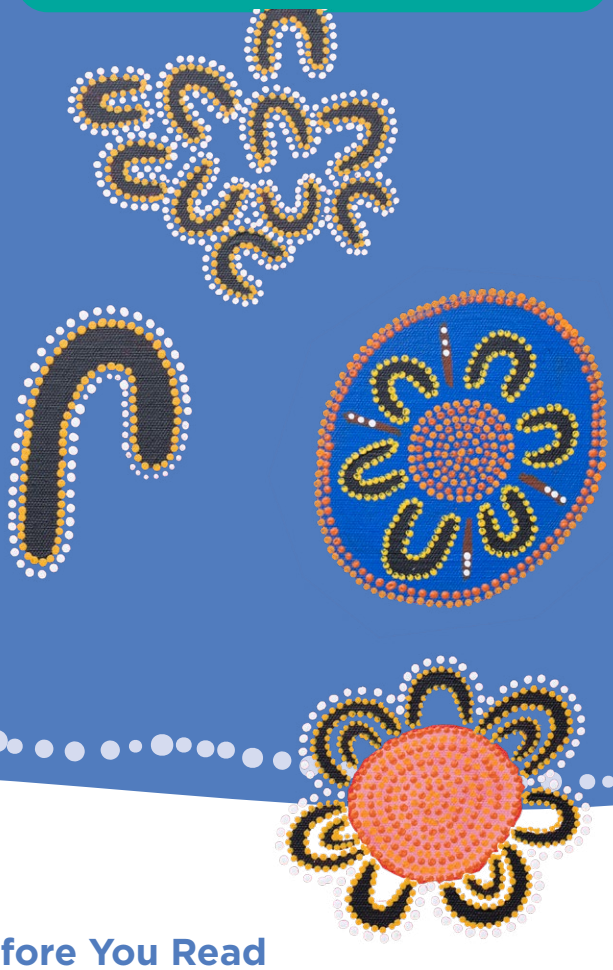
Position Statement

Policy Position Statement - Ageing and Disability



Cultural and Content Advisory: A Note Before You Read

This position statement discusses the lived experiences, rights, and systemic exclusion of First Nations people with disability as they age. This statement includes discussion of issues that may be distressing for some readers, including forced removal from Country, institutionalisation, trauma, elder abuse, restrictive practices, suicide, and end-of-life care. If this content raises difficult feelings, readers are encouraged to take care while engaging with this material and to pause or seek support if needed.

The evidence base for this paper draws on the work of the National Disability Footprint, including the Data and Research Footprint (Element 2) delivered in partnership with Dr Scott Avery and Girra Maa Indigenous Health, University of Technology Sydney.

First Peoples Disability Network

Executive summary and introduction

Older First Nations people with disability experience a major policy and service gap at the intersection of disability, ageing, health and housing. Nearly half of First Nations people aged 55 and over live with disability (Avery & ABS 2025). No national dataset adequately connects Indigeneity, disability and age, and current systems respond to only one part of this experience at a time: a disability system with an age cutoff, an aged care system with limited disability competence, a health system that is often not culturally safe, and a housing system that is frequently inaccessible. As a result, many older First Nations people with disability face delayed or inappropriate access to supports, are required to leave Country to obtain care, enter residential aged care at younger ages than non-Indigenous Australians, are subjected to chemical restraint because staff cannot interpret behaviour shaped by trauma and culture, are retraumatised by institutional settings that are reminiscent of their childhood removal, and remain largely invisible in national policy and accountability frameworks. No Closing the Gap target measures their outcomes. No national dataset tracks their trajectories. No integrated policy framework addresses the compounded reality of their lives.

