SUBMISSION

National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026

Community Affairs Legislation Committee Inquiry

Submission by **Australian Physiotherapy Association**
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Authorised by:

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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.

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 and is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association. Of the potential nine Directors, seven must be financial members of the APA, and up to two may be external, non-physiotherapist Directors.

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 and are committed to embedding cultural safety within the organisation, policy and education programs.

1. Executive summary

The Australian Physiotherapy Association (APA) thanks the Senate Community Affairs Legislation Committee for the opportunity to provide feedback on the National Disability Insurance Scheme (NDIS) Amendment (Securing the NDIS for Future Generations) Bill 2026 (the Bill).

Physiotherapists witness daily the transformative impact of the scheme in maintaining independence, preventing deterioration of participant capacity, reducing falls, supporting early childhood development, enabling community participation and reducing demand on hospitals, carers and mainstream systems.

The APA supports reforms that improve participant safety, address fraud, strengthen provider quality, and ensure the long-term sustainability of the NDIS.

However, we contend the Bill goes beyond integrity and sustainability measures. It gives the Minister broad powers to reduce support funding, narrows access and planning criteria, and shifts responsibility to families and mainstream systems that are not yet equipped to meet need.

The APA is concerned that tightening access and eligibility settings, expanding budgeting and expenditure controls, and changing how plans are structured and managed puts at risk participants' rights to choice and control, inclusion and participation in the community, and access to reasonable and necessary supports based on individual need.

A 10 per cent cut to capacity-building supports is not a neutral administrative adjustment. For many participants, funding is already insufficient to provide consistent, goal-directed intervention. Reducing these supports risks poorer mobility, increased falls, delayed equipment prescription, loss of developmental gains, increased carer burden and greater reliance on costly healthcare systems hospitals and emergency services.

The Bill moves the NDIS from an individualised, participant-centred model towards a cost-containment model in which participants may receive less support than they have been assessed as needing. Aspects of these reforms may adversely affect the rights of people with disability and Australia's ability to uphold its commitments under the United Nations Convention on the Rights of Persons with Disabilities.

The APA has sourced feedback from members working within the Scheme and included it throughout this submission verbatim and as appendices. However, we stress that the timelines available for consultation and feedback on the Bill have been patently disproportionate to the scale of reform proposed. Where cost containment is a key driver, additional caution is needed to ensure that reductions in the accessibility of supports do not impact participant safety, dignity and participation in their community.

The APA joins Allied Health Professions Australia (AHPA), the participant community and other disability stakeholders in arguing in the strongest possible terms that additional time is essential to allow the Bill to be reviewed in detail, to enable people to understand its full implications, and for meaningful consultation on the proposed changes.

2. Recommendations

Section	Recommendation
General	The reforms contained within the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 require proper scrutiny, transparent modelling and genuine engagement with participants and supporting professionals. The reforms should not proceed without proper scrutiny.
Schedule 1 Part 1 **Defining functional capacity**	Amend section 9B to ensure functional capacity assessment takes into consideration personal circumstances and environmental context. Ensure physiotherapists and other allied health professionals are represented in the Technical Advisory Group and in the development of assessment thresholds.
Part 2 **Limiting unscheduled plan reassessments**	Allow participants, nominees, guardians and treating providers, with participant consent and conflict-of-interest declarations, to submit clinical reassessment requests or trigger urgent review pathways until framework planning is fully rolled out.
Part 3 **Strengthening the link between impairment and need for support**	Ensure support needs can be considered where they are connected to the participant's disability, including secondary impacts, deterioration risks and participation barriers.
Part 4 **Support determinations**	Delete proposed section 34A. If s34A proceeds, add additional safeguards. This should include requiring consultation, parliamentary scrutiny and impact analyses for proposed determinations. Safety should be defined beyond imminent risks of harm. See appendices for examples. Determinations should be a reviewable decision, and determinations should be required to hold for a limited fixed period of time.
Part 5 **Plan renewal**	Permit carryover or protected access to unspent home modifications, assistive technology and corresponding capacity building budgets where delays are caused by hospitalisation, illness, equipment delays, access barriers, workforce/market capacity or NDIA administrative delay.

