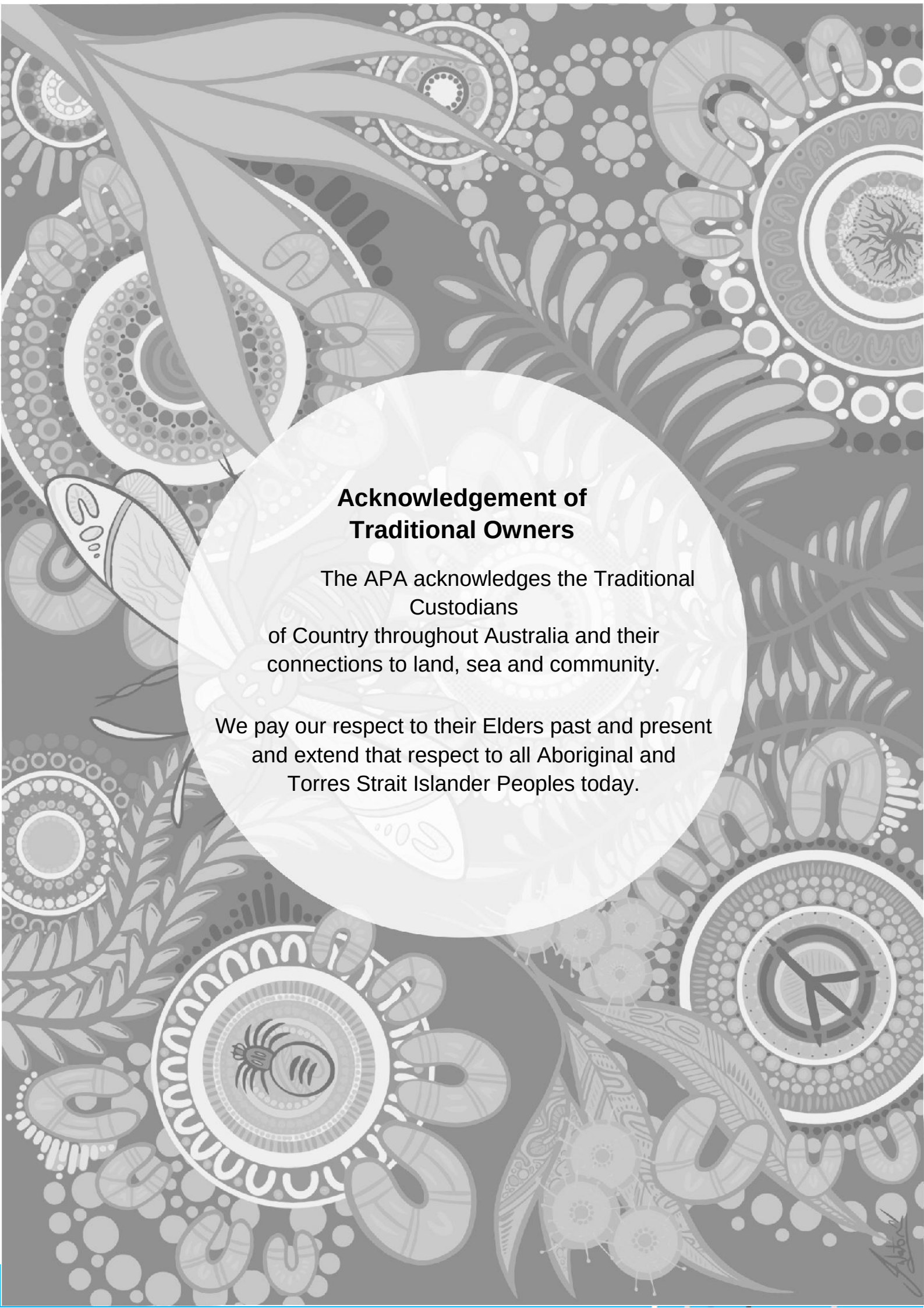
SUBMISSION

2027-28 National Disability Insurance Scheme Annual Pricing Review consultation

Submission by **Australian Physiotherapy Association (APA)**
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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.

SUBMISSION

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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About the Australian Physiotherapy Association

The Australian Physiotherapy Association's 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 37,000 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) welcomes the National Disability Insurance Agency's (NDIA) 2027–28 Annual Pricing Review (APR) and calls for a correction to physiotherapy pricing that protects participant access and supports sustainable service delivery.

