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SYSTEMATIC REVIEW **Open Access**

Disparities in access to health and support services for people with disability in Australia: a scoping review of the structural social determinants

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Abstract

Background Systemic inequities in health and social services exacerbate barriers for disadvantaged groups within the disability community, leading to poorer health outcomes and diminished quality of life. We aimed to evaluate how structural determinants function to shape disparities in access to health and support services for people with disability.

Methods We followed Arksey and O'Malley's methodological framework. A comprehensive search strategy was implemented across five major databases—Medline, Embase, CINAHL, PsycINFO, and Scopus—focusing on four key concepts: social determinants, disability, services (both support and health services), and Australia. Articles published after 2013 were included in the review.

Results After screening 2,506 records, 54 studies were included in the review. These studies identified key drivers of inequities in access to health and social support services. Structural determinants, such as policy gaps, geographic disparities, service integration challenges, cultural misalignment, and socioeconomic marginalisation, significantly hinder equitable access. Additionally, social determinants—including household income, educational attainment, employment status, and gender — shaped individuals' ability to engage with systems and services. Low-income individuals, those with limited education, and other disadvantaged communities, such as Indigenous and culturally diverse groups, face compounded barriers when seeking support.

Conclusions People with disability face significant structural barriers to access health and support services, especially those from disadvantaged backgrounds. The implementation of interventions and efforts to improve the health and well-being of this population should be primarily viewed through the lens of those facing intersectional disadvantage. Future research should focus on generating disaggregated evidence to support policy efforts aimed at better targeting disadvantaged groups.

Keywords Disability, Social determinants of health, Inequity, Socioeconomic factors, NDIS, Health services, Australia

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Introduction

In 2022, more than one in five Australians—21.4% of the population—were living with disability, with 2 million (7.9%) experiencing profound or severe disability requiring assistance with daily living [1]. Access to health and support services, including medical care, rehabilitation, assistive technologies, and social support systems, is essential for improving the quality of life, independence, and social inclusion [2]. However, structural social determinants remain a significant barrier to delivering equitable disability support, disproportionately affecting disadvantaged groups [3].

Population-level structural social determinants of health—such as socioeconomic status, education, employment, and geographic location—are well-documented drivers of health inequities across populations [4]. For people with disability, these determinants often impact individuals in more significant ways, contributing to higher rates of poverty, unstable housing, and lower levels of education and employment [5]. They also often face systemic exclusion that limits their economic and social participation [3, 6]. For example, inaccessible public transportation, discriminatory hiring practices, and a lack of inclusive educational and community programs can in turn result in isolation, unemployment, and limited opportunities to fully engage in social and economic life [6]. These challenges create cycles of marginalisation, reinforcing socioeconomic inequities and narrowing pathways to financial stability and community inclusion [7].

In Australia, people with disability experience poorer health outcomes compared to the general population, marked by higher rates of premature mortality, increased morbidity, and greater functional limitations [3]. For example, a recent study found that Australians with disability are four times more likely to die prematurely, often from causes unrelated to their disability [8]. Similarly, research by Trollor et al. (2017) found that 38% of deaths among adults with intellectual disability in New South Wales were potentially avoidable, compared to only 17% in the general population, highlighting the critical role of poor access to quality healthcare [9].

Australia's Disability Strategy 2021–2031 which underpins national disability policy is grounded in the social model of disability and guided by an intersectional approach that acknowledges diverse experiences and needs [2]. The country has also introduced progressive, globally recognised disability programs, with the National Disability Insurance Scheme (NDIS) serving as its flagship initiative [2]. The Scheme offers individualised funding through a personal budget to address disability-related needs and services—such as daily living assistance, community engagement activities, therapies, and assistive technologies with the aim of enhancing independence and social inclusion [10]. Established in 2013, the NDIS provides support to Australians under 65 years of age who are citizens, and permanent residents. Eligibility requires demonstrating a permanent and significant disability that substantially reduces functional capacity in areas such as mobility, communication, learning, or self-care, and requires ongoing support when applying to access the Scheme (7). However, the Scheme's model of self-direction of supports (which is not effectively implemented for some groups), reliance on detailed documentation, and complex application processes can impose substantial administrative burdens that may disproportionately affect some groups of people with disability, potentially limiting equitable access [11].

Most existing reviews focus on single social determinants—such as the effects of remoteness—or on particular disability groups, offering only a partial view of the broader structural conditions shaping access [12, 13]. As a result, evidence remains fragmented, with limited synthesis specifically examining how structural social determinants shape access in the Australian context. This gap highlights the need for a comprehensive scoping review to map existing knowledge, identify areas where evidence is lacking, and inform more equitable policy and system reform. To address this, our scoping review maps the literature on how structural social determinants shape disparities in access to health and support services for people with disability in Australia.

Conceptual framework

In order to systematically map how social factors shape health and well-being for people with disability, we adopted the World Health Organisation's (WHO) "Conceptual Framework for Action on the Social Determinants of Health (SDoH)," which offers a structured approach to understanding both the origins and pathways of health and social inequities [4]. This framework identifies two broad categories of determinants: structural and intermediary. Structural determinants include the socioeconomic, political, and cultural systems that define the conditions of daily life, including governance structures, economic policies, and societal values. These macro-level forces create and perpetuate inequities by distributing power, wealth, and status unevenly across populations.

These structural forces give rise to individuals' socioeconomic positions—defined by education, occupation, income, gender, race or ethnicity, and social class—which in turn govern exposure to risk factors, vulnerability, and health outcomes [4]. For people with disability in Australia, variations in educational attainment, employment status, and income are critical in determining whether they can afford and physically reach health and support services, and how accepted or welcome they feel when trying to use those services [3].