FPDN is the only national organisation focused on the intersection of First Nations advocacy, disability rights, and the lived experience of this population. This position statement, grounded in the principle that everyone has a place and purpose, addresses what it means to age as a First Nations person with disability. This position statement sets out the policy issues affecting older First Nations people with disability across the full course of ageing, including demographic change, dementia and sensory disability, displacement from Country, elder abuse and restrictive practices, pressure on kinship care, failures at the interface between aged care and the National Disability Insurance Scheme (NDIS), end-of-life care, and data sovereignty. FPDN has published a separate position statement on aged care. This paper addresses the broader structural conditions shaping ageing for First Nations people with disability across systems.

Key messages

Disability prevalence among older First Nations people

High disability prevalence among older First Nations people.	Among First Nations people aged 55 and over, 48.4% have disability and 26.4% have profound or severe limitations (Avery & ABS, 2025); among the general population of people aged 65 and over, 52.3% have disability and 41.4% had a profound or severe limitation (ABS, 2022b). These figures exclude very remote communities, meaning true prevalence is likely higher for First Nations people. Among First Nations people aged 65 and over, 79% have some form of disability (NATSIHS 2018-19). The aged care-eligible First Nations population is projected to nearly double to 250,000 within a decade, and the number of First Nations people living with dementia is projected to increase 4.5 to 5.5 times by 2051 (Temple et al., 2022). This level of need has significant implications for aged care, disability, health and community support systems. Current systems are not well prepared for this level of growth in need.
Untreated sensory disability is compounding cognitive decline.	More than two in five First Nations people (43%) have hearing loss, rising to 59% in remote areas, and 79% of cases are undiagnosed (ABS, 2022a). Hearing loss increases dementia risk by 16% for each 10-decibel worsening.
First Nations people under 65 continue to enter residential aged care because community-based alternatives are not available.	First Nations people comprise 35% of all younger people entering residential aged care, and 38% of First Nations home support users are under 65 (GEN, 2023-25). This includes people with acquired brain injury, early-onset dementia and intellectual disability who are entering aged care because appropriate disability and community-based supports are not available. Their exclusion from national YPIRAC reduction targets limits policy visibility and weakens accountability for reducing these admissions.

48%

Among First Nations people aged 55 and over, 48.4% have disability and 26.4% have profound or severe limitations.

35%

First Nations people comprise 35% of all younger people entering residential aged care.

Sources: Avery & ABS, 2025, GEN, 2023-25

How current systems create additional harm

The transition between the NDIS and aged care creates avoidable loss of support for First Nations people with disability.	First Nations people eligible for aged care from 50 may never have been assessed for the NDIS due to remoteness, diagnostic barriers, and the absence of Aboriginal-controlled providers (just 144 nationally). At age 65, people are permanently excluded from NDIS uncapped funding and instead rely on an aged care assistive technology cap of $15,000 per year. No linked dataset tracks what happens to First Nations people with disability as they move between, or fall out of, both systems, limiting the capacity to monitor outcomes and address service gaps.
Elder abuse affecting First Nations people with disability is not adequately measured, preventing an effective policy response.	Australia's only elder abuse prevalence study excluded First Nations people by design. Existing evidence indicates specific risks for this population, including financial abuse linked to disability payments, increased vulnerability to exploitation for people with cognitive disability, and institutional abuse through restrictive practices. Chemical restraint is used on approximately 22% of aged care residents, and current clinical guidance acknowledges the risk of inappropriate psychotropic use for First Nations people while also noting the limited evidence base. The absence of prevalence data limits policy design, monitoring and targeted reform.
The absence of disability supports on Country is forcing older First Nations people into inappropriate and culturally unsafe care pathways.	When an Elder with mobility impairment or dementia cannot access home modifications, assistive technology or personal care on Country, the only available pathway is often relocation to town-based residential care. For Stolen Generations survivors, this may replicate earlier experiences of institutionalisation and forced removal. Dementia prevalence among First Nations people increases with remoteness, yet supports remain least available in remote areas. This creates a direct policy and service gap between where need is highest and where care is available. Removing people with dementia from community to access care intensifies cognitive decline, depression, and functional deterioration. Connection to Country is not supplementary to health; it is foundational.

The transition between the NDIS and aged care creates avoidable loss of support for First Nations people with disability.