Part 6 **Reasonable and necessary supports**	Delete item 66 and retain the principles to be considered for a participant's plan outlined in section 31. Delete proposed item 68 - addition of s32 (2EA) and (2EB) which will permit caps on funding or intensity of supports. If this item is retained add additional participant safeguards such as a requirement for the Minister to consider immediate and longer-term safety implications of caps and the ability to review the decision. Amend proposed item 73- addition of s34 (1E) and (1F) to remove the clause that enables the NDIA CEO to disregard other evidence, including a participant's own evidence of effectiveness, in determining if a support is reasonable and necessary.
Part 8 **Tightening meaning of permanence**	Amend the permanence test so "appropriate treatment" means treatment that is reasonably available, affordable, accessible and culturally safe.
Part 9 **Eligibility based on access to other services**	Do not exclude participants from the NDIS unless an alternative system is demonstrably available, accessible, timely, adequately funded and able to meet a person's disability-related support needs.
Schedule 2 Part 1 **Registration of NDIS providers**	Adopt an enrolment or streamlined registration model for Aphra-registered clinicians, avoiding duplicative audits and unnecessary costs.
Part 5 **Reducing claim times**	Retain a longer claiming period for therapy supports or include exceptions where delays are outside provider control. Require NDIA modelling of the impact on small and rural allied health providers.
Schedule 3 Part 1 **Decision-making on pricing**	Require consultation with provider peaks, explicit consideration of safe service delivery costs in the development of independent pricing advice, publication of the methodology used, and publication of the advice received by the Minister.

3. Schedule 1: Access and planning measures

Part 1: Defining functional capacity

The proposed amendment to assess functional capacity (section 9B) without assistance from other people, assistive technology or modifications, and in a context that excludes, as far as possible, environmental and personal context.

The International Classification of Functioning, Disability, and Health (ICF), developed by the World Health Organization (WHO), is the recommended measurement framework and standard for various applications in disability evaluation. The ICF applies a biopsychosocial model to measure how a person's health, disability, and environment affect their ability to function. Part 2 of the ICF focuses specifically on contextual factors.[1] The ICF offers a best practice approach to understanding human functioning and disability by considering a person's medical condition and environmental and personal factors.[2]

Physiotherapists commonly work within a biopsychosocial and functional framework, where assessment and planning consider personal goals, environmental enablers and support systems. Amending functional capacity in a way that excludes these elements undermines the construct at the heart of evidence-based practice and threatens equitable support access.

Functional capacity cannot be clinically understood by stripping away assistive technology, home modifications, personal supports, fatigue, pain, safety, transport, housing, geography and family capacity. Physiotherapists assess real-world function, not abstract task performance in artificial conditions.

Disregarding environmental and personal context is not representative of how a person's disability impacts them on a day-to-day basis and does not give the scheme an indication of what disability related support needs are.

The proposed definition to assess functional capacity in isolation and without consideration to a person's real-life environment or personal circumstances risks misrepresenting the lived experience of people with disability.

In a rapid member survey, conducted by the APA, Respondents emphasised that functional capacity cannot be understood in isolation from environmental and personal factors.

Member feedback:

"Functional capacity cannot ignore a person's environment or personal characteristics. Ignoring these is to ignore the ICF and undermines global efforts to shift views on disability."

"It is not my professional opinion, nor is it best practice, to examine any person, let alone a person with disability, in a context that excludes the impact of a person's environmental and personal circumstances."