Structural determinants—such as governance models that exclude disability perspectives or economic policies that limit welfare support—directly shape socioeconomic position for the people with disability, creating cycles of disadvantage [2, 4]. For example, lower educational attainment or unemployment among people with disability may stem from inaccessible infrastructure or workplace discrimination, further reducing their capacity to navigate health and social service systems. These structural barriers compound vulnerabilities, influencing intermediary determinants like material conditions (e.g., housing, transportation) and psychosocial stressors (e.g., stigma), and behavioral patterns—that ultimately mediate health and service utilisation, providing a clear pathway for targeted interventions to promote equity.

Methods

We conducted the scoping review following Arksey and O'Malley's methodological framework [14] and further refined by Levac and colleagues [15]. The review was carried out in five stages: (1) identification of the research question, (2) identification of relevant studies, (3) selection of relevant studies, (4) charting the data, and (5) collating, summarising, and reporting results. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines (See Supplementary file 1).

Identification of the research question

Our primary research question was: What is known about the role of structural determinants in shaping disparities in access to health and support services for people with disability in Australia? Three sub-questions were developed to further support a comprehensive exploration of this topic: (1) What types of structural determinants have been identified in the literature as influencing access to services? (2) How do these determinants affect access for different groups within the disability community, including variations by disability type, age, gender, or geographic location? and (3) What gaps exist in current research or policy addressing these structural barriers?

Identification of relevant studies

To identify relevant studies, a comprehensive search strategy was developed and implemented across five major databases: Medline, Embase, CINAHL, PsycINFO, and Scopus. The search was structured around four key concepts: social determinants, disability, services (including both support services and health services), and Australia. For each concept, relevant keywords and MeSH terms were identified. The search strategy was first developed and optimised for Medline, using Boolean operators (AND, OR) to combine the terms effectively (See supplementary file 2). The development of the search strategy was conducted in consultation with university librarians.

This search strategy was then adapted for the other databases to account for variations in search syntax and indexing methods. The search was limited to publications from 2013 to 2024, aligning with the introduction of the NDIS, which marked a significant shift in how disability supports were provided in Australia. A targeted search of grey literature was also conducted using Google Scholar to capture relevant reports from government agencies, universities, and advocacy organisations, as well as other non-indexed materials that provide valuable insight. Database searches were carried out on October 15, 2024. To supplement the electronic search, the reference lists of included studies were also reviewed to identify additional relevant literature.

Selection of relevant studies

The selection of relevant studies was guided by predefined inclusion and exclusion criteria, which are presented in Table 1. The screening and selection process was conducted using Covidence software, which facilitated citation management, title and abstract screening, full-text review, and data extraction.

While there is no single, universally agreed-upon definition of disability, as it can vary across legal, medical, social, and cultural contexts, international frameworks commonly conceptualise disability as arising from the interaction between an individual's impairments and societal barriers, rather than solely as a medical condition. This aligns with the United Nations Convention on the Rights of Persons with Disabilities (2006). For this review, we included studies examining conditions commonly recognised as disabilities, such as intellectual disability or autism. We also included studies that explicitly defined their study population as people with disability.

A two-stage screening process was employed. In the first stage, titles and abstracts were independently screened by at least two reviewers from the team (IY, JH, and FB) to identify potentially relevant studies. In the second stage, full-text articles of selected citations were reviewed by two authors (JH and FB) to assess eligibility against the inclusion criteria.

Data from the included studies were extracted using a two-reviewer system involving the same three authors (IY, JH, and FB). One author (FB) consolidated the extracted data and resolved any discrepancies through comparison and discussion to reach consensus. In instances of uncertainty or disagreement arose at any stage of the selection or extraction process, the team met

Table 1 Inclusion and exclusion criteria

	Include	Exclude
Population	– Articles specifically studying disability and/or impairment	– Studies that do not involve people with disability.
Concept	– Studies that assessed disparities or inequities in access to health and/or disability support services. – Studies that provided a direct linkage between access barriers and social determinants. – Studies that included a conceptual, empirical, or policy-oriented analysis of how social determinants influence access to services.	– Studies only focused on health outcomes or clinical interventions without addressing access or the role of social determinants – Intervention studies that did not examine how social factors influence or mediate access to care – Studies that lacked any framing of analysis, discussion, or findings within a social determinants or health equity context.
Context	– Only studies conducted in Australia. – Published between 2013 to 2024	– Studies set in other countries that do not provide Australia-specific data or contextual analysis. – Before 2013
Types of evidence	– Peer-reviewed, published journal articles employing qualitative, quantitative, or mixed methods designs; as well as systematic reviews, scoping reviews, mapping studies, and policy analyses that report on social determinants influencing disparities in access – Grey literature, including relevant non–peer-reviewed sources that contribute to understanding the social determinants.	– Conference abstracts, book reviews, editorials, commentaries, or opinion pieces that do not present extractable empirical data or detailed analysis. – Reports or protocols without subsequent full-text publication unless you decide that grey literature is essential for the review.

to discuss the issues, and final decisions were made by consensus.

Charting the data

A standardised data extraction form was developed to capture key study characteristics and relevant contextual information (see supplementary file 3). The following details were extracted from each included study: lead author and year of publication, Australian state or territory, study methodology, disability type, perspective (e.g., people with disability, caregiver, provider), intersectional considerations (e.g., age, gender, location), and study population. Outcomes were charted across two categories: access to health services and access to support services.

Data extraction was guided by a conceptual framework grounded in the WHO SDoH model, with a particular focus on structural determinants [4]. In line with the WHO SDoH framework, we also extracted data related to socioeconomic and political context, including indicators such as gender, ethnicity, income, education, and employment.

Consistent with scoping review methodology, we did not conduct a formal quality appraisal of the included studies. This approach aligns with the aim of scoping reviews, which is to map the existing evidence base and identify key themes, gaps, and patterns, rather than to evaluate the effectiveness or quality of specific interventions.