Policy conditions required for self-determination

Kinship-based care remains under-recognised and under-resourced in current disability and aged care policy settings.	First Nations carers are relatively young (mean age 38.8 years), predominantly female (73.4%), and often live with disability themselves. Formal respite services in remote communities are limited. Current disability and aged care models are built around individualised, consumer-directed funding, which does not align well with collective and kinship-based care arrangements that are common in many First Nations families. As a result, an important source of care remains insufficiently recognised and supported in policy design.
Existing rights frameworks are not being translated into policy and service design for older First Nations people with disability.	UNDRIP Article 22 requires particular attention to the rights of Indigenous Elders and persons with disabilities, and the UNCRPD, under Article 28, requires adequate social protection without discrimination. The Disability Royal Commission dedicated Volume 9 to First Nations people with disability, yet FPDN found that only one of 57 relevant recommendations was fully accepted by the Australian Government. This gap between recognised rights and policy implementation remains evident in areas such as ageing on Country, culturally safe disability support, and accountability across systems. The right to age and die on Country with appropriate disability supports is beginning to be recognised in Australian aged care rights frameworks, but remains insufficiently operationalised through funding, disability support, service delivery and accountability mechanisms.

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The Disability Royal Commission dedicated Volume 9 to First Nations people with disability, yet FPDN found that only one of 57 relevant recommendations was fully accepted by the Australian Government.

Key evidence and statistics

- **First Nations people aged 55 and over experience disability at 48.4%, with profound or severe limitations at 26.4%, up sharply from 17.9% in 2018** (ABS SDAC, 2022). These figures exclude approximately 17% of the First Nations population living in very remote areas and everyone in residential care, meaning true prevalence is higher.
- **Dementia prevalence among First Nations people aged 60 and over is approximately three times higher than the general population** (21% versus 6.8%), with onset seven years earlier (AIHW, 2025). In the Kimberley, prevalence among those aged 45 and over reaches 12.4% (Smith et al., 2008). Among Aboriginal people in residential aged care in Alice Springs, the most frequent diagnoses driving admission are vascular dementia (30%), Alzheimer's disease (26%), and brain injury (20%) (Garvey et al., 2019).
- **Hearing loss affects 43% of First Nations people, rising to 59% in remote areas, with 79% undiagnosed** (ABS, 2022a). Vision impairment is three times higher, and moderate vision impairment six times higher, than among non-Indigenous Australians (AEEHS, 2024-25). Untreated hearing loss increases dementia risk by 16% per 10-decibel worsening (Bao et al., 2024).
- **In July-September 2023, First Nations people aged 50-64 constituted 35% of all younger people entering residential aged care, despite comprising 3.8% of the total population** (GEN YPIRAC Fact Sheet, September 2023). They are excluded from YPIRAC reduction targets.
- **From 1 November 2025, new aged care legislation aims to prevent entry to residential aged care for people under 65, while continuing to allow access for First Nations people aged 50–64 (and people experiencing homelessness aged 50–64) where this reflects individual preference, comfort and safety.** FPDN supports self-determination and the right of First Nations people with disability to make decisions about their care. However, in practice, these choices are often shaped by the absence of alternative culturally safe, community-based disability supports, including on Country. As a result, entry into residential aged care for many First Nations people under 65 reflects constrained choice rather than genuine preference.

48%

First Nations people aged 55 and over experience disability at 48.4%, with profound or severe limitations at 26.4%.

3X

Dementia prevalence among First Nations people aged 60 and over is approximately three times higher than the general population.

Sources: ABS SDAC, 2022, AIHW, 2025.

