Submission

2025-26 National Disability Insurance Scheme Annual Pricing Review consultation

Submission by the **Australian Physiotherapy Association**

February 2026

Authorised by:

Rob LoPresti
Chief Executive Officer
Australian Physiotherapy Association
Level 1, 1175 Toorak Rd Camberwell VIC 3124
Phone: (03) 9092 0888
Fax: (03) 9092 0899
www.australian.physio

Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 35,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Table of Contents

1. Executive Summary **5**

Introduction **5**

APA position **5**

Reform pricing now 6

APA inputs to the current review 6

2. Recommendations **8**

3. Consultation questions **9**

Differentiated Pricing **9**

Q1. If the NDIA implements differentiated pricing (different price limits for different circumstances) what should be the primary basis for differentiation? 9

Q2: What is the single biggest risk of differentiated pricing the NDIA must address? 14

Q3: What participant support characteristics require different staffing, supervision or delivery approaches for DSW supports? 14

Q4: Compared to delivering similar supports in other sectors (for example, aged care, health or community services), what aspects of the NDIS environment make DSW service delivery more or less complex? 15

Q5: Compared to therapy in health/aged care settings, rate how much additional time/effort each aspect requires under the NDIS? 15

Therapy Supports **27**

Q6: How is your therapy workforce primarily employed? 27

Q7: What is the typical duration of a NDIS therapy session delivered by your organisation or practice? 27

Q8: What percentage of this session time is direct therapy, documentation, coordination or other? 28

Q9. Since the change to travel claiming was introduced on 1 July 2025, has it been hard to find a therapist who will travel to you? Q9.1: If you had your choice, what would you prefer? Q9.2 Why do your therapists travel to you? 29

Q10. Is there anything else you'd like to tell us about NDIS pricing? 30

Appendix: Review of the 2024-5 APR with respect to physiotherapy **32**

1. Executive Summary

Introduction

The Australian Physiotherapy Association (APA) welcomes the National Disability Insurance Agency's 2025–26 Annual Pricing Review (APR) as a critical step toward a pricing system that is transparent, evidence-driven and responsive to the needs of participants and providers. Representing more than 35,000 physiotherapists nationwide, the APA supports reforms that ensure people with disability can access high-quality, safe and sustainable physiotherapy supports.

As part of the NDIA's three-year pricing workplan, the APR is intended to keep NDIS pricing aligned with contemporary service delivery, workforce realities and participant expectations. Last year's pricing decision has since been widely recognised as resting on a flawed methodological foundation, raising legitimate concerns about its suitability as the basis for the current review. This year's review therefore represents a necessary corrective moment, one that must restore pricing settings to a level that accurately reflects the true cost and professional demands of physiotherapy supports.

This review also comes at a time when the APA and the NDIA are still working through the pricing issues triggered by last year's decision and confirmed by the independent Nous review. [1]Physiotherapy remains one of the disciplines where these acknowledged gaps have yet to be resolved, with impacts on service viability and workforce retention unfolding in real time. The APR offers an essential opportunity to correct these structural issues and ensure therapy pricing reflects the regulatory load, the full scope of physiotherapy practice and real-world costs of delivering high-quality physiotherapy within the NDIS. This policy imperative is made even clearer by the ongoing doubts about the methodological integrity of the 2024–25 APR.

APA position

The APA has previously put forward robust recommendations to government highlighting key cost drivers, service delivery complexities and market sustainability pressures evident in the sector.

In its 2024-25 APR, the NDIA announced a 5.2% reduction in the national price limit for physiotherapy from $193.99 to $183.99 per hour for 2025-26 after six years without indexation since 2019-20, The APR justified this reduction by benchmarking against broader market rates and a revised methodology that drew on MBS and PHI data, other government schemes and regression analysis of private website listings. It also harmonised jurisdictional price limits bringing previously higher price limits in WA, SA, NT and TAS into line with other states.

However, the APR's modelling approach produced results that diverge sharply from real-market conditions. The new MBS and PHI-based methods generated hourly benchmarks of $151-$159, which sits 18-22 per cent below the NDIA's own price limit ($193.99) during the modelling period. By contrast, six other methods reviewed in the same report produced benchmarks between $215 and $240, with other published approaches pointing even higher. The APR also claimed comparable schemes sit between $140 and $190, despite its own data showing a median near $200 and a 75th percentile around $215.

[1] Nous Group (2025). Review of the 2024-25 APR with respect to physiotherapy. 21 October 2025

A key factor for this gap is the APR's regression-based session-duration estimates, which assumed 45-minute sessions rather than the 30-minute norm, pushing hourly rates sharply downward. Taken together, these modelling choices produced benchmarks well below prevailing market rates and weakened confidence in the process. **Please refer to the Nous Report at Appendix 1**

Reform pricing now

The NDIA's phased three-year pricing workplan asks the sector to build reform on top of a pricing architecture already proven to be structurally unsound by providers and independent review and in need of urgent correction. Last year's decision left physiotherapy operating within a framework that is commercially unworkable and professionally misaligned, pressures now visible in diminished service viability, workforce instability and reduced participant access. Until these foundational issues are corrected, the system cannot deliver sustainable, high-quality physiotherapy. The APA maintains that the pricing methodology requires urgent, front-loaded reform, not a slow correction stretched across a phased workplan.

In progressing this aim, the APA urges the NDIA to draw on the Nous review's recommendations and pair immediate stabilisation with a credible long-term pricing strategy. In the short term, the system needs to move away from a regression model that guesses at prices and instead base decisions on clear market signals grounded in cost transparency and market validation. The longer-term solution is a bottom-up costing model built on rigorous and recurring cost surveys of physiotherapy providers. This approach restores transparency, reflects the true cost of service delivery, aligns NDIS pricing with evidence-based methods and creates the platform for session-based pricing that better reflects physiotherapy practice and supports both participant needs and provider stability. This two-stage pathway delivers immediate correction while building the durable pricing architecture the sector has been missing.

APA inputs to the current review

2025-26 National Disability Insurance Scheme Annual Pricing Review consultation

This review leaves key gaps in both approach and prioritisation, including unresolved questions about the validity of its methodology. And while the NDIA is consulting on new reform elements such as differentiated pricing and the treatment of face-to-face and non-face-to-face work, it is notable that travel, one of physiotherapy's major cost pressures, has been omitted from provider consultation despite appearing in the participant survey. As noted above, these discussions must sit alongside, not replace, the urgent task of fixing the underlying pricing failures.

The APA provides this advice in good faith. Several elements of the consultation fall outside the purview of physiotherapy and are not directly relevant to our workforce or service model. Our response therefore focuses on the two survey questions (Q1 and 10) and the corresponding sections of the consultation paper on differentiated pricing (Q2-5) and therapy supports (Q6-8), where physiotherapy has clear expertise and where NDIA decisions will directly affect service viability, participant access and workforce stability.

In relation to differentiated pricing, the APA cautions against expanding differentiation beyond the current areas where it already operates, such as service type and geographic location. Broader

differentiation introduces complexity without improving accuracy, increases administrative and compliance burdens for providers and the NDIA, and heightens the risk of unintended consequences. Any move toward complexity-based or context-based pricing must be grounded in validated cost data and reflect the real resource requirements.

Similarly, the treatment of therapy supports must recognise the distinct service profile of physiotherapy within the NDIS. This includes lower billable utilisation, higher non-clinical workload and the need for flexible service models to meet participant goals across diverse environments. Any pricing reform that fails to account for these realities will undermine both service quality and workforce sustainability.

In the context of travel, which appears only in the participant survey and not in provider consultation, we note again that this remains one of physiotherapy's most significant cost pressures. Travel is integral to delivering functional, community-based physiotherapy and cannot be treated as a peripheral or optional component of service delivery. We provide further detail on this issue in the supplementary section (Q9).

Finally, we note that the survey is directed solely at individual providers rather than peak bodies. This limits the ability of the consultation to capture sector-wide pressures, workforce dynamics and system-level impacts that cannot be observed at the level of individual practice experience.

Conclusion

If executed well, this Review can begin to reset the foundations of NDIS therapy pricing and ensure physiotherapy supports are delivered safely, sustainably and in line with participant needs. The Nous review has already confirmed that the existing pricing architecture is structurally unsound, methodologically inconsistent and disconnected from the realities of contemporary physiotherapy practice. These findings make clear that incremental adjustments are insufficient. The APR must adopt pricing that reflects validated costs and regulatory requirements, supported by transparent modelling that withstands scrutiny; a framework built on this foundation will restore service viability, stabilise the workforce and improve outcomes for participants, while rebuilding confidence in the integrity of NDIS pricing.

2. Recommendations

Recommendation 1 **Introduce a fair, sustainable and transparent costing model**	The NDIA should review and correct the physiotherapy pricing decision made in the 2024-25 APR. The true cost of physiotherapy services must be reflected in the pricing, considering actual session durations and the full range of costs associated with service delivery, including travel, administration, CPI and compliance. The NDIA should adopt a bottom-up costing model based on detailed, regular cost surveys of providers. This would allow for a more accurate and sustainable pricing model that reflects the real costs of service delivery.
Recommendation 2 **Ensure costing is based on comprehensive and representative data sources**	The NDIA should review provider costs related to quality disability supports and employ representative data sources to inform pricing decisions. This should include data from multiple private health insurers, independent surveys, and other relevant government schemes, which reflect the true cost of physiotherapy services and are better aligned with NDIS service delivery.
Recommendation 3 **Address the complexity of NDIS service delivery**	The NDIS pricing model must account for the complexities of delivering services in a disability context, including the need for multidisciplinary coordination, regulatory compliance, and the delivery of services in participants' homes and other natural settings.
Recommendation 4 **Fund travel as a standalone item.** **Conduct an urgent review and consultation with sector on 24-5 changes to travel reimbursement**	To maintain the delivery of high-quality physiotherapy services across all areas, equitably, travel should be fully-funded, and treated as a separate line item in NDIS care plans. The 2024–25 Annual Pricing Review's abrupt reduction in travel reimbursement has created significant barriers to service delivery. There is no indication that the NDIA is actively monitoring the impact of these changes on access, nor any evidence of meaningful engagement with the provider sector to gather feedback. This lack of consultation and oversight undermines participant choice and outcomes has resulted in service curtailment and withdrawal. Failure to consult and remediate risks further deterioration of service delivery in the communities that need it most.
Recommendation 5 **Review and address Scheme workforce sustainability**	The NDIA must consider the long-term sustainability of the physiotherapy workforce within the scheme under the current pricing structure. The profession is facing increasing pressure due to the misalignment of NDIS pricing with actual service delivery costs including the time and cost of providing supports to participants away from clinic environments and in natural environments and this threatens the stability and availability of services for participants.

3. Consultation questions

Differentiated Pricing

Q1. If the NDIA implements differentiated pricing (different price limits for different circumstances) what should be the primary basis for differentiation?

The APA does not support the NDIA's current direction on pricing differentiation, as the foundations required for credible reform are not in place.

Effective differentiated pricing starts with a credible, evidence-based cost picture for physiotherapy and a clear understanding of how participant complexity shapes service delivery. That foundation has been absent across successive pricing cycles, leaving the scheme without a reliable baseline for therapy costs. Adding further layers of differentiation on top of this gap risks cementing existing pricing errors rather than correcting them. The outcome would be greater system complexity and heavier administrative load for providers already carrying significant compliance demands.

The APA notes that the NDIA's current work on pricing differentiation spans four domains: registration and assurance, participant complexity and intensity, provider capability and quality, and market alignment and benchmarking. While some differentiation already exists, expanding these levers now is not a credible reform step.

Several mechanisms under consideration, including registration-based distinctions, have been examined repeatedly, and the same structural problems remain. These measures have been found to not scale well, likely to increase administrative burden and there is little evidence they provide a viable basis for future pricing. Revisiting them does not strengthen the framework.

Tiers based on provider size, registration status or years of experience introduce complexity without improving outcomes. They rely on blunt proxies for quality, risk suppressing fees for small and solo providers, and create multiple price points for the same therapy, encouraging participants to select the cheaper option and distorting genuine choice. This weakens market functioning and diverts attention from the real drivers of cost and risk in physiotherapy and allied health.

1.1 The APA has outlined our response to the policy consultation domains below and has expanded our focus to include the issues highlighted in the provider survey.

i. **Registration and assurance requirements**: recognising the compliance and quality investments required of registered providers.