Collating, summarising and reporting results

Following data extraction in Covidence, the information was exported into Microsoft Excel for further organisation and analysis. A descriptive analysis was conducted to summarise the characteristics of the included studies, such as publication year, geographic location, study design, and target population. The extracted data were then organised according to predefined categories of structural determinants, which were considered key equity dimensions in line with the conceptual framework guiding this review. These structural determinants provided the analytical categories for synthesising the data and identifying patterns across the studies.

Using a thematic analysis, we systematically examined how each equity dimension influenced access to health and support services. An inductive approach was employed to identify and interpret emerging themes within each equity dimension. While themes were primarily derived inductively from the data, their organisation and interpretation were structured through the lens of the WHO framework.

Results

A total of 171 studies were identified as possibly relevant after screening 2,491 records identified through database searches and identifying 15 from other sources. Of the 171 studies assessed for eligibility, 54 met the inclusion criteria and were retained for extraction and analysis (Fig. 1).

The included studies explored a range of health and support services. In terms of support services, the most frequently studied area was the NDIS, featured in 19 studies. Other areas of focus included housing (2), disability employment services (2), social capital (1), and various forms of disability support services such as education, rehabilitation, and childhood services (6). In the domain of health services, studies addressed diverse areas, including general health services (4), rehabilitation services (2), and telehealth (3). Other specific services included mental health, emergency department use, diagnostic services, General Practitioner (GP) services, oral health, and specialist care.

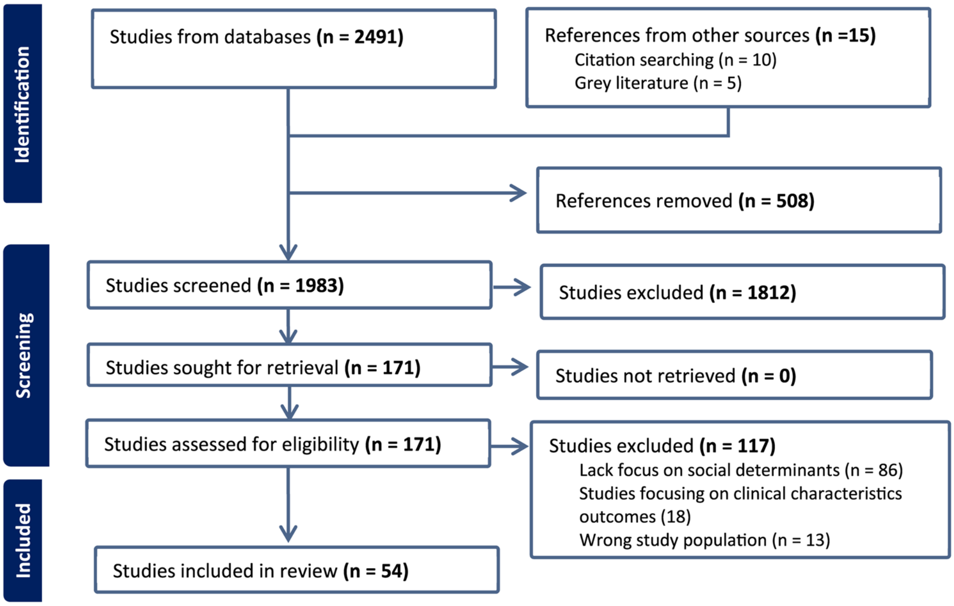

Fig. 1 PRISMA flowchart describing study screening and reasons for exclusion

Most studies were national in scope, with 26 papers examining issues across Australia. State-specific studies were also represented, with studies focusing on New South Wales (7), Victoria (5), Queensland (4), Western Australia (3), Australian Capital Territory (2), Northern Territory (2), and (1) South Australia, and four more studies addressing multiple states. This distribution indicates a concentration of research at the national level, with variable representation across states and territories. The included studies employed a range of research methodologies. Qualitative methods were used in 23 studies, quantitative approaches in 16, mixed methods in 6, and literature reviews in 9.

Half of the studies did not specify a particular disability type, focusing instead on general disability populations (26 studies). The most frequently addressed disability type was psychosocial disability (15), followed by physical disability (4), sensory disability (4), intellectual and developmental disability (3), and acquired brain injury (2, including head injury or stroke). See supplementary material 3 for individual study charting.

Structural determinants

Socioeconomic and political context

Evidence relating to the socioeconomic and political context highlights multiple factors that contribute to existing inequities. Our review identified key 'upstream' factors shaping these conditions including gaps in policy design and implementation, geographic disparities in service access and availability, service integration and coordination challenges, cultural misalignment, and socioeconomic marginalisation.

Gaps in policy design and implementation

Given the dominance of the NDIS within the Australian national disability policy landscape, the NDIS was understandably a key topic across the studies. A majority of studies highlighted the bureaucratic complexity of the NDIS, including strict eligibility criteria and administrative barriers that limit access to support services [7, 16–21].

Gaps in policy design and implementation have had significant impacts across most disability types, but these have been especially acute for people with psychosocial disability. For example, narrow eligibility criteria and burdensome proof of disability requirements have posed significant barriers to access [17, 22, 23].

Seven studies highlighted policy misalignment with diverse needs leading to system failures. This misalignment is particularly significant for individuals with psychosocial disability who must often receive support across multiple service systems, with studies reflecting on the inconsistent integration of recovery-oriented mental health services with the NDIS framework causing disruption of care continuity [22–24].

The transition of mental health funding from state programs to the NDIS is one example of a structural policy change that has further widened these gaps. This change has left people ineligible for the NDIS without adequate support because of the closure of more targeted programs with less restrictive access requirements in favour of the NDIS, which is pan-disability in focus but has strict eligibility criteria based on permanence [23, 24]. Moreover, weak coordination between federal, state, and local governments has led to jurisdictional inconsistencies, causing uneven service delivery across regions [23].