The APA asks the NDIA to recommend to the Minister a correction to the physiotherapy price limit for 2027–28 (at minimum restoring the pre-July 2025 rate of $193.99 in addition to appropriate geographical loadings and recurring indexation that reflects the HPSS Award wage increases. The APA's indexed sustainable hourly rate guidance of $273 per hour, based on the Nous methodology, shows the scale of the gap between current pricing and the cost of sustainable practice (APA 2026a). Future reviews, including the 2027 Therapy Pricing Review, should be informed by independent bottom-up costing.

Independent analysis from the Nous Group indicates that:

- the cost of delivering physiotherapy under the NDIS exceeds $220 per hour;
- market rates are typically in the $215-$259 per hour range; and
- a sustainable, value-based benchmark is approximately $273.

The current price limit of $183.99 falls significantly below these benchmarks. Had the rate kept pace with cumulative inflation since 2019 - approximately 28 per cent - it would now be approximately $249 per hour.

Physiotherapy enables participants to develop and maintain the capacity needed for everyday activities, independence and participation. Its contribution includes direct therapy, assessment, equipment prescription, clinical coordination and guidance for families and support workers. Pricing must recognise the full work required to deliver these outcomes, including services provided in participants' homes, schools and communities.

For the approximately 100,000 NDIS participants who access physiotherapy each year, the gap between cost and pricing has implications for access to supports and continuity of care (NDIA 2026a). **Reduced access to physiotherapy does not eliminate demand for care but risks shifting that demand to more acute and costly parts of the heath system.**

Physiotherapy pricing within the scheme has had no indexation since 2019-20 and following the 2024–25 APR. Effective from 1 July 2025, the reduction from $193.99 to $183.99 was approximately 5.2 per cent in NSW, Victoria, Queensland and the ACT. Providers in WA, SA, the NT and Tasmania experienced a larger gap because the higher jurisdictional rate was also removed. Independent analysis commissioned by the APA identified material limitations in the methodology underpinning the 2024–25 pricing review, including session-duration assumptions, the representativeness of comparator data and recognition of disability service delivery costs which the 2026-27 review has not resolved. (Nous Group 2025b).

The APA maintains that benchmarking NDIS physiotherapy services against Medicare and a limited number of private health insurance data risks understating the true cost of service delivery, as these funding systems were not designed to support the same levels of complexity, coordination, travel and participant-specific requirements that exist within the NDIS.

The NDIA has subsequently revised its physiotherapy sessional length benchmarking assumptions but retained the reduced price, citing sensitivity in the benchmarking and monitoring that did not identify disrupted access or accelerated provider exit through December 2025 (NDIA 2026a, section 8.6.2).

Fees drawn from other funding systems and continued provider participation do not establish whether the retained price covers the efficient cost of delivering NDIS physiotherapy.

This is particularly relevant given changes to the Health Professionals and Support Services (HPSS) Award following the Fair Work Commission's (FWC) gender undervaluation review. The initial wage changes took effect from the first pay period starting on or after 1 October 2026, with increases continuing in further phases on 30 June each year from 2027 to 2030 meaning many physiotherapy providers will face higher staffing costs without corresponding changes to NDIS pricing in the current review period (Fair Work Commission 2026a).

The NDIA indexes Disability Support Worker (DSW) prices to the SCHADS Award and has scheduled a DSW Cost Model review to incorporate the FWC gender undervaluation outcomes (NDIA 2026a, Recommendations 1–2). Therapy prices have no equivalent wage mechanism.

The APA's October 2026 provider survey (595 responses), conducted in response to this consultation, outlines the significant pressures within providers that remain active in the Scheme. Among respondents to the relevant questions, 80.6 per cent reported that NDIS price guidance did not reflect their organisation's delivery costs, 52.3 per cent reported reducing or restricting travel following the travel changes, and 43.5 per cent reported having not provided therapy because of pricing. Respondents also estimated that, on average, 31 per cent of non-face-to-face work went unbilled to preserve participant funding (APA 2026b).

The NDIA's monitoring looked at provider counts, participants per provider and payments. These measures do not reveal closed books, reduced travel radius or unbilled work. In fact, the most recent APR report concedes that claiming data cannot clearly distinguish direct therapy, non-face-to-face work and travel, and it cannot detect providers absorbing unpaid work (NDIA 2026a, section 8.10.2).

These findings highlight why monitoring must extend beyond provider numbers. A provider may remain active in the Scheme while restricting referrals, reducing geographic coverage or absorbing essential work without payment.