The Technical Advisory Group (TAG) will be pivotal to functional capacity assessments and thresholds in the context of eligibility for the NDIS. Allied health clinicians are the primary professionals who understand and undertake functional capacity assessments. The APA affirms AHPA's stance that appropriately experienced clinicians from the key allied health

professions responsible for assessing functional capacity must comprise the majority of membership within the TAG alongside participant representatives.

Furthermore, allied health professionals and the evidence they provide must play roles in both the assessment of functional capacity and delivering support needs in any future version of the NDIS.

Standardised tools cannot and are not designed to capture the complexity of function. Clinical judgement is imperative and must complement these tools to ensure assessments align with real-world capability and participation.

Recommendations:

Amend section 9B so functional capacity assessment must consider personal circumstances and environmental context.

Ensure physiotherapists and other allied health professionals are represented in the Technical Advisory Group and in the development of assessment thresholds.

Part 2: Limiting unscheduled plan reassessments

With the introduction of any new process for determining eligibility and support needs, there will be a clear need to evaluate and, at times, recalibrate assessment processes and outcomes. Extending reassessment windows and restricting unscheduled reviews may delay necessary plan adjustments.

Given changes to the right for legal review of administrative decisions, participants are facing a scenario in which there will be almost no recourse for them when plans fail to meet their needs. This appears to hold true regardless of the level of risk of harm.

The APA is aligned with AHPA in recommending that specific provisions are implemented, until framework planning is fully rolled out, to enable additional access to plan reassessments.

Advocates, including providers, should be able to support participants where appropriate to make requests during this time. Treating providers do not need unilateral control over reviews, but they must be able to clinically prompt, support or provide evidence for reassessment when function changes.

In a rapid member poll, almost half of the respondents said their NDIS participants may be negatively affected if providers have a reduced ability to support plan reviews when therapy needs change.

Physiotherapists are often the first professionals to identify deterioration, increased falls risk, changes in mobility, emerging equipment needs, school transition issues or increased carer strain. Restricting provider involvement risks delays until a participant has already experienced significant functional decline.

Member feedback:

“This is a huge area of concern and will further disadvantage participants with cognitive impairment, overwhelm, lower health literacy. Many NDIS participants have very complex

social situations and limited informal supports and would have no capacity to navigate a review without external support. Incredibly unethical."

"75 per cent of my clients do not have capacity to advocate for themselves without significant support from therapists and support coordinators. Due to language barriers, mental health issues, exhaustion and overwhelmed. Not knowing what services they can access to meet their needs- or in fact what the needs actually are."

Recommendation

Allow participants, nominees, guardians and treating providers, with participant consent and conflict-of-interest declarations, to submit reassessment requests or trigger urgent review pathways until framework planning is fully rolled out.

Part 3: Strengthening the link between impairment and need for support

The Bill narrows supports to needs arising 'directly' from eligible impairments. Participants often have interacting impairments, secondary conditions, deconditioning, mental health impacts and environmental barriers that affect function and participation.

A narrow "direct impairment" test risks excluding supports that address secondary deterioration, prevent avoidable functional decline or support participation. This is particularly concerning for participants with complex psychosocial disability, progressive conditions, newly acquired disabilities, developmental delay or fluctuating function.

The decision to restrict access to supports based on a direct link to an impairment, should only be made where there are other mainstream and foundational supports in the disability ecosystem to help participants meet their support needs.

There are limited non-NDIS therapy supports available in the community, and existing reviews consistently conclude that Medicare funding of allied health services is significantly below the real cost of service delivery.[3,4] As a consequence, non-NDIS services are often inaccessible to people with limited financial means. Medicare and other non-NDIS programs also frequently fail to meet the additional costs associated with accessing services for people with disability, who are more likely to require travel support in order to attend those services.

Given the evidence before government from previous reviews and about the purchasing power of people with disability[5], this provision appears to ignore the likely increase in inequity of access for people with disability.

Recommendation

Ensure support needs are considered where they are functionally connected to the participant's disability, including secondary impacts, deterioration risks and participation barriers.