Institutional fragmentation in support systems

Several studies highlighted institutional fragmentation in disability support services, commenting on weak integration between the NDIS and key sectors such as housing, health, and employment [20, 23, 25–27]. Three studies highlighted that poor alignment between the NDIS and housing, or health systems, often leads to delays or denials for individuals needing accessible housing or integrated healthcare due to jurisdictional overlaps and unclear responsibilities [20, 23, 27]. Green et al. (2022) argued that policies overly focus on impairments, neglecting broader social determinants like housing and employment [27].

This system-wide fragmentation has affected service access across all disability types, with disproportionate impacts on rural, culturally diverse, and low-income groups. Psychosocial disability was consistently associated with fragmented service delivery, particularly due to funding transitions, the absence of trauma-informed care, and weak integration with mental health systems.

Geographic disparities in service access

Several studies have highlighted that geographic disparities pose a significant barrier to equitable disability service delivery, particularly for individuals in rural and remote areas. Residents of these regions often struggle to navigate the NDIS's complex eligibility criteria, largely due to a lack of local resources, such as disability advocates and service providers who can assist with applications [19, 23, 24, 28, 29]. Even when NDIS access is granted, utilising approved plans remains difficult due to the scarcity of local services [7, 19, 28]. Additionally, NDIS pricing structures do not adequately cover travel costs, creating a financial burden for both participants and providers [19, 30].

Many studies highlight the limited availability of general practitioners and restricted access to specialised services in rural and remote areas [12, 31–33]. The centralisation of specialist health services in urban centres further exacerbates these urban-rural disparities [34, 35]. Additionally, resource shortages in rural areas contribute to inadequate care, longer hospital stays, and delayed access to childcare [36–38]. Poor communication and coordination between services in regional, rural, and remote areas further hinder effective healthcare delivery [26, 39]. This pattern was observed across all disability types including psychosocial, sensory, physical, and intellectual—with most studies reporting service scarcity, transport barriers.

Cultural misalignment and socioeconomic marginalisation

The limited alignment of the NDIS's implementation with culturally appropriate care models may contribute to systemic inequities, particularly affecting Aboriginal and Torres Strait Islander peoples as well as Culturally and Linguistically Diverse communities [20, 26, 27, 40]. For Aboriginal and Torres Strait Islander individuals, the absence of Indigenous-led disability support services means they often receive care that does not reflect their cultural values or community needs. This misalignment heightens existing reduced engagement and trust in the system, making it difficult for this population to access and navigate the support they require [20, 40]. Similarly, culturally and linguistically diverse individuals face additional challenges due to the lack of culturally safe supports, such as language-appropriate resources and providers trained in cultural competency [24, 41]. Issues with funding allocations were mentioned in five studies. Two studies highlighted inadequate resources for culturally safe services [26, 42], while another reported insufficient or inconsistent funding for rehabilitation services in remote areas [36]. Additionally, one study emphasised the lack of adequate support for individuals with high-care and complex needs [27].

Overall, bureaucratic complexities and gaps in policy design and implementation within disability support systems disproportionately affected disadvantaged groups, especially individuals from lower socioeconomic backgrounds, who often lack the education or advocacy support needed to navigate the system [7, 18, 19, 28, 43]. For example, a study by Cortese et al. (2021) found that awareness gaps were particularly significant in some populations, with 72% of 32 qualitative interviewees from lower socioeconomic backgrounds either unaware of the scheme or misinformed about its services [43]. Those who do not qualify for the NDIS often find themselves without adequate alternative supports, as state-funded or community-based services are limited [17, 24, 30]. This gap disproportionately affects disadvantaged groups who cannot afford private services, lack the resources to compile evidence for support applications, or do not have the means to advocate for additional assistance [18, 28, 43].

Income

Income levels significantly influence how individuals with disability engage with and benefit from support systems, including health, the NDIS, housing, and employment. Five studies link socioeconomic disadvantage to healthcare disparities. For example, Hui et al. (2018) notes that poverty exacerbates disability by preventing individuals from affording medication and transport to medical appointments [17]. Families of children with intellectual disability incurred higher healthcare costs, placing additional burden on low-income households [38]. High rates of poverty and homelessness were noted among some groups of people with disability (e.g., those with psychosocial disability) and their carers [37]. Preventable hospitalisations [44] and higher healthcare non-attendance rates were more common among disadvantaged groups due to financial barriers [45].

Income-related barriers to service access

Key ways that income impacts access to services and support include travel costs, specialist assessments, service fees, and advocacy support. Travel costs leading to financial strain were identified as a significant obstacle [19, 34, 35, 43, 46–48]. As above, this particularly affected rural and remote individuals and families who had to travel to population centres to access care. Indirect costs, such as parking fees and meals during care-seeking, further exacerbate this burden [19]. Specialist assessments, a critical requirement for applications for NDIS access, are often unaffordable for low-income individuals and families [23, 24]. Low-socioeconomic status families also report being unable to access advocacy services, which limits their ability to navigate complex NDIS–related systems and access the support they need [21, 43]. Participants living in disadvantaged areas or with low SES—measured by the Index of Relative Socio-economic Disadvantage (IRSD)—also tend to receive smaller NDIS plans and spend less on services [18, 41]. Low-SES households are further disadvantaged by inflated service prices—for instance, some service providers have increased their fees under the NDIS, disproportionately impacting families who do not receive NDIS funding but need to access supports [21]. This burden is greater for families who receive no government support, or for low-income families who cannot afford rising costs.

Thin markets and low-income households

Three studies highlighted how 'market failures' within the NDIS framework, particularly the emergence of thin markets. The NDIS operates as a market-based system of disability support, where participants purchase services from providers rather than receiving them directly from government. Thin markets occur when service supply is limited, fragmented, or absent relative to demand. They are most evident in remote regions, specialist service areas, and among groups with complex needs or who need to access culturally specific services. This disproportionately affects low-SES households, which often have limited access to the knowledge, support, and infrastructure—such as transport or digital connectivity—needed to navigate and coordinate scarce services [7, 18, 28]. These studies note that some low-income participants in rural areas struggle to find available services, resulting in unspent funds. These unspent funds are then reclaimed by the system, effectively penalising these households for systemic shortcomings rather than their own choices.