Provider exit is also a lagging indicator. Practices wind down NDIS caseloads gradually to meet ethical handover obligations, staff contracts and lease commitments, so six months of post-change provider counts cannot show the full effect of the 2025 decision. Continued provider participation does not, by itself, demonstrate that participants can access appropriate services on sustainable terms.

Travel reform is integral to protecting access. The review must address the 50 per cent limit on reimbursement for therapy travel time and applicable travel-time limits. These arrangements must support viable outreach services, particularly where participants cannot attend a clinic or have limited access to local providers.

The decision to cut travel was not economically sound. Therapy-related travel payments were $49 million in July to December 2025, under 2 per cent of $2.67 billion in therapy payments and around 0.2 per cent of total Scheme payments (NDIA 2026a, Table 12). Despite its small share of expenditure, travel is fundamental to delivering therapy in natural environments. 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 policy 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.

The APA does not support differentiated price tiers based on participant complexity or registration as pricing currently stands. Complexity should be recognised through adequate funding and service intensity rather than separate complexity price limits, which create classification disputes and

administrative burden. Any proposed differentiation must be supported by validated cost evidence and assessment of its effects on participant access, administrative burden and service sustainability.

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 APA and the NDIA continue in dialogue on pricing and the independent Nous review (Nous Group 2025b). The APA has engaged further independent economic analysis of large data sets sourced from industry leaders to further evidence our position and inform improved pricing. The APA will provide this analysis to the Agency when complete; it should not delay a correction in this review.

This 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.

Physiotherapists want to continue supporting participants. The APA expect and look forward to further consultation in 2027 on the Therapy Pricing Review (NDIA 2026c).

2. Recommendations

Recommendation 1	**Correct physiotherapy pricing and establish an independent costing model** The APA asks the NDIA to recommend to the Minister a correction to the physiotherapy price limit for 2027–28 (at minimum restoring the pre-July 2025 rate of $193.99 in addition to appropriate geographical loadings and recurring indexation that reflects the HPSS Award wage increases. The APA's indexed sustainable hourly rate guidance of $273 per hour, based on the Nous methodology, shows the scale of the gap between current pricing and the cost of sustainable practice (APA 2026a). Commission independent bottom-up costing, supported by regular, representative provider cost surveys, to inform subsequent pricing reviews. The model should recognise the full cost of efficient physiotherapy delivery, including clinical time, necessary indirect work, travel, supervision, administration, compliance and workforce costs.
Recommendation 2	**Restore viable travel arrangements that protect participant access** Review and revise the 50 per cent limit on reimbursement for therapy travel time and applicable travel-time limits, so that reimbursement reflects reasonable delivery costs and supports necessary outreach services. Account for participant circumstances and geographic access, particularly where participants cannot attend a clinic or have limited access to local providers. Publish clear guidance and monitor providers' capacity to sustain home, school and community services.
Recommendation 3	**Establish transparent, recurring indexation for physiotherapy prices** Introduce a recurring indexation mechanism that recognises relevant movements in the Health Professionals and Support Services Award and other validated service delivery costs.
Recommendation 4	**Require evidence and safeguards for pricing differentiation** Establish a validated physiotherapy cost base before considering price differentiation based on provider registration status. Any proposed differentiation should be developed through consultation, reflect demonstrated cost differences and be assessed for its effects on participant access, choice, administrative burden and provider sustainability. Do not introduce differentiated price tiers based on participant complexity. Recognise participants' needs through an adequately costed physiotherapy price and funding for the additional time, intensity and coordination required to deliver appropriate services.
Recommendation 5	**Strengthen pricing transparency, consultation and access monitoring** Publish the methodology, assumptions, evidence limitations and reasons underpinning pricing decisions, with meaningful participant and provider consultation and adequate implementation notice. Monitor waiting times, acceptance of new referrals, travel coverage and continuity of support alongside provider numbers and expenditure. Include participant experience and provider evidence to identify restrictions within services that remain operating, and establish a clear process for responding when access deteriorates.

3. APA position

Physiotherapy enables the outcomes the NDIS exists to achieve

Physiotherapy helps participants develop and maintain the physical capacity needed for everyday activities, independence and participation. It supports practical goals such as transferring between a bed and wheelchair, moving safely around the home, managing daily routines, and accessing education, employment and community activities. The goals and approaches differ between participants, but the purpose remains consistent: supporting people to participate in the life they choose.