Part 4: Support determinations

Part 4 of schedule 1, grants the Minister powers to reduce funding for specified groups of support across the Scheme, with very limited safeguards. The APA stands with the disability

and allied health sector and strongly recommends the deletion of Section 34A. This proposed change risks weakening fundamental participant rights and safeguards embedded in the current scheme

Physiotherapy is not an optional or discretionary support in the Scheme. It is often the intervention that keeps a participant walking, transferring safely, using equipment, participating in school or work, maintaining respiratory function, reducing falls risk and avoiding hospitalisation.

Public reporting on proposed planning reforms, including automated plan generation and reduced human oversight, highlights widespread concern among disability advocates and peak bodies that participants may face diminished ability to meaningfully influence decisions about their supports and limited avenues to challenge or appeal unfavourable outcomes resulting from these excessive ministerial powers.

Reduced access to therapy may negatively affect developmental progress, caregiver burden, and overall quality of life. There is also concern that cuts to Capacity Building supports may disproportionately affect participants whose needs are primarily preventative or maintenance-focused. While these supports may not always produce rapid measurable "improvement," they are often critical in preventing decline and preserving current function.

The benefits of ongoing therapy are frequently seen in reduced hospitalisations, delayed equipment needs, reduced falls risk, and maintenance of independence. From a service delivery perspective, reduced funding may also increase administrative burden on clinicians, with greater pressure to justify ongoing intervention, prioritise only acute needs, and discharge participants earlier than clinically appropriate.

This can undermine continuity of care and reduce the ability to provide proactive, evidence-based intervention.

Additionally, participants and families may experience increased stress as they attempt to ration therapy supports across the year, potentially leading to inequitable access based on financial capacity or ability to self-fund services.

Member feedback:

"A proposed 10% reduction to Capacity Building supports, including physiotherapy, would have significant impacts on both participants and clinical practice.
As a physiotherapist working with people with disability, I am concerned that reduced therapy funding would limit access to early intervention, preventative care, and ongoing functional maintenance.
Many participants require regular physiotherapy not because they are expected to "recover," but because therapy helps maintain mobility, prevent deterioration, reduce pain, support participation, and minimise the development of secondary complications such as contractures, falls, reduced endurance, respiratory decline, or loss of independence. A reduction in available therapy funding would likely result in participants receiving less frequent intervention, delayed review, or shorter treatment blocks.
In practice, this often leads to deterioration in function before supports are reintroduced, resulting in poorer outcomes and potentially greater long-term costs to the healthcare and support systems.
I am particularly concerned about the impact on children and individuals with complex or lifelong disabilities. For many of these participants, physiotherapy is essential for supporting

gross motor development, postural management, equipment prescription, safe mobility, and participation in home, school, and community environments."

"I provide a mobile Neurophysio service. Many of my clients require therapeutic intervention in their homes due to barriers accessing clinic rooms (fatigue, transport, staffing to assist attendance etc). It makes little business sense to use this model of care. It makes more business sense to have your clients come to you as you don't lose time travelling/unpacking therapy table and equipment each time etc and you can service more people.
However we offer this service because we care about providing supports to the most vulnerable people living in our community and they should be able to access high quality and expert therapy.
Current NDIS travel rates are capped. That has already impacted on the sustainability of my service. To further reduce Capacity Building supports for my clients (where already 4/10 are going through the ART process at this time as their budget has been reduced by 50%-75% for Capacity Building supports; have been refused essential AT requirements) further increases the risk of injury, adverse patient outcomes and hospitalisation."