Financial barriers to service engagement

Financial constraints hinder engagement with employment services and opportunities. According to two studies, low-income individuals with disability struggle to cover costs related to job searching—such as interview clothing and further education—even when supported by Disability Employment Services (DES) [49, 50]. High housing costs relative to income limit the resources available for other support services. Baldry et al. (2023) reported that 41% of people with disability spend over 30% of their income on housing, reducing their capacity to afford additional support [51]. Another study indicated that socioeconomic deprivation, poverty, and homelessness among people with psychosocial disability hinders their ability to receive adequate mental health care, illustrating the broader impact of income on mental health services [37].

Four studies demonstrated that financial hardship forces many low-income individuals to prioritise immediate survival needs, such as rent and transportation, over exploring NDIS support options [21, 43, 47, 52]. This focus on day-to-day expenses leaves little room for navigating complex systems or planning for long-term care. People reliant on income support are often also hesitant to engage with the NDIS due to uncertainties about how it might affect their welfare payments [52].

Income and intersecting disadvantages

The intersection of income with other social determinants exacerbates inequities in accessing disability supports. Geographic disadvantage magnifies financial limitations, as low-income individuals in rural/remote areas face significant travel and accommodation costs [35, 46]. These costs, coupled with service scarcity, create a "double burden" for those already constrained by limited incomes. Disability type further compounds disparities: individuals with intellectual or psychosocial disability are disproportionately affected by poverty and homelessness compared to others with disability, limiting their ability to engage with support systems [7, 37]. Indigenous carers, particularly lone carers on single incomes, face financial hardship from care-related expenses with cultural obligations in remote communities resulting in additional financial strain [20, 47]. One study also critiqued systemic flaws in welfare means-testing, noting that partnered individuals can be penalised under current reporting structures, which restricts access to the Disability Support Pension [53].

Education

Education emerged as a critical determinant, with 14 studies linking lower educational attainment to reduced health literacy and service access. The reviewed studies consistently emphasise the multifaceted impact of education and literacy on access to, engagement with, and outcomes from disability services.

A prominent theme, supported by at least six studies, is the significant influence of education on access to disability services. Higher levels of education are linked to improved advocacy skills, better navigation of support systems, and enhanced employment opportunities [21, 22, 54, 55]. On the other hand, individuals with lower education or literacy levels frequently encounter challenges in accessing these services. For example, Hui et al. (2018) identified illiteracy and lack of digital literacy as barriers, particularly in navigating online applications.

Deficiencies in health literacy, digital literacy, and administrative literacy significantly hinder the ability of people with disability to access and utilise health and support services [12, 17, 19, 23]. These challenges are particularly acute in remote areas and among individuals with intellectual disability, where limited service availability compounds the problem [19]. The intersection of low system navigation skills and geographic remoteness disproportionately affects those living in remote areas. Parents with higher education are more effective at navigating the service landscape and thereby securing necessary support for their children. On the other hand, those with lower education encounter greater difficulties, often resulting in inadequate support or missed care [39]. Navigating the scheme requires substantial administrative, digital, and health literacy; without these skills, families are more likely to submit incomplete applications, have limited engagement with providers, and struggle to advocate for appropriate supports. Additionally, a lack of awareness about available services, further limits access for those with lower education, reflecting broader systemic failures rather than individual shortcomings [53, 56].

The education system and support services such as those provided under the NDIS and Disability employment services sometimes struggle to fully address the diverse needs of individuals with disabilities. Challenges include insufficient support for learning disabilities, and gaps in training or service processes, which can lead to longer periods of engagement and reduced outcomes [50, 57].

Lower educational attainment, often interconnected with socioeconomic disadvantage, exacerbates these challenges [21, 46, 58, 59]. For example, children from socioeconomically disadvantaged backgrounds, typically characterised by lower parental education, face an increased risk of missed care, particularly when additional disabilities are present [45].

Employment

Employment was considered from two perspectives. Firstly, as a key component of disability support services, we examined how employment-related programs facilitate workforce participation for people with disability. Second, as a structural social determinant, employment plays a crucial role in shaping an individual's socioeconomic position.

We identified 12 papers highlighting systemic and individual-level impacts on employment for people with disability. Two studies highlighted the high unemployment rates and limited workforce participation challenges for people with disability and caregivers in Australia [17, 51]. Long periods of unemployment are common, with systemic barriers preventing sustained employment [49]. One study found only 50% of disability service organisations employ at least one person with a disability, while 24% employ none [60]. This study highlights significant gaps in occupational roles, as people with disability remain markedly underrepresented in higher-level positions. Only 19% of organisations employ them in management roles, and just 24% include them on their boards. Additionally, when employed, individuals with disabilities are often relegated to low wage, casualised roles, highlighting income disparities within the workforce [60].

People with disability encounter multiple barriers to income-earning employment. Workplace environments are often difficult to navigate, with behaviours associated with disabilities misunderstood [61]. One study highlighted weak implementation of employment targets and a focus on "soft" market-based approaches (e.g., awareness training) rather than enforceable "hard" levers like quotas [60]. Another study further emphasised structural gaps, indicating a lack of pathways for people with disability to access education and training, which perpetuates employment inequities [27]. One study highlighted challenges within the implementation of DES, revealing that staff often lack the necessary skills to support individuals with mental health challenges, particularly those who have experienced trauma [50].

Four studies explored the theme of workplace discrimination and culture. Two studies discussed discriminatory practices in hiring, such as the requirement to disclose disability status during job interviews or the revocation of job offers post-disclosure [27, 61]. Discrimination and stigma are widespread, with employers perceiving the hiring of people with disability as "too much trouble" or requiring excessive accommodations [27]. Additionally, hostile workplace environments were identified, characterised by job insecurity, mistrust of employers, workplace bullying, and the assignment of inappropriate roles [22, 61].