This lever has been examined extensively in earlier consultation processes. The sector has already explored whether Ahpra registration, even when supplemented by additional requirements, could form a workable basis for pricing differentiation.

Physiotherapists are required to be registered through the National Registration and Accreditation Scheme (NRAS). Maintenance of registration is regulated by an external authority, the Physiotherapy Board of Australia (PhysioBA). The PhysioBA works in partnership with Ahpra to implement the NRAS under the Health Practitioner Regulation National Law.

Ahpra sets registration standards, accreditation standards, and codes and guidelines to ensure high quality care. All physiotherapists, including those providing services in Residential Aged Care Facilities (RACFs) and aged community care, to veterans and to those living with disability, are required to meet regulations set by Ahpra.

The APA also has the National Professional Standards Panel (NPSP). The purpose of the NPSP is to educate, encourage and assist APA members to uphold standards of professional conduct, meet professional and ethical obligations and achieve a high-quality standards of practice.

Member insights include:

"This (differentiation through registration status) is a SIGNIFICANT issue - it creates an unfair environment where registered providers, doing the right thing, do not receive any financial or recognised benefit for the thousands of dollars of registration investment."

"Provider registration adds additional work and incurs additional financial costs for businesses. The fact that we are all registered with Ahpra should be enough proof of compliance."

"We have been registered from day one of rollout in our region in 2017. Been through two audits. Huge expense. But improves our standard of care and safety. NDIS quality and safeguards want this but NDIS don't care or want to pay more for quality and safety. Families not given more money to see us."

ii. **Participant complexity and intensity**: accounting for additional time, skill and workforce structures need to support participants with complex needs.

Clinical complexity is a major driver of cost, time and workforce demand, and any pricing model must acknowledge this reality. However, recognising complexity does not mean introducing differentiated price tiers.

While the NDIA notes that differentiation does not necessarily require multiple price limits, introducing formal complexity categories inevitably pushes the system toward separate pricing structures. In practice, complexity-based differentiation cannot operate without distinct price points, and this shift

risks creating new administrative burdens, inconsistent incentives and further fragmentation of the pricing framework.

For these reasons, we do not support a differentiated pricing model based on participant complexity. The risks outweigh the benefits, and the underlying issues, particularly the undervaluation of physiotherapy and the failure to recognise the full scope of work are better addressed through a single, adequately costed price that reflects the true intensity of care required across the spectrum of participants.

Member insights include:

"The complexity of participants in the NDIS is often far greater and we are working with them holistically and managing all the barriers which are often disregarded in health and aged care."

"Families with children with disability need more education and support as they are often new to the world of disability, the NDIS system adds frustration and fear to their journey which then requires us as therapists to support them mentally and emotionally as well as physically with their children . We have a 24/7 phone service so families can allows speak to an expert paediatric physiotherapist in their moment of need at any time of the day."

iii. Workforce qualifications:

Physiotherapy supports delivered under the NDIS require a highly qualified, regulated workforce to ensure participant safety, clinical effectiveness and compliance with Scheme safeguards. These supports are not interchangeable with lower-qualified roles, nor can they be safely or effectively substituted without undermining outcomes.

Physiotherapists are university-trained health professionals regulated under the National Registration and Accreditation Scheme and accountable to the Physiotherapy Board of Australia.

Evidence from the Nous review confirms that current pricing assumptions underestimate the skill intensity required to deliver physiotherapy supports under the Scheme.

Feedback from APA members and Ability Roundtable data consistently demonstrates that allied health assistants and support workers cannot replace physiotherapists.

Member insights include:

"NDIS needs to understand that paediatric participants have complex needs that allied health assistants or supporter workers cannot and are not qualified to be treating in place of physiotherapists."

"Therapy assistants are not able to take over input for many of my clients with complex tone as they could cause harm."

iv. Geographic location:

The 2024–25 NDIS Annual Pricing Review's abrupt reduction in travel reimbursement has created significant barriers to service delivery. These changes were introduced with insufficient consultation and minimal notice, forcing physiotherapy providers to adapt quickly to cuts while grappling with rising costs. This rapid shift has placed undue stress on an already strained workforce and undermines best practice, which is explicitly endorsed by NDIS guidance. Delivering therapy in natural settings, such as participants' homes or communities, is critical to achieving meaningful outcomes, particularly for those who struggle with mobility or are unable to travel due to their disability or other barriers including geographic location.

In the Northern Territory, where access to services is already limited, these cuts have had devastating effects. For example, Groote Eylandt, which has the highest known prevalence of Machado-Joseph Disease (MJD) per capita globally, relied on fortnightly outreach visits for participants. MJD causes progressive loss of mobility, speech, and independence, and without regular, on-country physiotherapy, these individuals now face worsening health outcomes. Members report the necessary outreach across Groote Eylandt and five Homelands has ceased due to the unsustainable economics of travel under the new pricing structure.

A recent survey of APA members revealed that close to 50 per cent had reduced or ceased travel outreach services in the past six months because of the new pricing limits. Without urgent action to restore fair travel compensation, these cuts will continue to undermine the accessibility, quality, and equity of services under the NDIS.

There is no evidence that the NDIA is actively monitoring the impact of these changes on access, nor any evidence of meaningful engagement with the provider sector to gather feedback. The current NDIS Annual Pricing Review consultation on pricing explicitly excluded feedback from providers on travel pricing, despite asking participants to provide input. This lack of consultation and oversight risks further deterioration of service delivery in the communities that need it most. Geographic location is a cost factor that requires concerted consultation and review.

Member insights include:

"Travel is no longer financially viable."

"Due to the complexity of the average neurological patient, either they are difficult to relocate (wheelchair taxis, support worker (1 or sometimes 2) required to drive patient, so home visits make more economical sense."

v. Service quality metrics:

NDIS-registered physiotherapy providers are subject to significant quality, governance and safeguarding obligations. Meeting these requirements requires sustained investment in workforce training, supervision, systems, documentation and compliance processes.

At the same time, pricing decisions have reduced the funding available to meet these obligations. This creates a fundamental misalignment between regulatory expectations and pricing settings. Providers are required to demonstrate compliance with increasingly complex quality standards while operating within price limits that do not reflect the cost of delivering safe, high-quality supports.

Quality cannot be sustained without appropriate pricing. Any use of service quality metrics in future pricing decisions must recognise the real costs associated with governance, safeguarding and clinical oversight, rather than assuming these requirements can be absorbed without consequence.

Member insights include:

"NDIS quality and safeguards commission demand proof of meeting criteria at audit. Then NDIS slash the funding to meet those criteria. It's as if they don't communicate at all."

vi. Provider size or scale:

Pricing pressure is incentivising volume-driven service models at the expense of supervision, mentoring and clinical quality, particularly for early-career clinicians working with complex participants.

Member feedback indicates that NDIS-only service models are increasingly unviable under current pricing. Many practices report cross-subsidising NDIS services with private billing to remain operational. Even with this cross-subsidisation, overall revenue and clinician take-home pay have declined, placing sustained pressure on business viability.

A sustainable pricing framework must support the full range of provider models, including sole practitioners and small practices, which play a critical role in delivering personalised, community-based physiotherapy supports under the NDIS.

Member insights include:

"The current pricing is pushing towards volume not quality. My business is becoming unsustainable, as I cannot keep up with wages when things are being cut. I could see more clients, but then my junior staff will flounder and clients will be seen but not well."

"It is not viable to run a practice that only sees NDIS clients. If we were unable to also see private clients, who are paying the full value of their appointments, our business would fail. We are essentially cross subsidising our NDIS clients with our private billing clients. In spite of this, my overall revenue has dropped and my take home pay is lower than it was a year ago."

Q2: What is the single biggest risk of differentiated pricing the NDIA must address?

The APA sees the biggest risk is introducing differentiated pricing on top of an already weak cost base.

Reform is necessary, but it must occur in the correct sequence. A credible **cost base** must be established first, with differentiation only considered where it demonstrably improves equity, access and long-term sustainability. If the underlying cost base is flawed, differentiation will not resolve structural under-pricing; it will simply move the deficit across new tiers. This risks locking inaccurate assumptions into the pricing framework at the very moment the system requires correction.

The Nous analysis reinforces this concern, confirming that the current cost base is already unreliable, built on limited data, flawed modelling assumptions and prices that sit well below the sustainable cost of delivery. These weaknesses must be addressed before the NDIA can responsibly introduce any form of differentiated pricing. The APA is actively working with the NDIA to correct the last price determination and ensure the underlying cost base is rebuilt on credible evidence.

In addition to the structural risk created by the absence of a credible cost base, the APA also recognises that differentiated pricing can trigger significant unintended consequences if introduced prematurely. Inadequate price limits could reduce access as providers exit the scheme, and pricing that fails to support early-career professionals risks undermining future workforce supply. For therapy supports already facing shortages and underutilised plan funds, poorly designed pricing could further constrain availability and limit participant choice. Without changes to plan budgets, differentiation may also drive a shift toward lower-cost, lower-quality services and encourage businesses to narrow the range of supports they offer, distorting the market and weakening outcomes.

Our concern about any differentiated model is that, without validated cost evidence, it risks distorting the market rather than strengthening it. Physiotherapy is particularly exposed as a high-volume, high-need support with limited substitutability and already thin margins. For this reason, establishing a credible cost base is therefore the necessary first step before the NDIA pursues tiering, benchmarking or value-based reforms.

Q3: What participant support characteristics require different staffing, supervision or delivery approaches for DSW supports?

The APA contends that a range of participant support characteristics shape workforce demand, influencing the time, skill and coordination required to deliver safe, high-quality supports. These factors, rather than formal complexity categories, are what drive variation in staffing, supervision and delivery approaches.

In practical terms, certain participant needs change the way support work is organised and delivered. Participants with significant mobility limitations, behavioural or cognitive challenges, multiple comorbidities or high-risk manual handling needs require a different mix of skills, more structured supervision and tighter coordination across the support team. These characteristics increase the time, judgement and risk management required, and they shift the cost profile of delivering safe, effective supports.

A model that assumes uniform participant needs risks misrepresenting the real demands of safe, high-quality service delivery. Supporting Australians with disability requires varying levels of clinical skill, time, coordination and oversight, factors that cannot be meaningfully captured through simple categorisation. In physiotherapy, these pressures are particularly visible: many participants require sustained input and careful oversight, and these requirements cannot be compressed or standardised without compromising safety, quality or workforce stability.

Q4: Compared to delivering similar supports in other sectors (for example, aged care, health or community services), what aspects of the NDIS environment make DSW service delivery more or less complex?

The APA maintains that the NDIS presents a distinct set of structural complexities that materially shape how supports are delivered.

While service delivery is becoming more demanding across all primary and community healthcare, the NDIS introduces additional pressures. Providers must navigate individualised plans, inconsistent funding decisions, fragmented pricing rules and an unvalidated cost base for physiotherapy. These features generate revenue volatility, shift financial and clinical risk onto providers, and substantially elevate the coordination, compliance and oversight required for safe delivery.

A further point of divergence is the NDIS approach is the NDIS approach to in-home, domiciliary service delivery, which underpins how many supports must be delivered. A significant proportion of participants cannot reliably attend clinic-based appointments due to mobility limitations, transport barriers or safety concerns, making in-home work essential rather than optional.

Yet travel remains inconsistently funded. Providers absorb unfunded time, manage wide geographic caseloads and operate within rules that often fail to reflect the realities of delivering supports in people's homes. This pressure is not confined to rural and regional areas. Even in metropolitan settings, travel between appointments, congestion, parking constraints and dispersed participant locations create substantial, unfunded time that providers must absorb.

The result is a persistent gap between how support must be delivered and how the NDIS prices that delivery, adding operational strain and undermining the stability of services that rely on mobility to maintain equitable access.

A significant challenge for the sector is the cumulative effect of policy fatigue and reform drift, with repeated adjustments, lagging implementation and shifting intentions across successive reform cycles have created an operating environment that is unpredictable and operationally fragile. This instability is distinct from, and often more volatile than, other service systems.

Q5: Compared to therapy in health/aged care settings, rate how much additional time/effort each aspect requires under the NDIS?

The APA's position is that the NDIS imposes materially greater non-clinical workload demands on physiotherapy providers than other funding environments.