Physiotherapy also contributes to the effectiveness of a participant's broader support arrangements. Clinical assessment, equipment trials, movement and transfer training, and guidance for families and support workers help translate funded supports into outcomes.

Economic evidence supports the value of appropriately targeted physiotherapy. Nous Group's, Value of Physiotherapy in Australia, modelled benefit–cost ratios of 3.49:1 for a Parkinson's disease balance-training intervention and 2.13:1 for a cerebral palsy intervention (Nous Group 2020).

Lower expenditure on therapy cannot, by itself, establish better value. Assessment must consider the consequences for participants' function, participation and wider support needs. Preserving an ability that enables someone to remain involved in family or community life has value even when it does not produce an immediate reduction in their support budget.

Physiotherapy pricing requires correction for 2027–28

The APA asks the NDIA to recommend to the Minister a correction to the physiotherapy price limit for 2027–28 (at minimum restoring the pre-July 2025 rate of $193.99 in addition to appropriate geographical loadings and recurring indexation that reflects the HPSS Award wage increases. The APA's indexed sustainable hourly rate guidance of $273 per hour, based on the Nous methodology, shows the scale of the gap between current pricing and the cost of sustainable practice (APA 2026a). Future reviews, including the 2027 Therapy Pricing Review, should be informed by independent bottom-up costing.

Independent analysis from the Nous Group indicates that:

- the cost of delivering physiotherapy under the NDIS exceeds $220 per hour;
- market rates are typically in the $215-$259 per hour range; and
- a sustainable, value-based benchmark is approximately $273

The current price limit of $183.99 falls significantly below these benchmarks. Had the rate kept pace with cumulative inflation since 2019 - approximately 28 per cent - it would now be approximately $249 per hour.

The APA's central argument is that an efficient provider cannot deliver appropriate physiotherapy while meeting its clinical, workforce and regulatory obligations. A price that depends on unpaid work, cross-subsidisation or progressively narrower services does not provide a durable basis for participant access.

The July 2025 changes reduced the non-remote price from $193.99 to $183.99 per hour in New South Wales, Victoria, Queensland and the Australian Capital Territory, a reduction of approximately 5.2 per cent. Removal of the higher jurisdictional price in Western Australia, South Australia, the Northern Territory and Tasmania reduced it from $224.62 to $183.99, a reduction of $40.63 per hour.

The reduction followed six years without an increase in the physiotherapy price, while therapy travel reimbursement was separately limited to 50 per cent of the applicable therapy rate (NDIA 2025a; NDIA 2025b, pp. 22–23; Nous Group 2025b).

The effect is greater when inflation is considered. Using the ABS national all-groups quarterly CPI, the $193.99 price at the start of 2019–20 would be approximately $252.26 in September-quarter 2026 dollars. The current $183.99 price is approximately 27.1 per cent below that CPI-adjusted amount (ABS 2026, Table 17; APA calculation).

Pricing must also reflect contemporary workforce obligations. The HPSS Award changes commenced in October 2026, with subsequent phases scheduled for 30 June 2027, 2028, 2029 and 2030 (Fair Work Commission 2026a). Their effects depend on qualifications, classification, experience and existing pay arrangements.

The impact on provider wage costs can be substantial and cumulative. Under the new classification structure, Level 1 health professionals are paid according to the applicable qualification level for their profession and their years of experience. Reclassification from the first full pay period starting on or after 1 October 2026 increased minimum award rates by close to 19 per cent for some classification transitions. Further phased increases follow on 30 June each year from 2027 to 2030, in addition to Annual Wage Review outcomes. For example, the minimum weekly rate for a first-year AQF Level 7 health professional rises from the former four-year degree entry rate of $1,273.40 before October 2026 to $1,571.10 by 2030, an increase of approximately 23 per cent before future Annual Wage Review adjustments. Increases for individual employees and payrolls will vary with qualifications, experience and existing pay arrangements (Fair Work Commission 2026b, p. 3; Health Professionals and Support Services Award 2020, cls 17 and J.4).

The 2026–27 APR provides for disability support worker (DSW) cost-model changes linked to award obligations and further review of gender undervaluation outcomes (NDIA 2026a, Recommendations 1–2). Therapy pricing should similarly recognise relevant workforce obligations. A transparent mechanism linked to HPSS movements and other validated costs would reduce the gap between known wage changes and the prices available to meet them.