Intersectional challenges were identified across the studies, with one study highlighting that rural residents with disability experience overlapping geographic and disability-related inequities in service access and employment opportunities [51]. Five studies showed the cyclical relationship between unemployment and financial hardship [17, 28, 50, 51]. One study further emphasised that unemployment restricts access to critical support systems, such as advocacy and plan management services, which are vital for navigating disability-specific institutional frameworks [28].

The studies included in the review represented a wide range of disability types, though the distribution was uneven. Psychosocial disability was the most frequently examined, including conditions such as schizophrenia, depression, bipolar disorder, borderline personality disorder, and other mental health–related impairments. A large number of studies looked at diverse disability populations or to carers of people with disability whose employment outcomes are directly affected by caregiving responsibilities. Intellectual and developmental disabilities—including intellectual disability, developmental delay, and autism—were present but less commonly examined. Physical disabilities such as cerebral palsy, spinal cord injury, and acquired brain injury appeared in a smaller subset of studies.

Gender

We identified three primary themes from the analysis of 14 studies related to gender disparities and caregiving burdens, particularly in the context of disability and healthcare: gendered caregiving burdens, gender disparities in healthcare access and treatment, and compounded disadvantages faced by women.

Six papers addressed the theme of gendered caregiving burdens for people with disability [19, 20, 26, 47, 57, 62]. The studies consistently highlighted that caregiving roles are mainly undertaken by women, resulting in significant emotional, and economic challenges. For example, one study noted that carers, who are often women, manage substantial emotional and logistical burdens [19]. Similarly, another study found that female carers frequently exit the workforce due to the demands of managing appointments and providing care, particularly on non-school days [47]. One study noted the lack of institutional recognition for carers' roles [62]. Caregiving was also linked to risks such as homelessness among older women [51, 62].

Six papers explored gender disparities in healthcare access and treatment for people with disability [53, 54, 59, 62–64]. These studies revealed a range of challenges faced by women and gender minority populations in healthcare settings. One study reported perceived differences in how men and women experience accessing disability supports, noting that women, often socialised to be more passive, exhibit less confidence in self-advocacy and negotiation [62]. Gender discrimination was also reported in diagnosis, for example, one study focusing on autism among women reported dismissal of self-suspected autism, misdiagnosis (e.g., attributing traits to anxiety), due to healthcare providers' reliance on male-centric stereotypes and insufficient training in the heterogeneity of autism [54, 62]. On the other hand, one study highlighted that borderline personality disorder (BPD) is often perceived as a "gendered construct," with higher diagnosis rates among women. However, the study also noted an overrepresentation of women in the sample, which may have influenced this finding [64].

Three papers focused on the compounded disadvantages faced by women, particularly in terms of economic and social impacts [29, 47, 51]. Older women are at increased risk of homelessness due to low income, caregiving responsibilities, and experiences of domestic violence, highlighting the intersection of economic and social vulnerabilities [51]. One study linked caregiving burdens to economic consequences, noting that female carers often exit the workforce to meet caregiving demands, resulting in reduced financial stability and social opportunities [47]. For example, women are overrepresented among unpaid primary carers [51]. In two studies, all carer participants were women; however, it is unclear whether this reflects the researchers' sampling strategies or an actual absence of male carers [26, 47].

Ethnicity

Indigenous communities

A total of 15 studies addressed barriers faced by First Nations communities, highlighting a broad range of challenges. Four studies highlight the impact of cultural differences and stigma on service accessibility. One study explores how colonisation has shaped differing perceptions of disability [40]. Two studies emphasised cultural misalignment as a barrier, leading to lower service utilisation, and point to stigma around disability, compounded by a lack of culturally appropriate NDIS resources [19, 30]. Four studies point to systemic issues and historic mistrust as significant barriers. Two studies linked reluctance to access services to legacies of colonisation and the stolen generation. Systemic marginalisation in service design, along with broader structural barriers, was identified as impacting Indigenous populations [7, 20].

Three studies examine geographical and logistical challenges. One study found that Aboriginal and Torres Strait Islander participants in rural and remote areas had lower service utilisation due to limited availability [41]. The combined effects of distance-related barriers and systemic neglect were also highlighted [44]. Language barriers, discrimination, cultural expectations, and socioeconomic challenges all contribute to the difficulties Indigenous Australians face in accessing support services. One study highlights that English not being the first language for some Indigenous participants can hinder effective communication with service providers [52]. Another study reports that Aboriginal carers often feel judged or looked down upon by mainstream providers due to their ethnicity, with perceptions of racism discouraging re-engagement with services [26]. Additionally, extensive care responsibilities for extended family among Aboriginal women further restrict their ability to seek support [62]. Compounding these challenges, Aboriginal Australians experience homelessness at a higher rate than non-Indigenous populations, indirectly exacerbating barriers to service accessibility [51].

Culturally and linguistically diverse communities

We identified six studies that explored barriers faced by culturally and linguistically diverse communities. Four studies consistently highlight language as a primary obstacle, with three specifically noting language barriers for culturally and linguistically diverse participants [17, 28] and another emphasising higher needs, but lower service access [21]. Additionally, one study points to the lack of culturally competent services, indicating that service providers often fail to adequately address the cultural needs of culturally and linguistically diverse communities [28].

Two studies highlight broader systemic barriers affecting culturally and linguistically diverse groups, with one study reporting a significant gap in specialist disability services between culturally and linguistically diverse individuals and the broader community [7, 65]. Additionally, two studies identify delays in service engagement, noting that ethnic-minority families take significantly longer to enrol in early intervention programs [66]. Similarly, families from cultural minority backgrounds in rural, regional, and remote (RRR) areas access intervention services later than those from majority-culture families, further compounding disparities in care [39].