NDIS providers operate under a fundamentally different set of conditions than those in health or aged-care settings, with implications for both service delivery and financial sustainability. The NDIA

itself has acknowledged that provider operating costs often exceed price limits, as noted in the 2022–23 Annual Pricing Review.

These pressures arise from structural features of the scheme that introduce additional layers of complexity into routine clinical practice. Delivering therapy under the NDIS typically requires a more intensive, time-consuming approach. For example:

- NDIS therapy support often involves extended travel and circulation time that is non-billable.
- NDIS participants require additional preparation, documentation, and coordination across multidisciplinary teams
- NDIS has governance and compliance obligations, such as adherence to safeguarding protocols and audit requirements.

This complexity reduces the proportion of time available for funded therapeutic engagement and drives significantly lower productivity. Data from the Ability Roundtable shows consistently low billable productivity among NDIS physiotherapy providers, levels well below those expected in other funding environments such as Medicare or private health insurance.

Any pricing model that does not account for these structural differences will fail to reflect the true cost of delivering physiotherapy under the NDIS and will continue to place downward pressure on service viability and participant access.

Figure 7 | Ability Roundtable physiotherapy support hourly cost breakdown compared to the NDIS Price Limit (NSW, Vic, ACT, Qld) 2021 to 2025-26.

Figure 1 | Ability roundtable modelling of median profitability of all organisations participating in the NDIS FY19-20 to FY22-23(FY24 projection)**

Figure 2 | Ability Roundtable modelling of profitability of therapy supports for FY23 and FY24 with FY25 projection

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Member results from APA 2026 NDIS provider survey

Compared to therapy in health or aged care settings, rate how much additional time and effort does assessment and goal setting require under the NDIS?

Member insights include:

"(Additional time and effort includes) administration before assessment to ensure funding is available, service agreements signed, (ensuring) support coordinator, plan manager etc are all in agreement."

"Increased time associated with assessment and goal-setting due to often more complex or high-level goals in clients with neurological injuries under the NDIS."

"These aren't short term issues people are dealing with. Much more layers to goal setting, especially when involving families and complex social histories."

"As clients under the NDIS have more complex needs, extensive collaboration, liaison, assessment and goal setting is imperative to deliver high quality care."

"Almost double the amount of time"

Compared to therapy in health or aged care settings, rate how much additional time and effort does direct therapy provision require under the NDIS?

Member insights include:

"NDIS patients often, not always, have increased administrative burden. The cost of this has to be absorbed by the business. Clinically NDIS participants attend more regularly which can lead to inefficiency due to cancellations, reduced availability in the diary."

"Much more non face-to-face input. Especially regionally, where multidisciplinary teams are spread apart and no one works cohesively. Coordinating with specialists far away is time consuming. NDIS has caused a disjointed therapy system."

"The complex NDIS clients I see often need more frequent visits and the visits often take longer because most of my clients have severe communication difficulties and I have to gather info from support workers and/or the time taken to gather the info needed is longer. 'Effort' is an odd expression as my effort is 100% for all clients, but time taken to carry out a session is longer, not only due to communication but often there are other complicating factors such as mental health and physical disability requiring additional time to achieve session outcomes e.g. hoist process."

"NDIS participants by definition have severe and permanent disability. They have complex therapy needs and require a whole body approach to therapy. This takes longer than treating someone with a single injury or someone with normal age related changes."

"Significantly increased liaison time between key stakeholders. Lots of work is done without billing to preserve funding."

Compared to therapy in health or aged care settings, rate how much additional time and effort does family or carer consultation require under the NDIS?

Member insights include:

"Additional time needed to support families understanding the do and dont's, or can do/can't do, within the NDIS system. Particularly so when it comes to assistive technology and the time required for this - research, trials, prescriptions and applications. Liaising with families and the health setting when therapy gaps and equipment gaps exist - which sector/funder will provide?"

"Often clients have limited cognition or intellectual impairments, sometimes with no family involvement which makes communication and organisation challenging."

"I usually have to follow up most home visits with emails to family, support coordinators and supported independent living team leaders to ensure advice understood etc."

"Family are dealing with bigger burdens. More complex care needs. Carer burnout. NDIS complexity and a lack of clarity and stability from the NDIS."

"More than double the amount. I cannot keep on top of my emails each day."

"Many of our NDIS clients are minors or adults who are unable to manage their own health and therapy needs. There may be multiple family members and carers involved in supporting them who need to be involved in goal setting, appointment planning and implementation of home-based strategies."

"Significant discussion relating to insufficient plan funding, family stress - takes time away from clinical therapy"

Compared to therapy in health or aged care settings, rate how much additional time and effort does documentation require under the NDIS?

Member insights include:

"As the clients are complex it is way more. A client with multiple sclerosis (MS) is much more documentation than a sprained ankle, and I can't charge as much for the MS client under NDIS. Documentation is more, and the rate I can charge is significantly lower."

"Administration and compliance is insane. The report requirements are also very lengthy and eat into budgets and therapists' time. If a tribunal support request is made, this can blow everything out of the water and therapists often end up doing work in their own time to squeeze it in."

"Much more and because of cut in plans this reduces therapy time. School forms, preschool forms, feedback to all involved forms. Clinical notes are much more detailed in the NDIS setting. Reports are far more onerous in the NDIS compared to any other funding stream."

"The assistive technology forms are ridiculous. That lack of consistent template for plan review reports it is crazy. They need to follow suit with organisations such as TAC which have report templates that are consistent, and mandatory rather than optional."

"NDIS reporting is cumbersome and more time consuming than other reports. We have to spend time translating clinical information into language that is understood by lay people who have no tertiary education in health or disability."

Compared to therapy in health or aged care settings, rate how much additional time and effort does multidisciplinary coordination require under the NDIS?

Member insights include:

"Because it is in the community it needs to be intentional and having to work hard to bring people together. You don't have regular meetings like you would in health and aged care settings."

"Coordinating with plan managers and support coordinators takes the most time. Typically they have no disability background and need additional education to understand the multidisciplinary care team (MDT) meetings."

"Usually needing to deal with multiple factors - health setting, education setting, family and sometimes formal carers/departmental carers. If the client has a Support Co-ordinator, then co-ordination required by the clinician or therapy Key Worker is lessened, but we know that many NDIS participants do not have Support Co-ordinators. This can be age-related (really hard to get Support Co-ordination for children <3yrs of age), or simply a decision by the planner/delegate."

"There is often unbilled time used in communication with the MDT due to limited funding, however, this should be billed as it takes excess time and is often completed outside of clinician's working hours to ensure the client is not missing out."

Very difficult to communicate with other members of the MDT, particularly when their funds have been exhausted. More frequently, it doesn't happen or I don't charge for the time trying to get hold of occupational or speech therapy."

Compared to therapy in health or aged care settings, rate how much additional time and effort does compliance reporting require under the NDIS?

Member insights include:

"Registration is hugely expensive in dollars and time, with no direct benefit. Detailed reports often take longer than the time billed in the instance of complex clients."

"As a registered provider it takes a lot of admin burden on compliance monitoring - including maintaining knowledge of an ever changing system, staff HR compliance, clinical compliance, safety compliance. This all needs to be well documented and maintained. Reports require much more detail and time to research references to justify requests. Service agreements require constant updating. Policies requiring constant updating."

"More time as there is less transparency around expectations, less direct ability to liaise with the NDIS regarding their expectations vs. the TAC where you directly deal with them about what they want and need."

"Our admin team spend considerably longer on compliance reporting for NDIS than for any other funding source."

"The reporting requirements of NDIS are much higher than any other government service. The length and detail expected which still results in cuts is massive."

Compared to therapy in health or aged care settings, rate how much additional time and effort does travel requirements require under the NDIS?

Member insights include:

"Since travel funding has been reduced by 50 per cent, travel is taking less time than previously (i.e. sessions are needing to be more centre-based) but the families are having to fill/fund the gap if they still want travel as part of their therapy provision."

"Often clients are unable to physically travel into the clinic for sessions due to mobility impairments, limitations of cost of travel and impacts on fatigue, which can negate the effectiveness of sessions."

"NDIS participants should be receiving a large portion of their supports in their natural environments. Travel pricing has impacted this dramatically. It is much better now for businesses to stay in their clinics. This is not best practice and is letting down participants."

"NDIS provision says 30 hours of therapy but then you have to take out travel and this can often equate to a loss of 25 percent of therapy hours. Especially for complex clients that only certain therapists should see."

"In health service is provided in the clinic with rare exceptions. In our remote region I can spend four hours travelling in the day; this is now greatly reduced due to only being paid half, which results in clients having to travel more."

"Many of my NDIS clients require therapy in the home. My clients have complex and rare disabilities and require therapists with additional training in their specific disability needs. There is often no physiotherapist with the appropriate skill set close to their homes. Since the change in funding model to cut travel funding, I can no longer afford to travel to client homes to deliver therapy. Clients have to instead travel to the clinic. This can be exhausting for them and they are unable to benefit from the therapy as much as they would if it was delivered in their home. They usually also require a support worker to help get them ready to leave the house and transport them to the clinic. The support worker has to stay for the duration of the session. This can use 2-3 hours of support time which is more expensive than it would have been if I had been paid appropriate to travel to their home."

Compared to therapy in health or aged care settings, rate how much additional time and effort does workforce supervision require under the NDIS?

Member insights include:

"Way way way more. I am a titled neurological physiotherapist. I spend time and energy supervising therapists, especially new ones. It takes me away from direct client care as I have to support the therapists as the conditions are so complex."

"The compliance and risk, especially for assistive technology, documentation etc. requires rigorous supervision for those new to NDIS and ongoing for more junior staff."

"The majority of client cases raised for discussion at supervision sessions are NDIS clients due to the complexity of their impairments, issues and needs. This is an increased learning curve from health and aged care settings and requires additional training and supervision."

"Young clinicians require support for complex cases - NDIS participants are often complex. This supervision is not compensated for."

"More supervision is required initially to ensure adequate service provision due to home visits where the clinician is alone (not in a clinic with other professionals they can rely on for impromptu assistance)."

"More complex care needs. More complex reporting. More MDT. More complex mental health issues. More complex carer and family communication."

"Incredibly complex caseload - requires constant senior oversight in almost every case."

"The skills required to treat people with severe and permanent disability are not part of routine undergraduate training. New therapists require additional supervision and training to be competent in this area."

"There are so many inconsistencies within the NDIS system that people require more supervision to work within it."

Compared to therapy in health or aged care settings, rate how much additional time and effort does variability in participant needs require under the NDIS?

Member insights include:

"Every condition has a wide spectrum, whether it's cerebral palsy, Down syndrome or ASD, and paediatric conditions include the rare genetic disorder that no one even knows about."

"Clients with disability most often have more than one system involved so this naturally means a client presents with many impaired areas requiring complex intervention, ability to clinical prioritise needs is required. Often in health, you're dealing with one area/system at a time and go to different 'clinics' each attended to by teams, to deal with that specific issue."

"Needs vary immensely between participants but also over time with each participant. Often there is not the flexibility in funds to increase supports when needed leaving participants vulnerable at their greatest time of need."

"Some very complex clients in the NDIS with significant behaviours but in less ideal or supported setting than aged care."

"Many neurological patients with varying brain disorders and conditions causes much more fluctuation in patient needs."

"Working in the paediatric area there is a vast range of clients, compared to health where each condition has its own specialist team."

Therapy Supports

Q6: How is your therapy workforce primarily employed?

The APA advises that physiotherapy services for NDIS participants are most commonly delivered through a mixed workforce model, with employment remaining the predominant arrangement across the sector.

As a peak body, we do not employ clinicians directly, but member feedback indicates that most providers rely on a core employed workforce, supplemented by contracted practitioners where flexibility is required. This reflects the realities of NDIS service delivery, including variable participant demand, significant non-billable workload and the lower productivity compared with other funding environments.

The broader allied health sector operates across a wide spectrum of employment models, from sole traders and small businesses through to large provider organisations. Each model carries distinct opportunities and challenges, and a substantial proportion of therapy providers remain sole traders or small practices. Any future NDIS pricing settings must therefore support the viability of all models, not just larger organisations or traditional employment structures.

Insights from the Ability Roundtable reinforce the pressures shaping workforce decisions. Benchmarking shows sustained pressure on productivity and operating margins, with many organisations finding it difficult to maintain fully employed workforce models under high non-billable time and constrained price limits. This aligns with member feedback that a blended workforce is often essential to maintain service viability. Contracted practitioners provide flexibility to absorb fluctuating caseloads and administrative demands, while employed clinicians support continuity of care and organisational capability.