"A proposed 10% reduction to capacity building supports would have a disproportionate impact on participants in regional and remote areas where access to physiotherapy is already limited, delayed, and often dependent on outreach services or infrequent visiting clinicians. In many cases, the closest specialist services such as an MND clinic or hospital based neurological and respiratory supports are located 1.5 to 2 hours away, which makes regular attendance difficult or not feasible.
For a participant with MND, this level of travel is often unrealistic due to severe fatigue, reduced respiratory capacity, fluctuating function, and the physical and emotional stress of prolonged travel. A single return trip can take most of the day and may result in significant exhaustion lasting several days afterwards, directly impacting communication, mobility, swallowing, and safety. In this context, the local physiotherapist becomes the primary and sometimes only practical source of ongoing care. However, a 10% reduction in funding means access to the physiotherapist in these areas would be reduced, less frequent, or in some cases not available at all if service delivery becomes financially unviable. This would result in longer gaps between sessions, reduced ability to monitor rapid changes in condition, and delayed intervention for issues such as mobility decline, respiratory compromise, equipment needs, pain management, and falls risk.
For participants with MND, reduced access to local physiotherapy can lead to faster functional deterioration, loss of independence, and increased reliance on family carers who are often already under significant strain and living without nearby support networks. It also reduces opportunities for proactive intervention such as timely prescription of assistive technology, positioning strategies, respiratory management, and caregiver training, all of which are critical in maintaining safety and quality of life.
For other participants in regional and remote areas, reduced access means less consistent therapy for mobility, strength, balance, and developmental support.
Children may miss regular interventions that support participation in school and daily activities, while adults with disability may experience increased risk of falls, pain, and deconditioning.
In both cases, there is often no practical alternative service to replace local physiotherapy input, meaning gaps in funding directly translate into gaps in care.
From a physiotherapy practice perspective, I am a specialist physiotherapist who has completed additional training in the neurological and respiratory field, and I frequently work with complex and progressive conditions where early intervention and ongoing monitoring are essential.

In regional settings, reduced funding makes it increasingly difficult to sustain outreach services due to travel time, higher costs, and reduced appointment density. This may result in fewer clinicians servicing these regions, longer waitlists, and reduced continuity of care."

"Reducing clients access to evidence based therapy puts them at risk of deterioration, falls, hospitalisation.
This would directly reduce their independence, safety and quality of life whilst also costing the government more in hospital admissions and support services.
My practice and clients reply on an intensity of therapy that for their progressive neurological conditions works to slow progression. Limiting their access will have a direct impact on their independence, safety and quality of life."

Recommendation

Delete proposed section 34A. If s34A proceeds, add additional safeguards. This should include requiring consultation, parliamentary scrutiny and impact analyses for proposed determinations. Safety should be defined to not only include imminent risks of harm but also longer-term impacts of funding cuts. Determinations should be a reviewable decision, and determinations should be required to hold for a limited fixed period of time.

Part 5: Plan renewal

Member feedback:

"These proposed changes are likely to negatively affect both participant outcomes and the sustainability of small therapy practices. In paediatric disability services, therapy participation is often interrupted by planned holidays, school demands, illness, hospital admissions, surgeries, fatigue, behavioural burnout or fluctuating medical needs, particularly for children with complex disabilities.

Preventing the carryover of unspent funds may unfairly penalise families for circumstances outside their control and create a "use-it-or-lose-it" approach that pressures families to either overspend unnecessarily before plan end dates or lose funding intended for essential ongoing therapy.

The proposed 90-day claiming limit also creates significant risk for small providers and sole traders balancing large clinical and administrative workloads, where legitimate delays may occur due to plan manager processing times, family emergencies, temporary pauses in invoicing, provider illness or unforeseen personal circumstances.

These changes may increase cancellations, interrupt therapy continuity, create financial uncertainty for providers, increase administrative burden, and ultimately reduce the flexibility and family-centred responsiveness that many participants rely on to access consistent and effective therapy supports."

Recommendation

Permit carryover or protected access to unspent therapy funds where delays are caused by workforce shortages, illness, hospital admission, equipment delays, plan management issues, access barriers or NDIA administrative delay.