Some studies provide comparative insights among groups. One study highlights that both Indigenous and culturally and linguistically diverse families experience delays in accessing early intervention services, with higher rates compared to other groups [39]. Another study showed higher service usage among individuals from English-speaking backgrounds, suggesting lower engagement among non-English-speaking groups, including culturally and linguistically diverse populations [63].

Discussion

Our review of inequities in access to health and support services for people with disability in Australia highlights how intersecting socioeconomic, political, and cultural factors create complex structural barriers that disproportionately limit access to support services.

The scoping review's findings largely confirm established understandings of social determinants in relation to health and social support, particularly regarding income, gender disparities, and socioeconomic disadvantage, as seen in previous work [67]. However, it extends this work by providing a comprehensive, integrated analysis using the social determinants framework, including a wider range of structural determinants and highlighting NDIS-specific issues.

Our analysis documented the structural determinants that have shaped current conditions, resulting in inequitable access to health and support services. Socioeconomic and political contexts have played a critical role in reinforcing these disparities in various ways. Geographic inequity, in particular, remains a persistent issue, as rural and remote communities continue to face limited resources and inadequate policy adjustments to address this inequity. Cultural disconnects—particularly the lack of culturally safe and responsive approaches—undermine trust and engagement among both Indigenous and culturally and linguistically diverse populations. Economic disadvantage and poverty further worsen barriers to accessing services. Market-driven policies deepen these struggles, while limited education or bureaucracy literacy makes it difficult for individuals to navigate the system. Employment exclusion, rooted in structural barriers and discrimination, perpetuates unemployment and underrepresentation in meaningful roles. Gender-related burdens disproportionately affect women, revealing broader societal inequities in caregiving and healthcare access.

The most prevalent finding was the bureaucratic complexity of systems of support, which emerges as a central structural barrier, consistently limiting access for those least equipped to overcome it—namely, low-income, rural, Indigenous and culturally diverse individuals. More critically, the intersectionality of factors—such as low income, geography (remote), low education, gender, and ethnicity—creates a compounding effect that perpetuates disadvantage — indicating that support systems may be inadvertently failing the people that should be prioritised because of increased disadvantage.

Gaps in the existing literature

The body of literature addressing disparities in access to health and support services that we identified through this study reveals several critical gaps. These shortcomings, rooted in the focus, methodology, and scope of the studies, hinder a comprehensive understanding of inequities and limit the practical application of the findings to improve policy. The literature is heavily focused on generating evidence to understand barriers to accessing services and identifying policy gaps in support systems. Many studies focus on pinpointing specific obstacles—such as geographic isolation, inadequate funding, or administrative complexities—that prevent individuals or groups from obtaining necessary services. While this focus is valuable for uncovering the causes of inequities, it often fails to explore how these barriers result in differing levels of access across different population groups. For example, the studies may highlight transportation issues as a barrier but rarely examine how this disproportionately impacts rural versus urban residents or low-income versus high-income individuals. This narrow lens provides a generalised picture of challenges without offering insights into the varying degrees of disadvantage, thus limiting the ability to design targeted solutions.

A critical gap in the current Australian literature is the lack of disaggregated evidence. Current studies often treat people with disability as a homogeneous group, overlooking how factors such as race, gender, and socioeconomic status intersect with disability to create compounded disadvantages. For example, an Indigenous woman with disability may face unique barriers compared to another person with a similar disability, yet these distinctions are often ignored. Future research should prioritise an intersectional approach, examining how these overlapping identities shape experiences and access to services. This would provide critical insights into the compounded challenges faced by specific subgroups, enabling policymakers to design more inclusive and tailored interventions.

These limitations significantly affect the interpretation and generalisability of the research findings. The absence of detailed comparisons between population groups makes it difficult to assess the true extent of disparities or identify which segments of the population—such as the “haves” versus the “have-nots”—are most impacted by inequities. Without this comparative analysis, the literature cannot provide a clear picture of how structural factors, like policy gaps or resource distribution, differentially influence access across Australia’s diverse contexts. Furthermore, the reliance on qualitative data, while rich in detail, limits the ability to draw broader, systemic conclusions that apply beyond specific study samples. As a result, policymakers and practitioners are left with an incomplete understanding of how to address disparities on a national scale.

This gap is also a globally recognised concern. A recent review that looks at studies assessing health equity and health inequity rarely include disabled people as a group [68]. This exclusion becomes even more evident when examining specific subgroups within the disability community or the intersectionality of disability with other forms of marginalisation. Furthermore, the review highlights that many social determinants influencing the health equity and health inequity of disabled people are absent from studies [68]. In Australia, Fortune et al. (2021) highlighted significant gaps in administrative health data—such as hospital records and Medicare data—which hinder the ability to generate disability-specific insights into service equity [69]. Additionally, remote populations and institutionalised individuals are underrepresented in surveys, limiting the potential for comprehensive analysis [69]. The recent establishment of the National Disability Data Asset (NDDA) presents a significant opportunity to address evidence gaps by bringing together de-identified data from various government agencies about all Australians.

Policy reform to centre the social determinants of health

Many developed countries have established strong disability-specific legislative frameworks to safeguard the rights of people with disability and provide targeted support. However, studies indicate that persistent barriers—such as socioeconomic disparities, geographic inequities, and stigma—continue to hinder access to healthcare and support services [70–72]. These challenges are compounded, for example by disproportionately high unemployment rates, and exacerbating financial strain [73]. Our review suggests Australia’s system, despite being progressive, faces unique and critical challenges due to its design. Australia’s model is often celebrated internationally for its national and comprehensive approach – represented by the NDIS as its flagship program [74]. However, while the national design of the NDIS is internationally recognised as progressive, it is this national, individualised funding model that gives rise to unique implementation challenges —such as service gaps, complex and highly bureaucratic processes, workforce shortages, and difficulties integrating with other systems—particularly in rural, remote, and diverse communities [75, 76]. This suggests that even well-intentioned systems may lose momentum without continuous refinement and responsiveness to the lived experiences of people with disability. Putting this into practice is difficult because of the need to develop a model of support which can: (1) determine individual needs, (2) draw together multiple systems in order to meet identified needs, (3) understand which programs and services can best meet these needs and, (4) allocate individuals to these programs.