To ensure the full diversity of workforce models can operate sustainably, the NDIA will need to undertake further work, beyond the Quality Supports Pilot, to understand the specific pressures facing smaller providers and sole traders.

Q7: What is the typical duration of a NDIS therapy session delivered by your organisation or practice?

The APA notes that NDIS physiotherapy sessions do not follow a uniform duration, clinical considerations are the primary determinant of how long a session must be.

The complexity of participant needs, the safeguarding requirements of disability supports and the broader service realities of the NDIS mean that physiotherapy sessions typically require **a minimum of an hour** of direct therapeutic engagement. This pattern is consistently reflected across providers and helps explain why session durations in the NDIS differ from those seen in non-disability funding environments.

Member insights include:

“It varies so much depending on the client. I also have to base it on client’s funding not on their actual needs.”

"Typically 60minutes - can be 90+ minutes for equipment trials / joint MDT sessions."

In practice, the total time required extends well beyond the direct contact period. Preparation, documentation, communication with families and support coordinators, and follow-up tasks are integral components of safe and effective disability care and cannot be compressed without compromising quality.

It is important that NDIS pricing avoids repeating past methodological errors by importing assumptions from unrelated funding environments. A key issue in the current approach is the assumption of a 45-minute session when converting PHI and MBS fees into hourly rates, despite evidence that real-world PHI and MBS sessions are typically closer to 30 minutes. This inflates the assumed duration and leads to an underestimation of the true hourly rate required for physiotherapy under the NDIS.

Q8: What percentage of this session time is direct therapy, documentation, coordination or other?

The APA advises that NDIS physiotherapy involves a significantly higher proportion of non-clinical work than other funding environments, and that this distribution of time must be recognised in pricing decisions.

Member-reported patterns indicate that the proportion of time spent on direct therapy compared with documentation, coordination and other tasks is markedly different under the NDIS. While the exact distribution varies by participant and service context, providers consistently describe the following approximate breakdown:

- **Direct therapy**: around 60 per cent

- **Documentation**, reporting and clinical record-keeping: around 15–20 per cent
- **Coordination** with families, support coordinators, schools, providers and multidisciplinary teams: around 15–20 per cent
- **Other non-billable requirements** (travel, scheduling, compliance, audit preparation): around 10–20 per cent

These member-reported patterns are consistent with findings from the Ability Roundtable, which has repeatedly identified lower billable utilisation and higher non-billable workload among NDIS physiotherapy providers compared with other funding environments. Roundtable data shows that the operational demands of the scheme, including extensive coordination, documentation, compliance activity and travel, materially reduce the proportion of time that can be spent in direct, billable therapy.

This structural imbalance contributes to the persistent gap between actual operating costs and current NDIS price limits. It highlights the need for a pricing methodology that reflects the real service delivery profile of physiotherapy under the scheme and the significant proportion of time required for non-clinical work

Member insights include:

"That is so variable as there is no "typical" NDIS participants we see. Some who come in to the clinic will be almost all direct therapy. There are others, where I will spend more time on indirect with travel, coordination, reporting, manual handling plans, chasing up with other MDT, especially those who don't have the support they need"

"For other healthcare patients approximately 85-90%."

"But I don't charge for all of the non-face- to-face…I should be stricter."

"I have ceased travel to a client's home due to the inadequate funding for this service."

Q9. Since the change to travel claiming was introduced on 1 July 2025, has it been hard to find a therapist who will travel to you?

Q9.1: If you had your choice, what would you prefer?
Q9.2 Why do your therapists travel to you?

The APA notes that these questions were directed to participants rather than providers, and it was a missed opportunity for the NDIA not to test these issues with the physiotherapy workforce. Our response reflects the experience and feedback of APA physiotherapy members.

The NDIA's July 2025 pricing decision to cap travel reimbursement raises serious concerns about service viability and policy coherence. This cost-containment measure directly conflicts with the *NDIS Practice Standards Supplementary Module for Early Childhood Supports*, which mandates access to supports in natural environments that foster inclusive participation in family and community life.

Reducing travel funding disincentivises outreach to homes, schools, and community settings undermining developmental best practice and the principles of value-based care. The result is a growing misalignment between pricing architecture and the standards that define quality, equity, and participant outcomes in the NDIS.

The system continues to fund essential enablers of service delivery, including travel, from core therapy budgets. This approach erodes the time available for therapeutic intervention and weakens inclusive access. Physiotherapists delivering NDIS supports report that the reduced reimbursement is already influencing decisions about where therapy can be delivered, particularly for children and

participants with complex needs. By disincentivising service delivery in natural environments, the pricing model is shifting practice away from the settings where supports are most effective.

The decision is also not economically sound. Travel accounts for approximately 1% of therapy expenditure ($26.1m) and around 0.1% of total scheme costs for July to December 2024 (~$21.8b 11). Despite its small share of expenditure, travel is fundamental to delivering therapy in natural environments, as required by the NDIS Practice Standards. There is a clear disconnect between regulatory expectations and pricing settings: providers are mandated to deliver supports in natural environments, and the clinical evidence strongly supports this as best practice for achieving functional outcomes. Reducing funding for such a small but essential component of service delivery creates disproportionate impacts on access, quality and participant outcomes.

In Treasury terms, the measure is poorly targeted, low yield and high impact. It delivers negligible savings while creating significant behavioural and equity consequences for participants who rely on outreach-based physiotherapy.

Q10. Is there anything else you'd like to tell us about NDIS pricing?

The NDIS was never designed to be cost-neutral. It was built to generate returns, both human and economic. That matters.

The scheme now supports more than 270,000 workers across over 20 professions, and modelling from the False Economy report estimates its economic contribution at over $52 billion in 2020–21, with a multiplier effect of 2.25. These are not marginal figures. They reflect the scale and reach of the NDIS as a driver of employment, business activity, and regional stability.

Yet the idea that providers are exploiting the Scheme continues to circulate, including within government. Isolated cases of misuse should be addressed, but this narrative obscures the broader economic role the NDIS plays. It stabilises domestic expenditure, sustains small businesses, and supports jobs in communities that rely on them. Treating it purely as a cost centre misses the point. It is economic infrastructure and it is functioning as intended.[2] [3]

Physiotherapists, as frontline providers, see disconnect between policy intent and participant experience.

Policy responses have focused on projected expenditure growth and participant volumes, while ignoring actual cost drivers. The result is a reform agenda shaped by optics rather than evidence. Misguided assumptions about oversubscription have produced blunt cost-containment measures that restrict access instead of addressing inefficiencies in pricing architecture, planning design and service delivery.

---

[2] Australian Government Productivity Commission. (2011). *Disability care and support: Inquiry report* (Report No. 54). Productivity Commission. https://www.pc.gov.au/inquiries-and-research/disability-support/report/

[3] *False Economy: The economic benefits of the NDIS and the consequences of government cost-cutting - Per Capita*. (2021). Per Capita. https://percapita.org.au/our_work/false-economy-the-economic-benefits-of-the-ndis-and-the-consequences-of-government-cost-cutting/

Underutilisation of allocated funds remains a persistent issue, but it is not evidence of excess. It signals a deeper structural failure. Participants are routinely funded for supports they cannot access, activate or coordinate. Workforce shortages, rigid pricing rules and poor plan design all contribute to this gap. When large portions of funding go unspent, it reflects a system that allocates without enabling. Using underspend to justify cost-cutting only reinforces the disconnect and risks locking in the very inefficiencies reform is meant to resolve.

To restore coherence, the pricing framework must be structurally reframed. Travel should be funded as a standalone item. Plans must reflect the true breakdown of provider recommendations. And reform must be grounded in actual expenditure data, not projections or assumptions about oversubscription. The longer planning relies on forecasts over reality, the further the Scheme drifts from delivering meaningful, person-centred support.

Government has a clear responsibility to ensure that people with disability have access to services that are well governed, safe, and delivered to best-practice standards.

High-quality support is not a feature. It is a rights-based obligation at the core of the NDIS. That obligation carries practical consequences for how services are funded, priced, and delivered. Downward pressure on pricing, when applied without regard for service complexity or quality, runs directly counter to that responsibility. Pricing decisions that prioritise cost containment over clinical integrity risk undermining safety, workforce capability, and long-term sustainability.

Current funding provisions are increasingly misaligned with the scheme's regulatory obligations.

The APR has faced criticism for lacking transparency and being shaped by internal agency priorities rather than independent oversight. While the IPC has produced strategic advice aimed at guiding reform, many of its key recommendations have not been adopted. Nor have those from other independent bodies, such as the Independent Health and Aged Care Pricing Authority (IHACPA), whose pricing data strategy remains unpublished and unacted upon. Instead, recent decisions reflect a shift toward tighter agency control, raising concerns about the integrity and independence of the pricing process.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Appendix: Review of the 2024-5 APR with respect to physiotherapy

Review of the 2024-25 APR with respect to physiotherapy

Australian Physiotherapy Association

21 October 2025

nous

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of Country throughout Australia. We pay our respect to Elders past and present, who maintain their culture, Country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities

Disclaimer:

*Nous Group (**Nous**) has prepared this report for the benefit of Australian Physiotherapy Association (the **Client**).*

The report should not be used or relied upon for any purpose other than as an expression of the conclusions and recommendations of Nous to the Client as to the matters within the scope of the report. Nous and its officers and employees expressly disclaim any liability to any person other than the Client who relies or purports to rely on the report for any other purpose.

Nous has prepared the report with care and diligence. The conclusions and recommendations given by Nous in the report are given in good faith and in the reasonable belief that they are correct and not misleading. The report has been prepared by Nous based on information provided by the Client and by other persons. Nous has relied on that information and has not independently verified or audited that information.

© Nous Group

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Contents

Executive summary **1**

Background and Context 1

Purpose of this report 2

Key findings 2

Recommendations and next steps 6

1 Background and context **7**

2 Methodology review **12**

2.1 The use of regression modelling to estimate session duration resulted in hourly rates that are misaligned to prevailing market prices. 12

2.2 The data sources relied upon for the APR are too limited to generate robust and reliable NDIS price limits. 20

2.3 The pricing method does not reflect the complexity involved in delivering disability supports 21

3 Alternative methodologies **24**

3.1 Short term approach 24

3.2 Longer term approach 25

4 Recommendations **27**

Appendix A Private health insurance claims data **28**

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Executive summary

Background and Context

The NDIS is essential to the lives of many Australians

The National Disability Insurance Scheme (NDIS) represents the most ambitious social reform since Medicare, having now supported over 700,000 participants to access essential services, pursue life goals and participate in everyday life. The Scheme has matured into a critical enabler of inclusion with tens of thousands of providers operating across the country. It functions as a national infrastructure that delivers long-term social and economic benefits.

Physiotherapy is an integral component of the NDIS

Physiotherapy is a cornerstone support within the NDIS, playing a vital role in enabling participants to achieve meaningful engagement across all domains of life—social, economic, and community. It is not merely a therapeutic intervention but a foundational enabler of independence, mobility, and functional capacity. Through tailored, evidence-based approaches, physiotherapy empowers individuals to participate in education, employment, recreation, and relationships - thereby fulfilling the core objectives of the NDIS.

Physiotherapy establishes the baseline of functional capacity that makes participation possible for many NDIS participants. It supports participants with complex needs to engage, build skills and better realise the opportunities in other funded supports. Without it, function is limited, independence is compromised, and other funded supports lose effectiveness. Physiotherapy enables participants to move, engage, and build capacity. It is the foundation that allows the NDIS to deliver on its promise.

NDIS price limit for physiotherapy was reduced this financial year after a 5-year price freeze

The National Disability Insurance Agency's (NDIA) 2024-25 Annual Pricing Review (APR) was released in June 2025 and introduced a:

- **Cut in hourly rate:** $10 (5.2%) reduction in the national price limit for physiotherapy, from $193.99 to $183.99 per hour. This followed a five-year NDIS price freeze for physiotherapy[1].
- **Cap on travel rates:** a cap on provider travel claims for therapy supports set at 50% of the claimable hourly rate.
- **Removal of regional pricing:** removed State and Territory Special Pricing Arrangements for Western Australia, South Australia, Northern Territory, and Tasmania.