Part 6: Reasonable and necessary supports

The APA aligns with AHPA and does not support the removal of principles to be considered for a participant's plan outlined in section 31 (Division 1 of Part 2 of Chapter 3), as proposed in item 66. These principles are critical in enabling reasonable and necessary individualised, person-centred supports.

Financial sustainability must not come at the expense of plans that are individualised, participant-directed, goal-oriented, offer choice and control and that maximise participation.

The APA further supports AHPA's call for assurances that there are protections in place to ensure the proposed powers for the CEO of the NDIA, to make decisions about whether there is evidence to consider a support reasonable and necessary, are rigorous and required to be informed by expert recommendations.

We also agree that the reliance on peer-reviewed published and generalisable evidence proposed by the reforms is inappropriate in light of the systemic structural barriers that limit disability-specific allied health research. It is noted that, for more than a decade, the NDIA has acknowledged the limitations of disability-specific research and has sought to address these gaps through the commissioning and collation of NDIS-specific research. The new Evidence Advisory Committee (EAC) process recognises the gaps in empirical research and is including a range of evidence sources within its work, including grey literature and evidence of lived experience. [7]

Any changes related to reasonable and necessary supports must not place additional undue requirements on families, carers and informal networks to support participants. These informal supports are often under significant stress, and many must reduce hours or cease work to take up roles as carers. The Act must not further enshrine this. We note that a key intention of the NDIS was to enable greater productivity among people with disability and their caregivers. Any considerations in relation to reasonable and necessary should also require consideration of how they impact productivity and participation.

In the APA survey, 93 per cent of respondents said increased expectations on families would affect patients significantly or somewhat.

The APA further agrees with AHPA's commentary surrounding scheme harmonisation and underlines that there are substantive differences across the schemes, including the paradigms in which they operate. The NDIS must continue to be underpinned by the social model of disability, irrespective of how other schemes operate in order to uphold Australia's obligations under the Convention on the Rights of Persons with Disabilities. Additionally, that until the ecosystem of supports outside of the NDIS is fully established, accessible, well-resourced and demonstrated to be effective, no substantial reductions in NDIS access or support should proceed.

Member feedback:

"Carers are already pushed to the edge with overload and anxiety. Often we have had primary caregivers hospitalised due to injury or burn out which leaves participants who are vulnerable without supports and the caregiver in a dangerous place for their own health and wellbeing. Extreme stress is known to cause poor health outcomes. Expecting carers to load

up further will result in vital management at home being missed or not able to be integrated into capacity which causes further deterioration, decline in function and risk of pain, hospitalization or loss of skills."

"This will have a massive effect. We are a paediatric service. Many of our families have other children, work, commitments etc and often do not have the time to dedicate one on one therapy plans daily. This is where frequency of therapy allows for practice of skills, development of strength etc to occur as it cannot be effectively implemented within the home environment. Our parents are already stretched thin."

"I have families on my caseload barely surviving with the complexities of their children's disabilities, the day to day care, school, work and other life commitments to add on additional tasks that can be completed by professionals is unfair and shows the total lack of compassion for families and a true understanding of what these families go through on a day to day basis."

Recommendation

Delete item 66 and retain the principles to be considered for a participant's plan outlined in section 31.

Delete proposed item 68- addition of s32 (2EA) and (2EB) which will permit caps on funding or intensity of supports. If this item is retained, add additional participant safeguards such as a requirement for the Minister to consider immediate and longer-term safety implications of caps and the ability to review the decision.

Amend proposed item 73- addition of s34 (1E) and (1F) to remove the clause that enables the NDIA CEO to disregard other evidence, including a participant's own evidence of effectiveness, in determining if a support is reasonable and necessary.

Part 8: Tightening meaning of permanence to reduce access where an impairment can be treated

This part clarifies permanence by introducing "all appropriate treatment", meaning the Bill would prevent consideration of whether a person's individual circumstances restrict access to treatment, including financial and geographic barriers. Participants should not be forced into inappropriate, harmful or inaccessible treatment pathways to prove permanence.