These changes affect providers differently according to their location, service model and travel requirements. Their combined effect should be assessed using actual patterns of service delivery. In many rural and remote areas, sole traders and small providers who travel to participants are the only available appropriate supports for participants.

Revised benchmarking has not resolved past flaws

The independent Nous review identified limitations in session-duration assumptions, comparator data and recognition of disability delivery costs. It recommended stronger market validation and combining reference pricing with provider costing over time (Nous Group 2025b).

The NDIA subsequently used a central 35-minute assumption for private health insurance (PHI) physiotherapy sessions. It retained $183.99 on the basis that benchmark sensitivity analysis using 32.5–37.5-minute assumptions produced values above and below that price, while monitoring through December 2025 did not indicate accelerated exit (NDIA 2026a, section 8.6.2). For an unchanged session fee, conversion using 35 rather than 45 minutes raises the hourly equivalent by 28.6 per cent. The APA seeks a clear explanation of how the revised evidence supports the retained price.

Converted PHI and Medicare fees are reference points, not direct measures of efficient NDIS delivery costs, especially as they are constrained by fund rebates and gap tolerance, not set by cost. Prices in other funding settings reflect their own rebates, patient contributions and service models. Converting them cannot establish the efficient cost of NDIS delivery, which carries non-billable coordination, compliance and travel, and lower utilisation. NDIS costing must account for the true cost of delivering high-quality, sustainable therapy supports.

The APA considers that this leaves the integrity of past APRs in question. A price falling within a range of converted market fees does not establish that it covers the efficient cost of delivering NDIS physiotherapy supports. Similarly, continued provider participation does not establish that the same services remain available on sustainable terms.

Monitoring provider participation does not reveal all restrictions within an operating practice. The APA survey records reduced travel, closed referrals and absorbed work. Provider exit is a lagging indicator. Practices wind down NDIS caseloads gradually to meet ethical handover obligations, staff contracts and lease commitments, six months of post-change provider counts cannot show the full effect of the 2025 decision. Service curtailment and intention to exit are throughout the APA survey. Continued provider participation does not, by itself, demonstrate that participants can access appropriate services on sustainable terms.

The 2026-27 APR acknowledges limited visibility of direct therapy, non-face-to-face work and travel in its claims data (NDIA 2026a, section 8.10.2). These limitations support broader access monitoring and direct examination of provider costs.

The NDIA acknowledges that some activities can be claimed separately from direct therapy and that differences in total reimbursement across funding systems have not been precisely quantified ((NDIA 2026a, Appendix B, p. 181).

Provider evidence identifies pressures on delivery and access

Ability Roundtable's 2025 published analysis reported average therapy unit operating costs at least 15 per cent above the NDIS price limit for the registered providers represented in its model (Ability Roundtable 2025). This is broader therapy evidence, not a physiotherapy-specific estimate. Applying 15 per cent to $183.99 produces approximately $211.59, but that calculation is not a costing of NDIS physiotherapy or a substitute for the APA's $273 benchmark. The analysis also predates the October 2026 HPSS changes.

The APA's Provider Survey, conducted 22-29 October 2026 (n=595), provides more recent evidence of the pressures respondents are experiencing.

Respondents reporting that NDIS price guidance did not reflect their organisation's delivery costs	80.6%
Average estimated proportion of non-face-to-face work left unbilled to preserve participant funding	**31.2%**
Respondents reporting reduced travel, fewer participants visited, no new participants requiring travel, or cessation of travel following the travel changes	**52.3%**
Respondents reporting no change to travel provision because they absorbed the cost	**22.9%**
Respondents reporting that their organisation had, at some point, not provided therapy to an NDIS participant because of the price	**43.5%**

These findings show why monitoring must extend beyond provider numbers. One respondent described the distinction clearly:

"I won't take on any further NDIS clients, but I have never stopped providing service to my current clients."

A provider in this position remains active in the Scheme but is unavailable to someone seeking a new service. Reduced travel coverage can have a similar effect: a practice may continue operating while becoming inaccessible to a participant who requires home-based support.

Unbilled work presents a further pressure. Absorbing essential coordination or other indirect work may preserve access but transfers its cost to the practice and its workforce.

The survey does not establish the prevalence of these experiences across all providers. It identifies specific access and sustainability concerns that the NDIA should investigate alongside claims data, participant experience and provider financial evidence.