- **No disaggregated elder abuse prevalence data exist for First Nations people.** The 2021 National Elder Abuse Prevalence Study excluded the population by design. Financial abuse linked to Disability Support Pension and NDIS funding is identified as a specific risk in Aboriginal communities (Elder Abuse Action Australia, 2022).
- **Approximately 22% of aged care residents in studied facilities are prescribed daily antipsychotics, with only approximately 10% of psychotropic prescriptions for people with dementia considered appropriate** (Monash University Clinical Practice Guideline, 2023). No disaggregated data exist on chemical restraint of First Nations people with dementia. NDIS and aged care restrictive practices frameworks are fundamentally misaligned: a restriction that does not constitute environmental restraint under aged care rules may be classified as one under the NDIS for participants in the same facility, leaving First Nations people aged 50-64 navigating between systems with inconsistent protections.
- **Residential aged care facilities constitute "places of detention" under the Optional Protocol to the Convention against Torture (OPCAT) where people are not free to leave** (Grenfell, 2019). The Commonwealth Ombudsman, as National Preventive Mechanism, has explicit oversight of aged care and disability facilities under Commonwealth control. For First Nations people with disability who may enter residential care at age 50 and spend decades in settings constituting de facto detention, with chemical and mechanical restraints widely used, the OPCAT framework demands scrutiny that has not yet been applied with cultural or disability specificity.
- **First Nations NDIS participants are 28% less likely to receive care via the NDIS than non-Indigenous Australians, and only 144 First Nations-owned disability providers exist nationally against 54,967 providers servicing First Nations participants** (NDIS Market and Sector Analysis, 2024). Remote areas have 36% of the allied health workforce per capita of major cities.
- **Among 124 Aboriginal carers in Kimberley communities, the mean age was 38.8 years, 73.4% were female, and 75.8% were children or grandchildren of the person receiving care.** Female carers were significantly less likely to feel empowered, and lack of empowerment was associated with depression (LoGiudice et al., AIHW, 2025). The Disability Sector Strengthening Plan explicitly notes that among First Nations people with disability, many carers themselves live with disability (Closing the Gap, 2022).

28%

First Nations NDIS participants are 28% less likely to receive care via the NDIS than non-Indigenous Australians, and only 144 First Nations-owned disability providers exist nationally against 54,967 providers servicing First Nations participants.

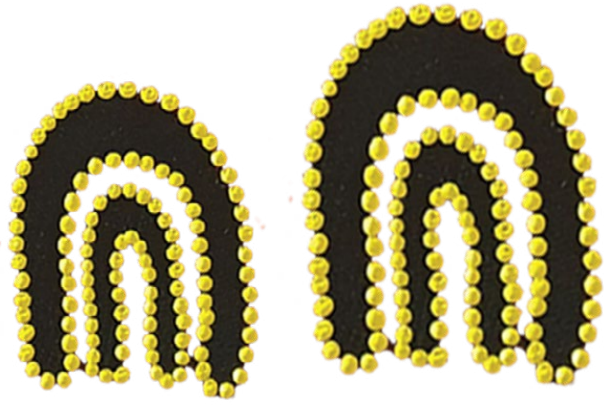
Sources: NDIS Market and Sector Analysis, 2024

- **Formal respite services in remote and very remote communities are critically deficient.** Northern Territory research documented that absence of respite forces patients and families to relocate to metropolitan areas, away from family, community, and Country, obstructing wishes for end-of-life care in the local community. The NDIS Review found the individually funded market-based model "persistently fails to meet the needs of both First Nations and remote communities," and that individualised funding works against Aboriginal concepts of holistic, community-based wellbeing (NDIS Review, 2023). In December 2024, 33,700 First Nations people were receiving Carer Allowance, but voluntary self-identification likely produces significant undercounting.

"I make them sad and I am myself sad far away from my family, my heart is crying. If I pass away here, it is far for me to get to my spirit, my culture, my ceremony." (Elder Mildred Numamurdirdi, Numbulwar Elder, NT) (Royal Commission into Aged Care Quality and Safety, Darwin hearing, 2019). This Elder was flown 800km from her remote community because no aged care or disability supports existed in Numbulwar. Her displacement illustrates the direct link between absent disability infrastructure and forced removal from Country.