Many in the physiotherapy sector are concerned the reduced rate will reduce access to care

Recent survey data from Australian Physiotherapy Association (APA) members and sector consultations indicate that many physiotherapy practices see the NDIS hourly rates as unsustainable. Sector survey and consultation data shows that 30% of providers report they do not

[1] The hourly rate for physiotherapy in the NDIS has not increased since the specific physiotherapy rate was introduced in 2019-20

accept NDIS participants due to low viability[2]. For those who do participate, they frequently claim they must cross-subsidise NDIS services from other client groups to sustain services to NDIS participants. Many in the sector worry the lack of viability in providing services through the NDIS will encourage additional providers to withdraw from the NDIS, leading to a loss of clinical expertise and reduce the sector's capacity to deliver complex, high-value care.

Purpose of this report

The purpose of this report is to present the findings of an independent review of the pricing methodology used in the NDIA's 2024-25 Annual Pricing Review.

The Australian Physiotherapy Association (the APA) engaged Nous Group (Nous) to complete an independent review the NDIA's 2024-25 Annual Pricing Review (APR) to better understand the NDIA's methodology for setting the new hourly rates and to identify opportunities to strengthen the methodology to ensure that reference market rates for Physiotherapy can be restored in the short term and reflected in future APRs. Although, detailed consideration of the rationale and impact of NDIA changes to travel rates and regional pricing were out of scope for the review, the implications of these changes on the viability and sustainability of physiotherapy support under the NDIS is noted. The report is intended for the use of the APA and its members.

To ensure the independence of this review, this report is focused on examining the APR methodology and identifying opportunities for its improvement to ensure that the true reference market rate for Physiotherapy is reflected in ongoing price determinations. Accordingly, this report:

- avoids commentary where there is no evidence base
- specifies where evidence is drawn from stakeholder input.

Key findings

Current NDIS pricing limits for physiotherapy are misaligned with current market conditions and service delivery realities for people living with disability.

The review confirms that the methodology used in the NDIA's 2024-25 Annual Pricing Review is likely to have underestimated the prevailing market rates for physiotherapy services, resulting in national pricing limits for 2025-26 that are misaligned with current market conditions and service delivery realities for people living with disability.

The review identified several methodological factors that have contributed to this misalignment:

- **First, the use of regression modelling to estimate session duration resulted in hourly rates that are misaligned to prevailing market prices.**

  Greater clarity from the NDIA is needed regarding how the hourly rates were derived. There is evidence that the APR's modelling choices generate rate estimates that diverge from market evidence. Analysis of private health insurance data from a major insurer made available for

[2] Australian Physiotherapy Association (2025), Hourly rate for the provision of physiotherapy services

Current NDIS pricing limits for physiotherapy are misaligned with current market conditions and service delivery realities for people living with disability.

the review (covering around 25 per cent of the national market) shows a 70th percentile session fee equivalent to $236.50 per hour. This is significantly higher than the 75th percentile hourly fee of $150.50 estimated by the APR method. The APR method assigns a session duration for private market and MBS fees using a regression formula based on web-based information. Session duration is then used to convert session fees into hourly rates. We conclude that the APR method yields session times (around 45 minutes) that are misaligned with current service delivery realities (around 30 minutes), resulting in the underestimation of hourly rates. This misalignment has significant implications for NDIS service costing and resource planning.

- **Second, the data sources relied upon for the APR are too limited to generate robust and reliable NDIS price limits.**

  The APR relies on MBS fee data, publicly available website data, and a single PHI dataset. The MBS data reflects GP-led chronic disease care, which is not comparable to disability supports. The private health insurance dataset, drawn from a single undisclosed insurer, which may not be representative, is unclear on the inclusion of preferred provider programs and excludes indicators of care complexity and service profile. Public website listings while helpful for linking fees to session duration can obscure price variations linked to funding arrangements, including MBS and NDIS. These limitations reduce the reliability of the pricing outputs and their value to inform evidence-based policy.

- **Lastly, the pricing method does not reflect the complexity involved in delivering disability supports**. The NDIA's approach, which sets therapy price limits by referencing private market rates and MBS pricing, does not adequately account for the complexity of operating in the NDIS system. NDIS providers operate under a set of different conditions that impact service delivery and financial sustainability. The system complexity reduces the time available for funded therapeutic engagement and significantly lowers productivity.

Comparative evidence consistently indicates APR undervaluation of physiotherapy support, with the actual 75th percentile market rate lying between $215 and $259 per hour

The NDIA national price limit for physiotherapy in 2025-26 is $183.99 per hour. This represents a $10 per hour (5.2%) reduction on the price limit in the previous year. The APR relied on insights from the introduction of limited private health insurance and MBS data and related analysis in the 2024-25 review to justify a decrease in the national price limit for physiotherapy.

Our review found that these insights are broadly inconsistent with those from other available evidence, including data sources and analysis used by the NDIA in the past and presented in the 2024-25 APR report (see Table 1).

Table 1: Comparative methods available to inform physiotherapy hourly fee benchmarks

APR methods/hourly fee estimate		Non-APR methods/hourly fee estimate	
Analysis of website listings	$240	Nous costing report on a sustainable hourly rate[3]	$261
Comparison of other schemes	$215	APA survey data[4]	$259
MBS modelling (new)	$159	APA reference PHI data[5]	$237
PHI modelling (new)	$151	Ability Roundtable costing[6]	$220

In summary:

- The new APR modelling of MBS and PHI data resulted in hourly fee benchmarks in the range of $151 to $159.
- Other methods used by the APR previously and presented in the 2024-25 report resulted in hourly fee benchmarks in the range of $215 to $240.
- Other methods not used by the APR but reported elsewhere resulted in hourly fee benchmarks in the range of $220 to $261.

While both of new APR methods resulted in hourly fee benchmarks that are below (ranging from 18% to 22 %) the 2024-25 national price limit of $193.99, the other six methods reviewed for this report all resulted in hourly fee benchmarks above (ranging from 14% to 35%) the 2024-25 price limit.

In addition, the APR claimed that the most comparable schemes to the NDIS have hourly rates that fall between $140 and $190, yet its own data presented in the report shows a median rate closer to $200 and a 75th percentile rate around $215.

Looking ahead, short-term improvements could be achieved by validating existing data and related analytical methods through closer consultation with physiotherapy providers and data custodians (including MBS and PHI and those related to other schemes and website information). Longer-term, reforms to the pricing approach should integrate bottom-up costing with ongoing reference pricing. This would align NDIA's approach with best practice models used by IHACPA in Australia, ACC in New Zealand, and the NHS in England.

[3] Nous group report for APA on the identification of a sustainable hourly rate for the provision of physiotherapy services.
[4] APA survey of physiotherapy practices on standard session durations and fees excluding the initial consultation.
[5] Private health insurance data received by APA from a major insurer covering around 25 per cent of the national market.
[6] Composite hourly cost estimate across four major allied health disciplines developed by the Ability Roundtable.

Changes to travel funding will likely have further implications for the availability and delivery of direct therapeutic supports.

The 2024-25 APR also introduced a change to travel funding whereby the maximum claimable rate for provider travel associated with therapy supports is halved, capped at 50% of the relevant hourly price limit per 10-minute increment. This is likely to affect ongoing service delivery models, particularly in relation to the NDIS Practice Standards, which encourage access to therapy supports in natural environments. This change extends the existing practice of funding enablers of service delivery from therapy budgets, which is likely to have further implications for the availability and delivery of direct therapeutic supports.

Recommendations and next steps

We recommend APA advocate to government on current physiotherapy price limits and find opportunities to collaborate with government to establish a sustainable pricing framework for the future .

The focus should be on realising the following key outcomes:

1 Review the 2025-26 pricing decision

Continue to advocate to the government to immediately review the decision to cut the physiotherapy price limit for 2025-26 by $10. This should be based on concerns of the methodology used to determine the price reduction and potential impacts on the sector and service access.

2 Reinstate use of 75th percentile of the true comparable market rate

Given commitments from the NDIA to use the 75th percentile of the prevailing market rate, it is unclear why it was not used in the recent APR. Our analysis suggests the true market rates lies between $215 and $259 per hour based on alternative methods. This may subsequently support the APA to advocate for a methodology that reflects the true market in 2025-26 and future financial years.

3 Review of changes to travel limits

While this report did not directly consider travel limits and differential jurisdictional pricing arrangements, the APA should consider including these related price settings in the advocacy on broader pricing reform, given the significant implications they have on ongoing community access to physiotherapy support for NDIS participants.

4 Embed sector input in ongoing pricing reviews

The APA should advocate for involvement of the sector as part of the annual review process for NDIS pricing, including physiotherapy providers, participants, peak bodies and advocacy groups.

5 Establish a transparent, evidence-based pricing method for the future

The APA should request a commitment from government for a transparent and evidence-based pricing methodology. This could include proposing alternative methodologies, to ensure prices reflect the true costs of delivering physiotherapy services under the NDIS and seek greater transparency on how prices are determined.

1 Background and context

The National Disability Insurance Scheme (NDIS) is a landmark reform in Australia's social policy landscape, designed to empower people with disability to pursue their goals, participate fully in society, and exercise choice and control over their supports. Since its establishment in 2013, the NDIS has grown rapidly, now supporting over half a million participants and engaging tens of thousands of providers across Australia[7].

Physiotherapy is a cornerstone support within the NDIS, playing a vital role in enabling participants to achieve meaningful engagement across all domains of life-social, economic, and community. It is not merely a therapeutic intervention but a foundational enabler of independence, mobility, and functional capacity. Through tailored, evidence - based approaches, physiotherapy empowers individuals to participate in education, employment, recreation, and relationships, thereby fulfilling the core objectives of the NDIS.

Physiotherapy establishes the baseline of functional capacity that makes participation possible for many NDIS participants. It supports participants with complex needs to engage, build skills and better realise the opportunities in other funded supports. Without it, function is limited, independence is compromised, and other funded supports lose effectiveness. Physiotherapy enables participants to move, engage, and build capacity. It is the foundation that allows the NDIS to deliver on its promise.

Importance of physiotherapy

Physiotherapists are among the few allied health professionals with diagnostic capabilities. Their clinical expertise allows them to assess, identify, and respond to a wide range of physical and functional impairments, often serving as the first point of contact in recognising emerging issues. This diagnostic capacity is especially critical in early intervention, particularly within paediatric populations, where timely identification of developmental delays, neuromuscular conditions, and motor impairments can profoundly influence a child's long-term trajectory.

Early physiotherapy intervention supports optimal physical development, prevents secondary complications, and facilitates smoother transitions into educational and social environments. Across the lifespan, physiotherapists provide continuity of care that adapts to the evolving needs of participants—from infancy through to ageing—ensuring that interventions remain relevant, goal-directed, and impactful.

Beyond their direct therapeutic and diagnostic contributions, physiotherapy often functions as a junctional support—a critical connector between multiple services such as occupational therapy, speech pathology, assistive technology, and personal care. Physiotherapists frequently coordinate with other providers to ensure that supports are delivered in a safe, goal-directed, and integrated manner. This coordination is essential for reducing fragmentation in service delivery and for maintaining continuity of care, especially for participants with complex needs.

[7] NDIS (2025), 2024-25 Annual Pricing Review

Too often, physiotherapy's role is misunderstood, and this disconnect has shaped policy settings that undervalue physiotherapy's essential contribution. The sustainability of physiotherapy services under the NDIS has become a significant concern. Recent survey data and sector consultations indicate that the current NDIS price limits are unsustainable for many practices, with nearly 30%[8] of physiotherapy providers reporting they do not accept NDIS participants due to low fees. Many who do participate must cross-subsidise NDIS services from other client groups, raising the risk of further provider withdrawal from the Scheme[9].

These concerns are reinforced by the Ability Roundtable's (Australia's largest benchmarking platform for disability service providers) financial and workforce benchmarking results for the 2023-24 financial year (Figure 1), which reveal entrenched sector-wide losses among NDIS registered providers[10]. The median profitability for participating organisations was -0.9% in 2023-24, following a -2.1% median result in 2022-23.

Figure 1 | Ability roundtable modelling of median profitability of all organisations participating in the NDIS FY19-20 to FY22-23(FY24 projection)**

For NDIS registered therapy supports specifically, the situation is even more acute as outlined in Figure 2. Median losses for therapy providers were -14% in 2022-23, and mid-year data for 2023-24 showed a median year-to-date loss of -7.9%. Only a small proportion of NDIS registered providers are making a profit, highlighting the growing risk of market withdrawals and failures.