Australia’s Disability Strategy 2021–2031 adopts the social model of disability, emphasising the need to remove systemic and structural barriers to enable people with disability to participate fully and equally in society. The *Strategy* also calls for an intersectional and diversity-informed approach in the implementation of its policy priorities [2]. However, translating these commitments into practice has proven challenging [75]. For example, the current eligibility criteria of the NDIS, which are grounded in a medical model, do not adequately account for intersectionality or systemic barriers [77]. This reflects a clear disconnect between the *Strategy’s* vision and its practical implementation. To bridge this gap, consideration must be given to embedding intersectionality and the broader social determinants into eligibility frameworks and the overall service design. For example, embedding systems for determining the needs of individuals in relation to their social determinants of health would enable those to be considered as part of the implementation of services to them, potentially making the services more targeted and effective. This approach has been implemented in closed systems such as the Kaiser Permanente model in the United States where assessments of social determinants of health are routinely conducted and referrals made to address needs. The aim of this approach is to increase the value of health care provided in terms of effectiveness [78]. Such an approach increases the ability of individuals to engage with services provided and reduces continued reliance on health services [78].

The NDIS operates as a market-driven program, meaning services are only available where providers choose to offer them. This model can disadvantage people living in regional and remote areas, where service delivery is often more costly and logistically challenging for providers [79]. As a result, access to essential support services in these areas can be limited or inconsistent. This highlights the need for stronger outreach initiatives and mobile service models to ensure equitable access to support for people with disability, regardless of location. It also highlights the need for increased stewardship of the market in order to direct supports where they are needed, including using both flexible funding and service agreements to commission services [80].

In 2022, an estimated 2 million Australians experienced a profound or severe disability—with a little more than half (1.1 million) being under the age of 65 [1]—the NDIS currently supports only around 650,000 to 700,000 participants. This indicates that a substantial majority of individuals with high support needs may be left without adequate assistance, particularly given the limited availability of alternative support mechanisms outside the NDIS. This gap raises serious equity concerns, especially for those who fall outside the scheme's eligibility criteria. The recent NDIS Review has recommended the introduction of "foundational supports" which may be a vehicle for providing a broader safety net for addressing these disparities [81]. If implemented effectively, foundational supports have the potential to significantly enhance equity by extending access to essential services and supports for people with disability who are currently underserved. However, a critical consideration in the design and rollout of foundational supports is ensuring that they are inclusive and responsive to the needs of individuals experiencing compounding and intersectional disadvantage—such as those affected by poverty, cultural and linguistic diversity, remote living, or systemic discrimination. Addressing these layers of disadvantage will be vital to ensuring that foundational supports do not replicate existing inequities but instead promote genuine inclusion and accessibility for all. Key to this will be strong connections between foundational supports which offer specific disability-related supports and those provided through, for example, the housing, education and employment sectors.

Strengths and limitations of this review

We conducted a comprehensive mapping of the evidence base, systematically identifying and describing a wide range of studies. This approach has brought together previously fragmented evidence, clarified the overall scope and key themes of this evidence, and highlighted important gaps in the literature. We applied a structural social determinants conceptual framework to organise findings around upstream drivers such as income, transport and policy design. Framing the review in this way helps shifts attention from individual-level explanations toward policy-relevant levers that can address systemic barriers to access.

This review has several limitations. First, as scoping reviews aim to map available evidence rather than assess study quality, rigorous studies may appear alongside weaker or anecdotal reports. Second, although we attempted to map different types of disability separately, most included studies treated "disability" as a single category, masking important differences between physical, intellectual, psychosocial, and sensory impairments. Among the studies that examined a specific disability type, most focused on a narrow range—particularly psychosocial disability—while other disability types received comparatively little attention. It is important to note, however, that the limited evidence for other disability types does not imply the absence of substantial barriers to access. Third, inconsistent definitions of key terms—disability, access, and support services—and variations in systems and study designs further reduced comparability. Few studies used conceptual frameworks such as the social determinants of health or the social model of disability to guide their analyses, making it more difficult to identify structural factors. Finally, high heterogeneity in populations, settings, outcomes, and methods, combined with limited subgroup or stratified analyses, constrained our ability to determine the generalisability of findings across disability types, age groups, or geographic contexts.

Conclusion

Our review highlights the bureaucratic complexity of support systems as a key structural barrier, disproportionately restricting access for those least equipped to navigate it—particularly low-income, rural, Indigenous, and culturally and linguistically diverse populations.

These groups often face compounded disadvantages that are exacerbated by administrative burdens and fragmented service pathways. Improving the accessibility and responsiveness of support systems requires targeted reforms that simplify processes. Policymakers and service providers must prioritise the design of inclusive systems that account for diverse experiences and capabilities, ensuring that support reaches those who need it most. Future research should prioritise the generation of disaggregated, equity-oriented evidence to inform and strengthen policy initiatives aimed at better identifying and addressing the needs of disadvantaged groups. Such evidence is crucial for developing tailored interventions that not only enhance access but also promote fairness and effectiveness across the system.

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

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Author contributions

FTB, JH, IY, JC, and JSM contributed to the conceptualization of the study. FTB conducted the searches, and JH, IY, and FTB assessed study eligibility. JH, IY, and FTB extracted data. FTB synthesized the results. FTB and JSM drafted the original manuscript. JH, IY, JC, and JSM contributed to writing, review, and editing. All authors read and approved the final manuscript. FTB had final responsibility for submitting the manuscript for publication.

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Data availability

All data generated or analysed during this study are included in this manuscript and its supplementary information files. As this is a review, no primary data were collected. Relevant data and materials used for the analysis are publicly available and appropriately cited in the reference list.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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