Case study: A multidisciplinary provider facing rising wage pressure

A large registered multidisciplinary provider reported that wages consumed 74.3 per cent of therapy revenue in 2022–23, 75.4 per cent in 2023–24, 77.8 per cent in 2024–25 and 81.1 per cent in 2025–26. At the latter level, approximately 18.9 per cent remained for all other costs and any operating surplus. The provider reported that by comparison, a healthy service business operates at approximately 65%, while 70% is barely sustainable.

"We remained financially viable only by selling assets, reducing our vehicle fleet from 100 to 50, and having owners absorb additional responsibilities. The Head of People and Culture and purchasing roles were absorbed, accounts and intake staffing was reduced, and services were cut. Following a 20 per cent fee reduction, our Music Therapy team was made redundant in November 2025, while Psychology closed in January 2026."

This self-reported example covers several therapy disciplines and is not a physiotherapy-only cost estimate. It demonstrates how an organisation can remain operating while reducing its service capacity. The reported deterioration occurred before the October 2026 HPSS changes and strengthens the case for examining costs and service availability alongside provider counts.

Market evidence should inform an independent assessment

Nous Group's 2025 hourly rate report developed a sustainable and value-based benchmark for standard physiotherapy services. The APA's August 2026 guidance updated this benchmark to $273 per hour (Nous Group 2025a; APA 2026a). This provides a reference point for assessment, while requiring examination of its applicability to NDIS service delivery.

Published compensable scheme rates also warrant examination:

Benchmark or scheme	Published rate	Basis and relevant conditions
NDIS, 2026–27	$183.99/hour	National physiotherapy price retained following the review (NDIA 2026b).
Nous independent hourly rate report, September 2025	$261/hour	Sustainable and value-based benchmark for standard physiotherapy services (Nous Group 2025a).
APA updated guidance, August 2026	$273/hour	Updated sustainable benchmark, underpinned by the Nous methodology (APA 2026a).

WorkCover Queensland, July 2026	$231/hour	Specific physiotherapy assessments and consultations, including approved treatment of complex injuries; relevant item and approval requirements apply (WorkCover Queensland 2026, items 100406 and 100407).
WorkCover Queensland-independent case review, July 2026	$288/hour	Independent examination and report requested by the insurer; undertaken by someone other than the treating physiotherapist (WorkCover Queensland 2026, item 100226).
WorkCover Queensland - Tier 3 intervention, July 2026	$363/hour	Intervention by an eligible Tier 3 physiotherapist, aligned with their qualifications and subject to scheme requirements (WorkCover Queensland 2026, item 100500).
National Injury Insurance Scheme Queensland	WorkCover Queensland benchmark; relevant items include $231/hour	NIISQ uses WorkCover allied health fees to assess cost-effectiveness. Individual service approvals determine payment; this is a benchmark rather than a universal flat rate (National Injury Insurance Scheme Queensland Agency; WorkCover Queensland 2026).
South Australian Lifetime Support Authority, 2026–27	$238.20/hour	Physiotherapy consultation covering assessment, planning, education, treatment and clinical liaison (Lifetime Support Authority 2026, p. 2).
ReturnToWorkSA, July 2026	$238.20/hour	Approved restricted consultations, workplace visits and specified assessment services. Restricted consultations have a one-hour maximum (ReturnToWorkSA 2026, items PT214 and PT216).
NSW workers compensation -SIRA, February 2026	$235.20/hour equivalent	Complex Consultation C, including eligible home visits: explicitly priced at $19.60 per five minutes, to a maximum of one hour (State Insurance Regulatory Authority 2026, items PTA005 and PTA011; APA calculation).
Western Australian workers compensation, 2026 order	$$249.80 /hour	Specific physiotherapy assessments and interventions requiring insurer approval; intervention time limits apply (WorkCover WA 2026, Schedule 10, items PS001 and PW001).
WorkSafe Victoria - early intervention framework, October 2026	$232.20/hour	Workplace assessment and report, including travel; employer approval required, maximum three hours (WorkSafe Victoria 2026, item PY128).
Transport Accident Commission Victoria, July 2026	$200.14/hour	Approved extended consultations for complex or multiple injuries, billed in 15-minute increments (Transport Accident Commission 2026, item PHY300).
Comcare rates for physiotherapy services in the Northern Territory, effective 1 July 2026	$216.67 or $270.83 for 60 minutes	Standard complex consultation, with the applicable fee determined by practitioner level (Comcare 2026, items PL001 and PL003).

The table presents selected published fees and benchmarks relevant to assessing physiotherapy pricing. The entries cover different services, practitioner requirements and approval conditions and are not a weighted market average.

