

Statement from the Australian Physiotherapy Association on functional capacity assessment for NDIS access

From 1 January 2028, the Australian Government plans to introduce a new standardised approach to assessing functional capacity for NDIS access. Current participants will transition to the new access arrangements over three years. The assessment framework, tools, thresholds and detailed implementation arrangements are still being developed.

These changes follow the commencement of a new statutory definition of functional capacity on 27 August 2026

The design of the assessment process will have significant consequences for whether people with permanent and significant disability can access and remain in the Scheme.

The APA supports a proportionate, person-centred and clinically informed access assessment process that brings together the person's lived experience, relevant clinical evidence, appropriate standardised measures and profession-specific expertise.

When movement, mobility or physical function, including associated safety risks, is material to an access decision, the assessment pathway must require relevant physiotherapy input.

Reform 1: Require relevant physiotherapy input

What needs to happen: Require access to physiotherapy expertise whenever movement, mobility, physical safety or physical function is material to a NDIS access decision.

A standardised tool may identify that a person has difficulty completing an activity, but it may not explain the physical factors causing that difficulty or whether the activity can be performed safely, reliably and repeatedly.

Physiotherapists use clinical reasoning to assess and interpret movement and physical function, identify risks and distinguish among factors such as spasticity, rigidity, weakness, pain, fatigue, breathlessness, dizziness, impaired motor control and medication effects.

Requiring physiotherapy involvement will support more accurate interpretation of assessment findings and reduce the risk that significant physical limitations are overlooked.

The required input should be proportionate to the person's circumstances and the evidence already available. It should include existing treating-practitioner evidence, consultation and direct assessment. Any additional assessment required by the access process must be funded, timely and accessible, and avoid unnecessary duplication.



Reform 2: Preserve person-centred assessment

What needs to happen: Ensure standardised tools are not used in isolation and that participant evidence, relevant clinical evidence and real-world function inform access decisions.

Functional capacity assessments should be focused on a person's strengths, lived experience, circumstances and account of how their impairment affects everyday life. They should reflect choice and control, examine function in real world environments, and align with the WHO's International Classification of Functioning, Disability and Health and disability rights legislation.

Physiotherapists integrate objective measures and clinical reasoning, using a biopsychosocial approach to understand not only whether a participant can complete an activity, but how it is performed, whether it is safe and sustainable, and how function varies across different contexts. This supports a more comprehensive understanding of everyday function than isolated clinical findings or standardised scores alone.

Assessment must consider episodic and fluctuating limitations, fatigue, repetition and recovery.

Tools and thresholds to be tested and validated for their intended purpose and relevant populations. Clinical reasoning should remain available to explain findings, address conflicting evidence and identify limitations in the assessment.

People should receive accessible explanations of findings and decisions, have an opportunity to correct factual errors, and be supported to understand and exercise their review rights.

Reform 3: Match expertise to need

What needs to happen: Match assessors and multidisciplinary input to each participant's functional, cognitive and communication needs, circumstances, complexity and risks.

Functional capacity assessments should be undertaken by an appropriately qualified allied health clinician whose clinical expertise and demonstrated competence are matched to the person's disability, functional needs and the assessment methods required. This will often require more than one profession to provide clinical input.

People should be supported to identify their communication, cultural, gender and safety needs and preferences. These should inform how they are matched with an assessor who has the required professional expertise. Assessment arrangements should embed cultural safety and trauma-informed practice.

Where complex physical disability, movement impairment, mobility limitations or physical risk is central, the assessment pathway should require a physiotherapist to undertake or lead the relevant component of the assessment. Where needs span several domains, a multidisciplinary team should contribute distinct and complementary expertise.

The framework should establish clear competencies, referral requirements and escalation pathways when findings are uncertain or outside an assessor's scope. Evidence from treating practitioners must be properly considered, with reasons provided where relevant evidence is not accepted.