The APA concurs strongly with the assessment by AHPA that the proposed legislative changes for 'permanence' can only be seen as a risk for reintroducing equity issues – given that the legislation notes that the new requirement to have undertaken all appropriate treatment options before being able to access the NDIS holds irrespective of whether a person's individual circumstance enables them to access the treatment. This means people who are unable to afford or access these treatments may inadvertently be blocked from the scheme.

The proposed change will mean that applicants will have to show that they have pursued potentially expensive and lengthy processes to prove there are no treatments available for them. Treatment options may have significant wait times, be prohibitively expensive or not be geographically viable. For some, these challenges will delay access to the NDIS and supports they need, many of which may be time-sensitive to have the best outcomes. For others,

pursuing expensive and lengthy process will not be an option, and they will be unable to meet this permanence threshold to access the scheme, despite experiencing significantly reduced functional capacity. For the early intervention pathway in particular, AHPA notes that extensive delays to accessing the scheme, as a result of having to pursue all appropriate treatments, is at odds with the purpose of early intervention.

AHPA strongly recommends that 'all appropriate treatments' be defined to include only those that are available, affordable, culturally safe and accessible. Future rules must also include that it is reasonable for a participant to exercise their right to choose not to undergo a treatment and this must not prevent access.

In the survey, 93 per cent of respondents said this would negatively affect participants who rely on ongoing physiotherapy.

Member feedback:

"Requiring participants to trial "all appropriate treatments" before being considered permanent or eligible for the Scheme risks creating significant delays, inequities, and treatment burden for people with lifelong, progressive, or complex disabilities. In practice, access to many treatments is heavily influenced by geography, cost, public hospital waitlists, workforce shortages, and family capacity.
This is particularly concerning in paediatrics, where early intervention and timely supports are often critical to developmental outcomes. Delaying access to supports while families attempt to navigate multiple treatment pathways may result in lost developmental opportunities, increased family stress, deterioration in function, and higher long-term support needs.
There is also concern that this approach may create pressure for children to undergo invasive, costly, or clinically questionable interventions simply to demonstrate they have "tried everything" prior to accessing support.For example, a child with Cerebral Palsy may face expectations to pursue repeated medical or procedural interventions such as botulinum toxin programs, despite variable access, suitability, or family preference, before receiving adequate functional supports. Similarly, children with progressive neuromuscular conditions may experience delays accessing equipment, therapy, or environmental supports while exhausting treatment pathways that are unlikely to alter the long-term trajectory of their condition.
Eligibility for disability support should recognise the reality of permanent functional impairment and participation needs, rather than depending on whether families have been able to access every possible treatment option."

"People will be required to endure unnecessary testing and potentially harmful treatments to provide proof of eligibility in a system that already creates so much unnecessary burden. Rural people are again hugely disadvantaged - having to travel for many hours to access potentially unnecessary assessments (when travel may be inaccessible due to disability)."

"I work rurally. There is no way that population has the geographical access to try all possible treatments. I also take issue with the disregarding of the NDIS of professional opinion of treatments that are contraindicated, for example, surgical options, and that all relevant treatments must be trialled. This means, even if a person has access and financial means, they must undergo medical treatments that may be harmful, which is detrimental to the person, and violates ethical approaches."

Recommendation

Amend the permanence test so "appropriate treatment" means treatment that is reasonably available, affordable, accessible and culturally safe.

Part 9: Eligibility based on access to other services

A participant's support needs do not cease simply because another system is deemed to hold responsibility. Medicare, state health, workers compensation, transport systems, school systems and aged care are not consistently able to meet disability-related physiotherapy needs, particularly in rural and remote areas.