The assessment should examine the reasons for differences between schemes, including participant needs, service scope, practitioner requirements, session duration, reporting, travel and separately funded activities. This would allow comparator evidence to inform a defensible price. While most of the listed compensable rates are approval-based, the schemes generally fund travel and reports

separately, in some cases at or near the clinical rate (for example WorkCover Queensland at $171 per hour and the TAC at $200.14 per hour, subject to approval), so the effective gap to NDIS pricing is larger than the hourly rates suggest.

The APA proposes that the NDIA commission an independent assessment to inform the 2027–28 pricing arrangements. Consistent with Nous's recommendations, it should combine validated market evidence with an assessment of representative provider costs, while establishing a stronger basis for recurring cost reviews (Nous Group 2025b). The assessment should inform a correction for 2027–28 and establish a transparent model for subsequent reviews. Longer-term development of that model should strengthen future decisions while allowing the current review to address the evidence already available.

4. Case study - Outreach amputee physiotherapy across Sydney

Revenue = 60 min therapy ($183.99) + 30 min travel ($46) = ~$230.

Wage cost (**senior clinician)** = 60 min + 70-96 min travel = 130-156 min at ~$90/hr = ~$195-234

Result: 85-100%+ of session revenue before rent, admin, vehicle and compliance.

A member reports that providing physiotherapy for people with limb loss across metropolitan Sydney is being undermined by current travel pricing. Participants are first seen in clinic often alongside their prosthetist, where they build gait and mobility with their prosthesis in a controlled setting. The next stage is using the prosthesis at home and in the community, on stairs, uneven ground, car transfers, bathrooms and public transport. This is where rehabilitation succeeds or fails, and it can only be done in the participant's own environment.

To make this work, the member uses an outreach model. A senior clinician with specialist limb loss experience travels to participants with complex needs, while participants with less complex needs are managed by less experienced physiotherapists with senior support. The model is designed to match clinical need to clinician experience.

Current travel pricing prevents the model from operating as designed. Provider travel is funded at about half the hourly therapy rate ($92/hr), and only 30 minutes can be billed per visit. Average one-way travel for this service is 35 to 48 minutes, so a round trip is 70 to 96 minutes. A senior clinician on a base rate of $61.40/hr costs the provider about $90 per working hour once superannuation, leave, long service leave, workers compensation and payroll tax are included. Travel time for a single visit therefore costs $105 to $144, and the most the provider can recover is $46. That is a shortfall of $59 to $98 per visit, before any therapy is delivered. The 30-minute cap compounds an already inadequate hourly rate, because it funds less than half of real Sydney travel time.

Because senior clinician travel cannot be recovered, allocation is decided by geography and cost rather than participant need and staff experience. Visits to move from clinic to community are delayed, cannot be booked as a block, and cannot always reach the environments where participants need to function. Where a physiotherapist is located closer, care is handed over to a less experienced clinician, and the participant loses the continuity and specialist skills of the clinician who built their foundation in the clinic. Less experienced staff also carry clinical risk that the model was designed to avoid.

The result is delayed independence for participants, with a higher risk of poorer prosthetic outcomes, falls, secondary complications and prolonged reliance on other supports. These outcomes cost the scheme more than the travel funding that would have prevented them.

5. APA responses to the consultation questions

The APA notes that while peak bodies were named as desired respondents to the APR, the survey is directed solely at individual providers. 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.

Year round, the APA hears from providers both current and past, as well as participants, through formal consultation as well as correspondence and outreach. The organisation is in ongoing dialogue with the Agency and Department in good faith efforts to seek necessary remedy to past flawed pricing decisions, and has commissioned independent economic reviews that validate our positions.

The APA is presently engaged in sourcing large scale provider data to be independently analysed and presented to the Agency's pricing team to support better informed pricing decisions.

In recent years APA workforce census shows a marked decline in the experience of physiotherapists in disability services, with feedback affirming the grief, frustration and overwhelm of the profession in the sector (Survey Matters 2026). To best represent the significant portion of our members engaged in the scheme, who report staying in service despite the impacts of recent reforms, the APA conducted a survey to inform our response to provider specific questions (APA 2026b). Consultation question numbers identify the NDIA questions reproduced in this submission.

Several elements of the consultation fall outside the purview of physiotherapy and are not directly relevant to the physiotherapy workforce or service model. The APA's response therefore focuses on therapy supports questions and themes, where physiotherapy has clear expertise and where NDIA decisions will directly affect service viability, participant access and workforce stability.