[8] Australian Physiotherapy Association (2025), Hourly rate for the provision of physiotherapy services
[9] Australian Physiotherapy Association (2025), Hourly rate for the provision of physiotherapy services
[10] Ability Roundtable (2025), IHACPA Consultation – NDIS Pricing Reform Opportunities

Figure 2 | Ability Roundtable modelling of profitability of therapy supports for FY23 and FY24 with FY25 projection

It is noted that these concerns are not new. The APA has previously put forward robust recommendations to government highlighting key cost drivers, service delivery complexities and market sustainability pressures evident in the sector.

In its 2024-25 APR, the NDIA announced a 5.2% reduction in the national price limit for physiotherapy from $193.99 to $183.99 per hour for 2025-26 after five years without indexation since 2019-20, The APR cites benchmarking against broader market rates and a revised methodology as rationale for the reduction. The NDIA's approach leverages data from the Medicare Benefits Schedule (MBS), Private Health Insurance (PHI), and other government schemes, as well as regression analysis of private website listings. The APR also reviewed the price limit differentials between jurisdictions, resulting in the previously higher price limit in WA, SA, NT and TAS being brought in line with other jurisdictions.

In addition to these price reductions, the APR introduced a change to travel funding: from 1 July 2025, the maximum claimable rate for provider travel associated with therapy supports will be halved, capped at 50% of the relevant hourly price limit per 10-minute increment. While travel supports access to services, it currently only represents approximately 1% of therapy expenditure ($26.1m) and around 0.1% of total scheme costs for July to December 2024 (~$21.8b[11]). The NDIA's decision to cap travel reimbursement is likely to affect service delivery models, particularly in relation to the NDIS Practice Standards, which encourage access to therapy supports in natural environments. This change continues the existing practice of funding enablers of service delivery from therapy budgets, which is likely to have further implications for the availability and delivery of direct therapeutic supports.

[11] NDIS (2025), 2024-25 Annual Pricing Review

The NDIA's revision of physiotherapy fees highlights a potential gap between federal pricing structures and wage policy. After several years without indexation, providers are navigating rising wage and other operational costs, which stakeholders said could increase costs of employing physiotherapists by up to 30 per cent and is likely to increase more for entry-level employees (such as new graduates) than senior roles[12]. For example, the Fair Work Commission has announced provisional wage increases under the Health Professionals and Support Services Award 2020 (HPSS) – an award that covers the majority of allied health professionals employed in the private sector. These anticipated award changes are not isolated events—they are part of a broader pattern of rising costs that include insurance, compliance, administration, and workforce development.

While the NDIA has positioned the physiotherapy price reduction as a cost-containment measure, its impact on the overall NDIS budget is expected to be relatively limited. As outlined in Table 2, Physiotherapy represents approximately 1% of the total NDIS budget. Even within therapy supports, physiotherapy accounts for just 9.2% of total therapy spending. The estimated annual reduction in physiotherapy expenditure resulting from the price change is approximately $23 million[13], representing about 0.05% of estimated NDIS expenditure. Although modest in terms of overall budget impact, this change may have more pronounced implications for physiotherapy providers, particularly those already operating under financial pressure.

Table 2 | NDIS scale and the impact of proposed change (6 months Jul-Dec 24)

Total NDIS budget	$22.6 billion[14]
Total therapy spending	$2.417 billion (excluding early childhood supports)[15]
Total physiotherapy spending	$222.7 million[16]
Reduction from price change	$11.6 million (~$23 million annually)

There are concerns within the sector that the change pricing methodology employed by the NDIS for 2025-26 is flawed, particularly in its determination of session durations, data comparability, and the unique costs associated with serving NDIS participants.

As such, the APA has engaged Nous to review the NDIA's data and methodology, identify potential flaws, and support advocacy efforts to ensure pricing arrangements are transparent, evidence-based and sustainable. This report provides a critical analysis of the NDIA's 2024-25 APR methodology, drawing on sector expertise, independent data analysis, and stakeholder feedback.

[12] Australian Physiotherapy Association, Gender-based undervaluation – priority awards review, April 2025
[13] Based on an assumed half yearly physiotherapy spend of $222.7 million and a cost saving of 5.2% as per the percentage change in the NDIA hourly rate for physiotherapy.
[14] Transcript for National Quarterly Performance Dashboard as at 31 December 2024
[15] NDIS (2025), 2024-25 Annual Pricing Review. The $2.417 billion therapy spend (Jul – Dec 2024) excludes early childhood intervention supports, which are reported separately. This means the figure does not reflect the total therapy-related spend across the NDIS.
[16] NDIS (2025), 2024-25 Annual Pricing Review

The findings will inform ongoing advocacy to the NDIA and other relevant schemes, with the aim of supporting a viable and sustainable, high-quality physiotherapy market for NDIS participants.

It is noted that, while changes to the differential price limit between jurisdictions and to the travel funding are referenced in this report, the justification and implications of these changes were not explored in the scope of this review.

It is important to note that this report builds on a substantial body of existing work. Foundational recommendations and modelling have already been developed, including the Nous report on the value of physiotherapy in Australia and market research on a sustainable hourly rate for physiotherapy, which considered existing prices, sector sustainability, and economic value. In addition, the Ability Roundtable—Australia's largest benchmarking platform for disability service providers—has produced comprehensive 2024–25 pricing analysis identifying key cost drivers, service delivery complexity, and market sustainability considerations. These studies have been referenced throughout this report and provide valuable insights, although they have not been a focus in recent reform discussions.

2 Methodology review

2.1 The use of regression modelling to estimate session duration resulted in hourly rates that are misaligned to prevailing market prices.

While comparative pricing models can offer useful reference points, their new and extended application in the 2024–25 APR introduces several methodological flaws and data limitations that warrant closer scrutiny. Figure 3 outlines the NDIA's approach to pricing in the APR.

Figure 3 | APR 2024-25 methodology

2.1.1 Regression-based duration estimation

The APR methodology estimates session duration using a regression formula based on price, which is then used to calculate hourly rates. This introduces circular logic: the model defines the relationship between price and duration derived from website scraping, then uses that same relationship to impute duration and derive hourly rates for MBS and PHI services. This creates a deterministic link between price and time, assuming a fixed duration at each price point.

In reality, MBS and PHI session durations are generally either 30 or 45 minutes for any given price. For example, a $110 priced session might last either 30 or 45 minutes depending on provider, client needs, and context. Likewise, a 30-minute session can be priced differently across providers, overlapping with prices charged by some providers for 45-minute sessions. By enforcing a fixed duration at each price point based on a model that considers session duration as a continuous variable, the model does not reflect the market price variability at standard session durations.

As such, the 25th percentile, median, and 75th percentile estimates for the duration of physiotherapy sessions generated by the regression model - particularly those based on PHI data - are unexpectedly high and show very little variation. Table 3 shows the APR estimates as 43.5 minutes for the 25th percentile, 45 minutes for the median, and 46.8 minutes for the 75th percentile.

Table 3 | The APA physiotherapy provider survey outputs compared with APR outputs[17]

Question		25th percentile	Median	75th percentile
Excluding the initial consultation, what is the average session duration for a private patient? (minutes)		30	30	30
Duration determined by the APR (East Coast)	PHI	43.2	45.0	47
	MBS	30.0	30.0	34.0

In practice, a typical standard follow-up session is around 30 minutes, with only enhanced sessions lasting 45.

This is supported by a survey deployed by the APA which reached 212 physiotherapy providers focusing on standard musculoskeletal care. As outlined Table 4most practices reported that the average session duration for a private patient is 30 minutes. While the APR's duration estimate

[17] APA deployed a survey which reached 212 providers focusing on traditional musculoskeletal care to validate assertions in the APR about session price, duration and rate as well as a test the validity of using MBS data as a price comparator. The survey was distributed to physiotherapy business owners, both members and non-members of APA (MS Excel file with the full questions and survey outputs can be obtained from APA on request).

using MBS data aligns well with survey outputs, the estimate using PHI data not only exceed these norms but also suggest very little variation, which doesn't appear to match real-world patterns.

In addition, Nous previously conducted a survey[18] where 91% of respondents reported that a standard physiotherapy consultation physiotherapy (excluding initial consults, complex or specialised consults or consults for more than one concern) should be 30 minutes or less (see Table 4

The findings of these APA and Nous surveys further support the view that the APR methodology has likely overestimated the duration of standard physiotherapy sessions when using PHI data.

Table 4 | Data for quantitative survey questions

Question 1: How long should a standard physiotherapy consult be? This would not include initial consults, complex or specialised consults, or consults for more than one concern. (n=325)								
Multiple choice	<20min	20min	25min	30min	35min	40min	45min	>45min
# of responses	11	50	14	218	3	11	18	0
% of responses	3%	15%	4%	67%	1%	3%	6%	0%

Estimation of session duration is a core aspect of the APR methodology and impacts significantly on the calculation of hourly rates, given the sensitivity of rates to variations in estimates of session duration. In our view, this aspect of the methodology has the greatest likelihood of distorting the pricing of physiotherapy support.

By imputing session durations on MBS and PHI claims data using a regression formula, the NDIA is likely to have overestimated the average length of physiotherapy sessions at the various price points.

Overestimated session durations artificially lower the calculated hourly rate, resulting in rates that are misaligned with prevailing market conditions and run the risk of being disconnected from the actual cost of providing high-quality, disability-specific care.

[18] Australian Physiotherapy Association (2025), Hourly rate for the provision of physiotherapy services

QUESTIONS TO GUIDE FURTHER EXPLORATION

- What regression model was used? What were the regression coefficients? Was separate modelling undertaken for discrete session durations (e.g. 30 and 45 mins)?
- How was the regression output cross-validated with MBS and PHI data, considering these data sources do not include session durations?
- What are the range of prices collected by web scraping for sessions which are 30 minutes and 45 minutes? (**Rationale:** Nous hypothesises that there will be clustering of durations around the 30 minutes and 45 minutes. This would suggest that the duration of physiotherapy sessions should considered discrete values rather than a continuous variable.)
- What are the range of durations collected by web scraping for sessions at the 25th percentile, median and 75th percentile prices?

2.1.2 Hourly rate calculation

The APR calculates hourly rates by dividing the 75th percentile session fee by the imputed 75th percentile duration. This method does not necessarily yield a valid 75th percentile hourly rate, given higher fees can be associated with shorter sessions resulting in higher hourly charges.

Table 5 compares hourly rates derived using different duration assumptions—75th percentile, median, and reference source averages—and shows significant variation. For instance, using median durations yields hourly rates up to $180, while reference durations (e.g. Mystery Shopper data) push estimates as high as $270 per hour. This variation highlights how sensitive hourly rate estimates are to the duration assumption used.

Table 5 | Hourly rate calculated using the 75th percentile duration compared to the median duration and median/average duration of reference sources

METHOD	PHI		MBS	
Using the **75th percentile duration** and **75th percentile price** to estimate an hourly rate	East $118/s for 47min	West $104/s for 46.8min	East $90/s for 34min	West $79/s for 32.6min
	$150.50/h	$133.40/h	$158.70/h	$145.30/h
Using the **median duration** and **75th percentile price** to estimate an hourly rate	East PHI $118/s for 43.2min (median duration)	West PHI $104/s for 43.5min (median duration)	East MBS $90/s for 30min (median duration)	West MBS $79/s for 30min (median duration)
	$163.88/h	$143.45/h	$180/h	$158/h

METHOD	PHI		MBS	
Using the **median/average duration of reference data sources** (E.g. Mystery Shopper report (2022), intended MBS duration) and **75th percentile price** to estimate an hourly rate	East PHI $118/s for 32min	West PHI $104/s for 32min	East MBS $90/s for 20min	West MBS $79/s for 20min
	$221.25/h	$195/h	$270/h	$237/h

The methodology adopted in the 2024–25 APR consistently produced lower rates estimates than other reference methods mentioned in the review and outputs from research conducted in this review of the APR as shown in Figure 5 and Table 6

- Across therapy types, the APR methodology underestimates the 75th percentile hourly rate by an average of 33.0% compared to the other reference methods (Analysis of website listings and comparison to other government schemes). This is particularly the case for physiotherapy where it underestimates the 75th percentile hourly rate by 47%.

