
27. Improve processes for screening and diagnosis to identify disability and assess NDIS eligibility in criminal justice settings (which take into account the high rates of women who have experienced violence) to enable people with disability to access necessary supports and services in custody and post-release.
28. Introduce an Australian Disability Rights Act (DRA) to harmonise Australia's legal framework with the UN CRPD, including protecting people with disability from intersectional discrimination and amending migration laws and policies to protect people with disability from discrimination. An independent oversight body should be established nationally, and in each jurisdiction, and have statutory functions to support compliance with the DRA with respect to each government's responsibility for services such as health and education.
29. Abolish practices that violate the autonomy, independence and dignity of people with disability, including the involuntary detention of people with disability in psychiatric hospitals and the use of medical interventions and restrictive practices in health, education and care settings, and implement a nationally consistent supported decision-making framework.

PHAA resolves to:

30. Promote awareness in the health sector and other sectors impacting on health (e.g. housing, transportation, and justice) of inequities in access to healthcare for people with disability and actions to improve access.
31. Work with people with disability, disability networks, representative organisations and key non- government organisations to jointly advocate for a national, collaborative and multi-sectoral approach to improving health outcomes for people with disability.
32. Actively contribute to policy, advisory forums and consultation processes relating to disability policy and the determinants of health.
33. Apply the PHAA values of respect and inclusiveness in all PHAA policy and advocacy activities, with consideration to people with disability, as outlined in the PHAA Strategic Plan 2021-2025

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