"I wouldn't want to be back in one of them places because without your independence, you might as well lay down and die." (Uncle Wayne Garlett, Ballardong man, Stolen Generations survivor and person with disability, WA) (ABC News, via YourLifeChoices, 2025). Uncle Wayne's fear of residential aged care as re-institutionalisation is shared by many of the approximately 17,150 Stolen Generations survivors now of aged care-eligible age, who are 1.4 times more likely to have severe or profound disability than First Nations Elders who were not removed (AIHW, 2018).

"I think there's always been a difference in the aged care needs of Aboriginal people. We're in a system, an English system, and I think our care needs are different. Not that we need to be in a building with four walls and just sit there. They don't understand the Aboriginal way because they never learn it, we learnt their way." (Aboriginal Elder, Walgett, NSW) (McCausland et al., 2023, Ageing and Society). This Elder articulates a systemic incompatibility: a Western institutional model imposed on people whose concept of ageing well centres connection to Country, kin, and culture, not containment in facilities.



- **A study of 336 Aboriginal Australians aged 60 and over found 33.3% lifetime depression prevalence, 18.1% current late-life depression, and 11.1% suicidal ideation** (Almeida et al., 2018). Activity limitation due to disability is the most common psychosocial risk factor for suicide in people over 65. People under 65 who used disability services between 2013-2018 died by suicide at three times the general population rate (AIHW Suicide Monitoring, 2024).
- **The Support at Home End-of-Life Pathway provides $25,000 over 12 weeks (extendable to 16 weeks) for people with three months or less to live.** The Aged Care Act 2024 Statement of Rights is an important reform: it recognises rights to culturally safe care, respect for culture and identity, supported decision-making, and connection to community, Country and Island Home. However, these rights are not yet fully translated into the design of the End-of-Life Pathway. A short-term, prognosis-based pathway may not meet the needs of First Nations people with degenerative disabilities, including advanced dementia, motor neurone disease and progressive neurological conditions, and where end-of-life trajectories are often uncertain and whose cultural obligations may require return to Country, extended family presence and ceremony.

33%

A study of 336 Aboriginal Australians aged 60 and over found 33.3% lifetime depression prevalence, 18.1% current late-life depression, and 11.1% suicidal ideation.

Sources: Almeida et al., 2018.

Key recommendations

- **End the statistical erasure of First Nations people from YPIRAC targets.** First Nations people aged 50-64 in residential aged care must be included in national YPIRAC reduction reporting and targets, not hidden in supplementary tables. Their admission is driven by disability, not age, and their exclusion from targets renders them invisible. (Priority Reform 4; responsible actors: Department of Health, Disability and Ageing, AIHW.)
- **Close the NDIS-aged care transition gap for First Nations people with disability.** Legislate NDIS Review Action 2.11 to allow concurrent NDIS and aged care supports. Align the assistive technology cap in aged care with NDIS needs-based funding for First Nations people. Ensure no First Nations person with disability is denied supports solely because they were never assessed for the NDIS before turning 65. (Priority Reforms 2 and 3; responsible actors: NDIA, Department of Health, Disability and Ageing.)
- **Fund disability supports on Country to prevent forced displacement.** Block-fund Aboriginal Community Controlled Health Organisations to deliver integrated disability and aged care supports in remote communities, including home modifications, assistive technology, allied health, and personal care. Forced removal from Country due to absent disability infrastructure is a rights violation under both UNCRPD Article 28 and UNDRIP Article 22. (Priority Reform 2; responsible actors: Department of Health, Disability and Ageing, NIAA.)
- **Commission an elder abuse prevalence study inclusive of First Nations disability.** The 2021 study excluded this population entirely. The next iteration must use culturally safe, disability-accessible methodology; include people aged 50 and over; cover remote communities; and disaggregate by disability type and Indigenous status. This aligns with Focus Area 4, Priority Action 4.3 of the National Plan to End the Abuse and Mistreatment of Older People 2026-2036 (Prioritise and undertake research that addresses gaps in the Australian evidence base on the abuse and mistreatment of older people and ageism, including gaps identified in the National Elder Abuse Prevalence Study). (Priority Reform 4; responsible actors: Attorney-General's Department, Department of Social Services.)
- **Mandate culturally specific restrictive practices protections.** Behaviour support plans for First Nations people with dementia, intellectual disability, or acquired brain injury in aged care must be informed by Aboriginal understandings of cognitive change and communication. A Senior Practitioner model with First Nations cultural competency must be established across all jurisdictions. Chemical restraint data must be disaggregated by Indigenous status and disability type. (Priority Reform 3; responsible actors: Aged Care Quality and Safety Commission, NDIS Quality and Safeguards Commission.)
- **Invest in hearing and vision services as dementia prevention.** Fund universal hearing screening and audiological services for First Nations people aged 45 and over through ACCHOs, and ensure trachoma remains eliminated in Australia. Hearing loss is the single largest modifiable risk factor for dementia, and First Nations prevalence is 43% with 79% undiagnosed. (Priority Reform 3; responsible actors: Department of Health, Disability and Ageing, Hearing Australia.)