The survey of physiotherapy practices determined a 75th percentile average hourly rate of $259/h, 68% higher than the APR estimate. This data shows significantly stronger alignment with the reference methods than the APR-derived estimates.[19]

- The APA requested price data for standard (subsequent) physiotherapy sessions from one of Australia's largest private health insurers—representing approximately a quarter of the national market share— this indicated a 70th percentile session fee of $118.25, equating to $236.50 per hour.[20] Importantly, with standard indexation applied, the current market rate would be higher, further widening the gap between the APR's estimates and actual service costs.

- **As outlined in Table 6, the APR estimates the 75th percentile hourly rate for physiotherapy at a figure that is 54.6% lower than this insurer-derived benchmark of $236.50 per hour.**

- These discrepancies are not insignificant given the 2024-25 APR relied on the MBS and PHI estimated hourly rates as a primary driver for reducing the price limit for 2025-26.

[19] The APA conducted a parallel survey targeting practices specialising in podiatry, neurology, and disability, which received 154 responses. The 25th percentile, median, and 75th percentile hourly rates derived from this survey closely aligned with those from the survey focused on traditional musculoskeletal physiotherapy practices.
[20] The 25th, 50th, 75th percentile claims/fees for a standard consultation (excluding initial) are presented by state at Appendix A.

The 75th percentile hourly price from:

- Analysis of website listings of charges and session times was $240.
- Other government schemes was $215.
- APA's survey was $259.
- Supplementary PHI data[21] was $236.

These illustrate a degree of convergence well above $200 per hour and well above the prices generated by the APR method for 2024-25, which estimated the PHI hourly price at $151 and the MBS hourly price at $159.

The variance between the non-APR outputs and the APR outputs appears implausible and indicate the need for further analysis of the methods used for 2024-25.

Figure 4 | Comparison of the 75th percentile hourly rate determined by the APR compared to reference methods, the APA survey data and data from one of Australia's largest health insurers

[21] Refers to 70th percentile.

Table 6 | Hourly rates for physiotherapy as determined by the APR compared to reference methods, the APA survey data and data from one of Australia's largest health insurers

Question		25th percentile	Median	75th percentile
Survey data: Excluding the initial consultation, how much do you charge private patients per session? N=212 (converted to $/h)		$210.00/h	$230.00/h	$258.00/h
The APA reference PHI data (East Coast average)[22]: What is the 25th, 50th, 75th percentile claims/fees for a standard consultation (excluding initial), including high and low cut off (split by state)?		$192.50/h	$217.50/h	$236.50/h
Rate determined by the APR (East Coast)	PHI	$122.20/h	$136.00/h	$150.50/h
	MBS	$116.60/h	$116.60/h	$158.70/h
Rate determined by reference methods (East Coast)	Analysis of website listings	$182.00/h	$200.00/h	$240.00/h
	Comparison to other government schemes	$136.00/h	$202.00/h	$215.00/h

It is also noted that the APR misinterprets the comparative data from other government schemes by claiming that most physiotherapy hourly rate limits for comparable schemes fall between $140 to $190 per hour. However, APR report shows Figure 6 that the median hourly rate limit around $200 per hour and the 75th percentile is around $215 per hour which appears to contradict this assertion. The current hourly rate limit provided by NDIS sits between the 25th percentile and median, which is well below the 75th percentile.

[22] The private health insurer provided APA fees per session for percentiles at an increment of 10. To maintain conservative estimates, the 20th percentile and 70th percentile fee was used in this table for the 25th percentile and 75th percentile comparisons respectively. The assumption was made that the duration of a standard session was 30 minutes based on outputs of APA's provider survey (MS Excel file with the full questions and survey outputs can be obtained from APA on request. As such, the hourly rate was determined by doubling the session fee.

Figure 5: Comparison of NDIS Price Limits to other Government Schemes

Source: Figure 22 on page 81 of the NDIA's 2024-25 Annual Pricing Review

2.2 The data sources relied upon for the APR are too limited to generate robust and reliable NDIS price limits.

The APR relies on publicly available website data to identify session duration and associated prices and MBS fee data and a single PHI dataset to estimate private patient hourly prices. However, several limitations in this approach raise concerns about the reliability and representativeness of the data:

- **The interpretation of MBS Item 10960 within the Annual Pricing Review must be understood in the context of broader market dynamics:** It is widely acknowledged in the sector—though not yet formally validated—that MBS 10960 is frequently used in medical centres to fulfil the team care arrangement requirements that enable GPs to claim for the development of chronic disease management plans. These vertically integrated models streamline internal referrals and claiming processes, primarily serving the medical claiming budget rather than reflecting the complexity or duration of integrated allied health care. As a result, the service delivery data derived from MBS 10960 is skewed towards corporatised settings and does not represent the realities faced by independent providers, community clinics, or disability-specific services. The NDIA's reliance on MBS 10960 for disability support pricing risks embedding these distortions, overlooking the greater complexity, duration, and relational depth required in NDIS participant care. This concern is further reinforced by evidence that the APR's pricing outputs do not reflect real-world physiotherapy billing practices. For example, the APR's median session price of $58.30 implies widespread bulk billing, yet the APA survey data indicates that 83.5% of physiotherapists do not bulk bill. Additionally, reported session prices are, on average, 76% higher than those presented in the APR, as outlined in Table 7.

Table 7 | Comparison of MBS (10960) session fees estimated by the APR using MBS data and APA survey data

Method	25th percentile	Median	75th percentile
APA survey data (N=212)	$103	$118	$130
MBS (East Coast)	$58.3	$58.3	$88

- **Website data is not transparent:** Public listings often do not reflect internal pricing structures or MBS-specific arrangements. Many providers vary pricing based on the funding source (e.g. MBS vs. private billing), which is not always visible on websites and may misrepresent actual market prices and session durations for segments of the market.
- **PHI data is limited to one insurer:** While the dataset includes 830,021 physiotherapy claims, it is drawn from a single insurer. The review does not clarify if this insurer is representative of the broader PHI market, if it operates preferred provider programs that may suppress fee levels or if service types that could distort the interpretation of the rate for standard care, such as groups or classes, were included in the data. Data from the APA's reference insurer indicates that 30% of physiotherapy claims were made through preferred providers. If similar dynamics

apply to the dataset used by the NDIA, this could have exerted downward pressure on observed prices. In addition, the PHI data is based on HICAPS codes, which do not capture important contextual factors such as client type, service model, or complexity of care. This potentially limits the dataset's usefulness for informing national pricing decisions. In addition, as per section 2.1.2 the APR indicated an insurer-derived hourly rate 54.6% lower than data sourced by the APA from another major PHI organisation.

QUESTIONS TO GUIDE FURTHER EXPLORATION

- What types of services were included in the website scraping (e.g. 30 minute standard consults, 45 minute extended consults, extent of MBS session times, only follow-up sessions, home visits)?
- Did the PHI data used have sufficient national, urban/rural distribution, disability/general population and service model coverage, were standard consults separated from extended consults in the claims data?
- Was the insurer's preferred provider program considered in interpreting fee data?

2.3 The pricing method does not reflect the complexity involved in delivering disability supports

The NDIA's approach, which sets therapy price limits by referencing private market rates and MBS pricing, does not adequately account for the complexity of operating in the NDIS system. The benchmarking method assumes operational comparability across sectors, yet the realities of NDIS service provision appears to diverge significantly from these other sectors.

Feedback from sector stakeholders, including participants in the Deloitte Access Economics review, indicates that allied health services delivered under these alternative schemes typically involve lower complexity, fewer compliance requirements, and higher client throughput[23]. In contrast, NDIS providers operate under a set of different conditions that may impact service delivery and financial sustainability. The NDIA has acknowledged evidence of operator costs exceeding price limits, as documented in the NDIS 2022–23 Annual Pricing Review Report.

These difference conditions stem from the structural and systemic characteristics of the NDIS, which introduce challenges that can impact the efficiency of clinical practice. The nature of service provision within the scheme requires a more involved approach, due to the complexity of the system it operates within. For example:

- NDIS therapy support often involves extended travel and circulation time that is non-billable.
- NDIS participants require additional preparation, documentation, and coordination across multidisciplinary teams

[23] Deloitte Access Economics (2023) NDIS Therapy Pricing Structures Options Analysis, developed for Ability First Australia and participating organisations from the Ability Roundtable and provided to the NDIS Review and the NDIA.

- NDIS has governance and compliance obligations, such as adherence to safeguarding protocols and audit requirements.

This system complexity reduces the time available for funded therapeutic engagement and significantly lowers productivity. This is situation illustrated in the findings from the Ability Roundtable, which shows consistently low billable productivity levels of among NDIS physiotherapy providers (Figure 6[24]). These levels are understood to be well below those expected by the market when compared to other the funding environments such as services within the of PHI and Medicare systems.

Figure 6 | Total billed time as a proportion of total paid time. July 2023 to Jun 2025.

The apparent impact of the scheme's complexity on service delivery highlights the need for pricing models that recognise and account for the distinct operational realities faced by clinicians working within the NDIS. If these realities are overlooked, the funding framework is likely to systematically undervalue and underfund physiotherapy service provision within the NDIS.

The following cost breakdown developed by developed by the Ability Roundtable illustrates the apparent disconnect between current NDIS pricing and the actual cost of delivering physiotherapy services. Figure 7[25], shows the Ability Roundtable cost estimates have consistently exceeded the NDIA's price limit over the past 5 years, with the gap widening over time. The $10 price cut in 2025-26 expanded this gap, with projected costs over $220 per hour and exceeding the reduced NDIS price limit by nearly 22%.

[24] Ability Roundtable (2025), Therapy Insights, unpublished.
[25] Ability Roundtable (2025), Therapy Insights, unpublished.

Figure 7 | Ability Roundtable physiotherapy support hourly cost breakdown compared to the NDIS Price Limit (NSW, Vic, ACT, Qld) 2021 to 2025-26.

In addition, Nous previously supported the APA in modelling a sustainable and value-based hourly rate for standard physiotherapy sessions. That analysis identified a sustainable and value-based hourly rate of $261 per hour[26] based on sector sustainability, economic value, and service quality. It also identified additional premiums for experience, titling or equivalent, specialisation, and rural or remote service delivery to reflect the higher costs and/or value associated with these contexts.

Together, these estimates reinforce the need for a pricing methodology that reflects the unique service delivery profile of NDIS participants—characterised by lower utilisation rates, higher resource requirements, and more complex compliance obligations.

[26] Australian Physiotherapy Association (2025), Hourly rate for the provision of physiotherapy services

3 Alternative methodologies

Approaches to pricing in the short term and long term should be different as the most evidence-based approaches to pricing are likely to include data collection, cleaning and analysis that may not be plausible in the short term. Regardless, the approach should be well grounded in a set of agreed principles

We note the NDIA has in recent years moved towards a more data-driven approach and see this as essential to determining the hourly rates of services. However, we also know that leveraging data to determine prices requires cleaning and analysing data and the use of modelling assumptions. This is complex and often requires validation with stakeholders (e.g. data custodians, physiotherapists delivering services and practice managers responsible for managing costs and budgets).

Below we outline alternative approaches for how a pricing methodology could be leveraged for physiotherapy, or allied health more broadly, in the NDIS or other government schemes.

Foundational principles should underpin the pricing methodology

It is essential to articulate the foundational goals that should underpin any alternative methodology for pricing as adopted by other major pricing reforms (e.g. Independent Health and Aged Care Pricing Authority (IHACPA)[27]).

These could include:

- **Sustainability:** Supporting the ongoing viability of the sector, so that pricing arrangements do not inadvertently drive providers out of the market or undermine continuity of care.
- **Market alignment:** Avoiding pricing that distorts the broader allied health market, by ensuring NDIS rates are competitive but not so high as to significantly draw providers away from other sectors, including aged care and acute care.
- **Transparency and evidence:** Basing methodologies on clear, evidence-based processes, with all assumptions and data sources open to scrutiny.

Embedding these principles will ensure that any alternative pricing methodology delivers fair, sustainable, and market-responsive outcomes. This will help maintain sector viability and participant access, while supporting trust and transparency in NDIS pricing decisions.