Member feedback:

"The Thriving Kids initiative is a clear example where children with mild to moderate disabilities from 0 to 8 years of age are going to make them in eligible for NDIS supports. Currently the scaffolding and framework for this initiative is not clear, appears grossly in adequately funded, and will be provided by NGO and NFP's who has a very small workforce and hacks back to the pre-NDIS model of funding which was grossly inadequate. It is becoming very clear that there will be definitely children falling through the gaps and there will be significant delays in accessing therapy as well as a significant reduction in the amount of therapy a child can access. Furthermore, this model appears to be placing an increase in the burden of care back onto parents and carers."

Recommendation

Do not exclude participants from the NDIS unless an alternative system is demonstrably available, accessible, timely, adequately funded and able to meet the person's disability-related support needs.

4. Schedule 2: Fraud measures

Part 1: Registration of NDIS providers

The APA agrees with AHPA that future provider registration must be truly risk proportionate and take into account the existing health professional regulation requirements that apply to allied health professionals practising in the scheme, as well as current work by health ministers and the Health Workforce Taskforce to further strengthen regulation. The APA, like AHPA, supports a light touch registration (or enrolment) model for allied health, alongside a requirement for practitioners to be registered or certified by their health regulator.

Any proposal for future registration models must consider and address the failures of the current registration system, in particular the duplication of regulatory processes and the administrative costs associated with that duplication, as well as the high financial cost of third-party audits.

Recommendation

Adopt an enrolment or streamlined registration model for Ahpra-registered physiotherapists, avoiding duplicative audits and disproportionate compliance costs.

Part 5: Reducing claim times

The 90-day claiming limit may create viability risks where payment delays arise from plan manager issues, lack of budget visibility, participant circumstances or NDIA system problems.

The APA joins AHPA in seeking modelling of the effect of the 90-day claiming limit and calls for clear and easy to use pathways to rectify issues where timeframes are exceeded for reasons outside of a provider's control. Without this, this substantial reduction in timeframes may risk that claims are not paid, impacting on provider viability and ultimately on participants' access to supports.

Recommendation

Retain a longer claiming period for therapy supports or include exceptions where delays are outside provider control. Require NDIA modelling of the impact on small and rural allied health providers.

5. Schedule 3: Governance arrangements

Part 1: Decision-making on pricing

The Bill shifts pricing decisions to the Minister, with the Minister required to consider Agency advice, scheme sustainability and the objects and principles of the Act.

The APA backs sector calls for amendments that will require an independent pricing review to be undertaken and published, and for the Minister to make publicly available any and all advice received in relation to pricing, as well as an explanation of how pricing determinations have been made.

Recommendation

Require consultation with provider peaks, explicit consideration of safe service delivery costs in the development of independent pricing advice, publication of the methodology used, and publication of the advice received by the Minister.

6. Conclusion

The APA supports a sustainable NDIS that is safe, high quality and protected from fraud. However, sustainability must not be achieved by reducing access to essential physiotherapy supports, weakening individualised planning, shifting skilled care onto unpaid carers, or transferring costs to under-resourced mainstream systems.

Physiotherapy supports build and maintain capacity, prevent deterioration, reduce long-term costs and enable participants to live safely and participate in their communities.

The Bill should not proceed without significant amendment, transparent modelling and genuine consultation with people with disability, families, carers, physiotherapists and the broader allied health sector.

At minimum, the Bill should be amended to ensure that:

- reasonable and necessary supports are funded in full
- capacity-building daily activity supports, including physiotherapy, are not subject to blunt percentage cuts
- functional capacity is assessed holistically, consistent with the biopsychosocial model of disability
- access and permanence tests do not penalise participants who cannot afford or geographically access treatment or where they are culturally inappropriate.
- families and unpaid carers are not expected to substitute for skilled physiotherapy care
- pricing, automation and ministerial powers are subject to independent oversight, transparency and review
- any integrity, registration and fraud measures are risk proportionate and do not undermine provider viability.

Sustainability cannot be achieved at the cost of moving away from the Scheme's core statutory purposes.

7. References

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