- **Recognise and resource kinship care for older First Nations people with disability.** Develop a kinship care supplement within both the NDIS and aged care that reflects collective care arrangements, funds family members as paid carers in remote communities (implementing DRC recommendations), and provides culturally safe respite. (Priority Reform 2; responsible actors: NDIA, Department of Health, Disability and Ageing.)
- **Reform end-of-life pathways for First Nations people with degenerative disability.** Extend the Support at Home End-of-Life Pathway beyond 16 weeks for people with degenerative disabilities including advanced dementia. Operationalise the Aged Care Act 2024 Statement of Rights by ensuring end-of-life pathways can practically support return to Country or Island Home, extended family presence, cultural ceremony and culturally safe palliative care. Fund community-based palliative care models through ACCHOs. (Priority Reform 3; responsible actors: Department of Health, Disability and Ageing.)
- **Embed FPDN in First Nations aged care governance.** FPDN must have a formal role in the permanent statutory Aboriginal and Torres Strait Islander Aged Care Commissioner's advisory structures and in the 10-year Aged Care Framework (2025-2035). No other organisation holds the disability rights lens at this intersection. (Priority Reform 1; responsible actors: First Nations Aged Care Commissioner, Department of Health, Disability and Ageing.)
- **Establish a Closing the Gap target for older First Nations people.** A specific, measurable target covering aged care access, disability support, and quality outcomes for older First Nations people with disability should be agreed through the Joint Council mechanism. Without a target, there is no accountability. (Priority Reform 1; responsible actors: Joint Council on Closing the Gap, Coalition of Peaks.)
- **Build a linked national dataset on First Nations disability and ageing.** Mandate high-quality Indigenous identification across all aged care and disability data systems. Link NDIS and aged care administrative data to track transitions, service gaps, and outcomes. Ensure First Nations community governance over this data through partnership with the Maiam nayri Wingara Data Sovereignty Collective. (Priority Reform 4; responsible actors: Department of Health, Disability and Ageing, AIHW, NDIA.)
- **Reinstate the Equity of Access fee reduction supplement for aged care.** While financial hardship assistance (also referred to as a fee reduction supplement) is available to individuals who cannot meet aged care costs, this mechanism is limited to case-by-case financial hardship and does not address the structural inequities faced by First Nations people. The omission of the Aboriginal and Torres Strait Islander fee reduction supplement from the Aged Care Rules contradicts Royal Commission Recommendation 47 and risks ACCHO withdrawal from aged care provision. Exempt state-based Stolen Generations redress payments from aged care means testing. (Priority Reform 3; responsible actors: Minister for Aged Care, Department of Health, Disability and Ageing.)

This position statement should be read alongside FPDN's separate position statement on the aged care system for First Nations people with disability, which addresses the Aged Care Act 2024, Support at Home, and assessment pathways in more detail.

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