3.1 Short term approach

The NDIA has already undertaken significant work to collect and benchmark market data, including the use of advertised website prices and comparisons to other compensable schemes. While these methods are not without limitations, our review suggests these would provide a more appropriate basis for pricing than the current regression-based methodology. We would also suggest

[27] IHACPA, Pricing Framework for Australian Public Hospital Services 2025–26

consulting with the data custodians and the sector on the assumptions used for analysing this data to ensure they capture the nuance of delivering supports through the NDIS or relevant scheme.

Building on this foundation, we recommend the following actions:

- **Benchmarking against website data:** Continue to utilise advertised private session prices and durations from provider websites to establish a more accurate picture of prevailing market rates for physiotherapy services.
- **Benchmarking against other schemes:** Maintain and strengthen the practice of comparing NDIS rates to those paid by other compensable schemes (e.g. State Insurance Regulatory Authority, Lifetime Care and Support and Comcare) to ensure alignment with broader market conditions.
- **Consulting with key stakeholders:** Consult with the data custodians and the sector (through peak bodies) on the assumptions used for analysing this data to ensure they capture the nuance of delivering supports through the NDIS or relevant scheme.
- **Reviewing insights from this report**: Review the insights from this report, particularly those related analysis of the APA survey of providers and additional PHI data and the alignment with existing APR benchmarking using website data and data from other schemes.

If the NDIA is open to reconsidering prices for physiotherapy in the second half of 2025-26, these approaches could be principally relied upon to inform the price limits. Although these measures may not capture the nuance of the physiotherapy market for NDIS participants, they represent a significant improvement over the current methodology and provide a more robust foundation for short-term pricing decisions.

3.2 Longer term approach

Looking ahead, a more sophisticated and sustainable pricing methodology should be developed. This approach outlined below blends detailed, bottom-up costing with reference pricing, ensuring that price limits are both reflective of actual service delivery costs and responsive to market signals.

1. Bottom-up costing

Historically, the NDIS undertook annual financial benchmarking surveys of disability service providers, which provided valuable insights into sector costs and informed pricing decisions[28]. These surveys, conducted over several years, collected detailed data from a representative sample of providers and set a precedent for evidence-based pricing in the sector.

Building on this foundation, a robust long-term approach should involve conducting periodic, statistically robust cost surveys of a representative sample of physiotherapy providers, stratified by geography, provider size, and service model. These surveys should be designed to capture all relevant cost components for both standard and extended sessions, including:

- direct labour (wages, superannuation, on-costs)

[28] NDIS, Financial benchmarking

- non-billable time (documentation, care coordination, travel, supervision)
- compliance and regulatory costs (NDIS-specific governance, safeguarding, audit)
- overheads (rent, IT, insurance, administration)
- workforce development (training, supervision, professional development)
- sustainable profit margin (to support reinvestment and sector viability).

By reinstating and refining such cost surveys, the NDIS can ensure that pricing remains transparent, evidence-based, and responsive to the actual costs of delivering high-quality physiotherapy services to participants. This approach is consistent with the methodologies used by IHACPA[29] in Australia and NHS England[30], all of which use bottom-up costing methods to ensure that prices reflect actual service delivery costs and remain aligned with broader market conditions.

2. Compare with reference pricing

To ensure that NDIS price limits remain competitive and do not create market distortions, bottom-up cost estimates should be validated against:

- Rates paid by government schemes that are more closely aligned in complexity and service demand (e.g. TAC, SIRA, ACC NZ).
- Prevailing private market rates (PHI, website listings).
- International benchmarks where relevant (e.g. NHS England, New Zealand ACC).

This triangulation helps avoid "cost-plus" drift and ensures that NDIS pricing does not inadvertently draw providers away from other sectors or inflate costs.

Establishing a long-term pricing methodology grounded in cost transparency and market validation will enable the NDIS to move beyond reactive adjustments and toward a stable, strategic framework. This will support long-term sector viability, foster investment in service innovation, and ensure pricing remains responsive to evolving participant needs and market dynamics.

[29] IHACPA, Costing overview
[30] NHS, Approved costing guidance

4 Recommendations

We recommend APA advocate to government on current physiotherapy price limits and find opportunities to collaborate with government to establish a sustainable pricing framework for the future .

The focus should be on realising the following key outcomes:

1 Review the 2025-26 pricing decision

Continue to advocate to the government to immediately review the decision to cut the physiotherapy price limit for 2025-26 by $10. This should be based on concerns of the methodology used to determine the price reduction and potential impacts on the sector and service access.

2 Reinstate use of 75th percentile of the true comparable market rate

Given commitments from the NDIA to use the 75th percentile of the prevailing market rate, it is unclear why it was not used in the recent APR. Our analysis suggests the true market rates lies between $215 and $259 per hour based on alternative methods. This may subsequently support the APA to advocate for a methodology that reflects the true market in 2025-26 and future financial years.

3 Review of changes to travel limits

While this report did not directly consider travel limits and differential jurisdictional pricing arrangements, the APA should consider including these related price settings in the advocacy on broader pricing reform, given the significant implications they have on ongoing community access to physiotherapy support for NDIS participants.

4 Embed sector input in ongoing pricing reviews

The APA should advocate for involvement of the sector as part of the annual review process for NDIS pricing, including physiotherapy providers, participants, peak bodies and advocacy groups.

5 Establish a transparent, evidence-based pricing method for the future

The APA should request a commitment from government for a transparent and evidence-based pricing methodology. This could include proposing alternative methodologies, to ensure prices reflect the true costs of delivering physiotherapy services under the NDIS and seek greater transparency on how prices are determined.

Appendix A Private health insurance claims data

Question 1: What is the 25th, 50th, 75th percentile claims/fees for a standard consultation (excluding initial), including high and low cut off (split by state)?

Breakdown by percentile fees:

Item: T505

Extraction period: 1st Nov 23 – 31st Oct 24

	State							
Values	**ACT**	**NSW**	**QLD**	**WA**	**TAS**	**NT**	**SA**	**VIC**
10th percentile	100	80	90	80	92	90	75	79
20th percentile	110	90	96	86	99	95	80	89
30th percentile	110	94	100	92	102	99	85	95
40th percentile	115	98	105	95	111.25	100	90	100
50th percentile	120	100	110	99	111.25	110	94.5	105
60th percentile	120	110	115	102	118	110	99	110
70th percentile	123	115	120	106	124.6	115	104	115
80th percentile	125	120	128	114	127	115	109	125
90th percentile	133	132	140	120	140	119	115	130

Question 2: What proportion of claims is from preferred provider programs?

	Network	Non-Network
Services	242,839	576,607
Distinct Person Count	78,342	187,184

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Appendix: Valuing Skills: Physiotherapy in Disability

The APA Valuing Skills Series

Physiotherapy in disability

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

The NDIS is one of the fastest growing expenses of the federal Budget1 and yet many people with disability miss out on the care they need. This means there is a missed opportunity for greater social and economic participation.

One in six Australians,or about4.4 millionpeople,areestimated tolive with a disabilityand abouthalf ofthem need help with their mobility.2 There are almost 600,000 participants in the National Disability Insurance Scheme (NDIS) but only around 86,000 receive physiotherapy supports3.

Physiotherapists provide expertise in improving function and participation and building the capacity of people with disabilities; however, NDIS participants don't always receive the physiotherapy support they need. Those with disabilities who fall outside the Scheme have limited access to publicly funded physiotherapy services.

Why we need reform.

We can achieve better outcomes for people with disability by improving early and ongoing access to physiotherapy supports and treatments.

TheAPA calls for greateraccess to physiotherapy for people with disability in primary healthcareand acrossthe care and education sectors. By improving the participation of people with disability, we create value for society as a whole. It's an investment in the future.

Who is falling through the cracks?iv

Adults with disability are **six times** more likely than those without disability to assess their health as 'poor' or 'fair'.

People with disability are less physically active

72% Nearly three-quarters of those aged 15 and over with disability do not do enough physical activity.

52% This compares with about half of those without disability who do not do enough physical activity.

Physical activity levels are significantly lower in people with intellectual disability, which has implications for physical and emotional health.

They have a disproportionate risk for obesity

72% of adults with disability are overweight or obese compared with **55%** of those without disability.

And are less likely to be in the workforce

Labour force participation of people with a disability aged 15–64 years is **53.4%** compared to **84.1%** of people the same age without a disability.

Physiotherapy's role in improving participation.

The solution? Bridging the gaps to allow access to physiotherapy for all people with disability across all settings.

Asafirst step, the APAasks the federal government to fund early and ongoing access to physiotherapy (including cost-effective group sessions) for people with disability in primary care beyond the very limited MBS items that exist for chronic conditions. Timely physiotherapy improves functional outcomes for participants, which in turn reduces costs to government by facilitating return to work and participation in society.v

It is critical that governments ensure coordination and consistency of access, accessibility and availability of physiotherapy treatments and supports across states and within states, in the healthcare, aged care and education sectors and where required in recreational and sport community settings. For example, embedding physiotherapists in schools to provide therapy supports based on physical goals would improve inclusion, participation and interaction with peers. Likewise, greater access to physiotherapy for people over 65 and in aged care settings can help with the prevention of falls (a factor in acquiring a disability) and increase opportunities for independent living.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Benefits of physiotherapy.

Ensuringthat people with disabilitiesachieve the highest level of function, independence and mobility possible must be a national priority.

For Australians with disability, accesstophysiotherapyservicesmeans accessto clinicians whoarehighly skilled in the diagnosis, assessment and treatment of motor impairments and movement disorders, including the sensory, musculoskeletal and neurological contributors.

Physiotherapists can improve movement and function, treat and reduce pain, and increase participation in social and economic life, including by assisting with return-to-work capability. Physiotherapists are trained in the biomechanics of movement, combining knowledge of physics, physiology and anatomy to analyse movement and diagnose movement difficulties. As members of an Ahpra-regulated profession, physiotherapists use clinical reasoning to plan, develop, initiate and continue treatment programs for people with disabilities.

Why physiotherapy is important for people with a disability.

Physiotherapists provide essential healthcare for many people with disability.

Physiotherapists have expertknowledge in howpeople move and learnto move and inthe development of movement, specifically as these relate to the health, wellbeing and quality of life of people of all ages. People with disability benefit from physiotherapy services throughout the different phases of their lives and as their condition changes. Physiotherapy helps to meet their current needs and, where possible, to prevent future needs.

The physiotherapist role in disability care

1 | Identify physical impairments and investigate the interrelationship between movement and other neurological and physiological factors such as sensory perception and pain.

2 | Conduct rigorous assessments and continually monitor function and mobility for people with disabilities.

3 | Determine the treatment plan, the range of assistance needed and the education needs of the patient and their key team members.

4 | Provide manual therapy techniques to relieve pain symptoms and facilitate normal movement and function.

5 | Provide and teach specific exercise programs tailored to the individual.

6 | Reassess and progress rehabilitation plans.

7 | Trial, prescribe, tailor and fit out a range of assistive technology.

Skills in focus.

Physiotherapists maintain, develop and improve abilities and skills through specifically tailored exercise, functional training, therapies and support equipment that help develop new motor skills and advance existing abilities. Supporting movement and mobility, strengthening muscles and managing pain are specific physiotherapy treatments that enhance the ability to participate in activities and function more fully.

Physiotherapists also play a vital role in early childhood intervention.

Physiotherapists working with **children and families** in the community use a range of practices based on the Early Childhood Intervention Association's best practice guidelines.

Respiratory physiotherapy provides important support in disability care.

Patients with **neurodegenerative diagnoses** are at an increased risk of developing respiratory complications. Respiratory physiotherapy helps to support and improve participants' functional lung capacity and fitness.

Early physiotherapy interventions for cerebral palsy maximise neuroplasticity.

Physiotherapy interventions target specific motor symptoms of **cerebral palsy** and reduce long-term complications. Physiotherapists provide therapeutic interventions to help manage **cerebral palsy** and enhance functional outcomes.

References:

1. 1CommonwealthofAustralia (2023). Intergenerational report. Available at https://treasury.gov.au/sites/default/files/2023-08/p2023-435150.pdf **2.** AIHW(2022). *People with disability in Australia*Available at https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/summary. **3.** NDIA (2023).*NDIS 2022–23 Annual Pricing Review Report.*Available at https://www.ndis.gov.au/providers/pricing-arrangements/making-pricing-decisions/annual-pricing-review **4.** AIHW,op.cit.
5. Nous(2020).ValueofPhysiotherapy in Australia. Available at: https://australian.physio/advocacy/economic-value