Registration and pricing differentiation

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.

Several mechanisms under consideration, including registration-based distinctions, have been examined repeatedly 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 professionally regulated through the National Registration and Accreditation Scheme regardless of their organisation's NDIS registration status: the Physiotherapy Board of Australia develops professional standards, codes and guidelines, accreditation standards sit with the Australian Physiotherapy Council (Ahpra 2024) while Ahpra administers the National Scheme (Department of Health, Disability and Ageing 2025). NDIS organisational registration adds compliance obligations, but that distinction does not by itself establish a difference in clinical quality. The APR 2026-27 concedes registration 'would not mean registered providers deliver higher quality supports' (NDIA 2026a, section 5.3, p. 33).

Unregistered organisations represented approximately 87 per cent of therapy providers and 40 per cent of therapy payments in July–December 2025. The APR 26-7 also proposed differential treatment of unregistered providers in social, community and civic participation (SCCP) supports and a 10 per cent cut and indexation freeze for unregistered SCCP providers (NDIA 2026a, sections 5.4 and 8.2.3). Any extension to therapy requires evidence specific to therapy costs and access.

The APA survey asked unregistered providers about the potential impact of registration-based price differentiation. The proportion selecting “High impact; may consider market exit” increased with the size of the differential.

Price differential presented	High impact and may consider market exit
Zero to five per cent	31.0 per cent
Five to 10 per cent	46.7 per cent
10–20 per cent	69.6 per cent
20–30 per cent	83.6 per cent
More than 30 per cent	88.3 per cent

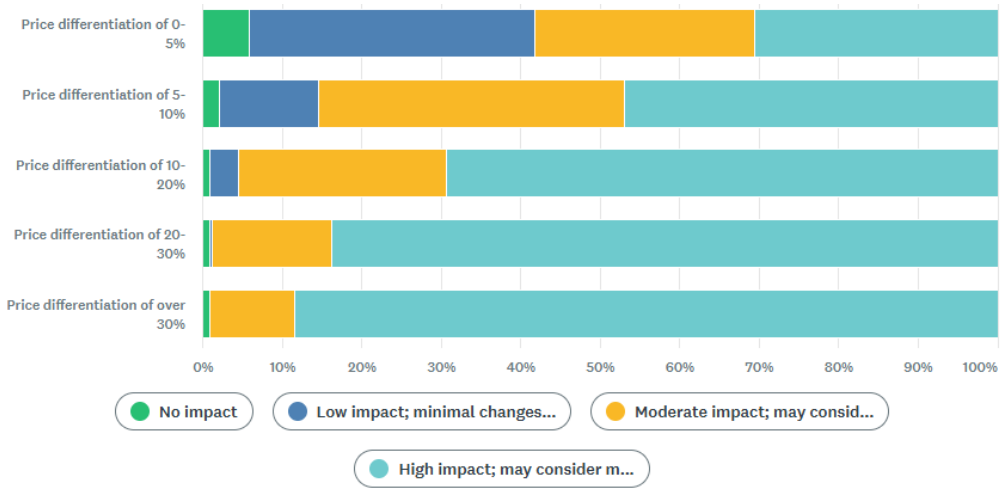
Reform is necessary, but it must occur in the correct sequence. A credible cost base must be established first, with differentiation only considered where it demonstrably improves equity, access and long-term sustainability. If the underlying cost base is flawed, differentiation will not resolve structural 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 (Nous Group 2025b, pp. 2-6). These weaknesses must be addressed before the NDIA can responsibly introduce any form of differentiated pricing.

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 the necessary first step before the NDIA pursues tiering, benchmarking or value based reforms.

As an unregistered provider, what would be the impact on you or your organisation if differentiated pricing was introduced based on registration status?



Member insights include:

"We have a small amount of patients with neurological conditions that come to us. We keep them as mobile and as minimally reliant as possible on walking aids and wheel chairs. We are only one of two businesses in our region that care for these clients as we do. Our clients are worried about their funding and we are concerned about covering our business outgoings as well as their wellbeing. We are currently being careful about how many NDIS clients we will be able to support and we are not seeking any new business at this stage. We are waiting to see where you go with all of this."

"Introducing tiered registrations status based price structuring is high risk. Only large organisations would benefit which would absolutely decimate small business impacting their ability to compete and create risk of market monopoly. This would also massively disadvantage regional providers who are typically smaller. "

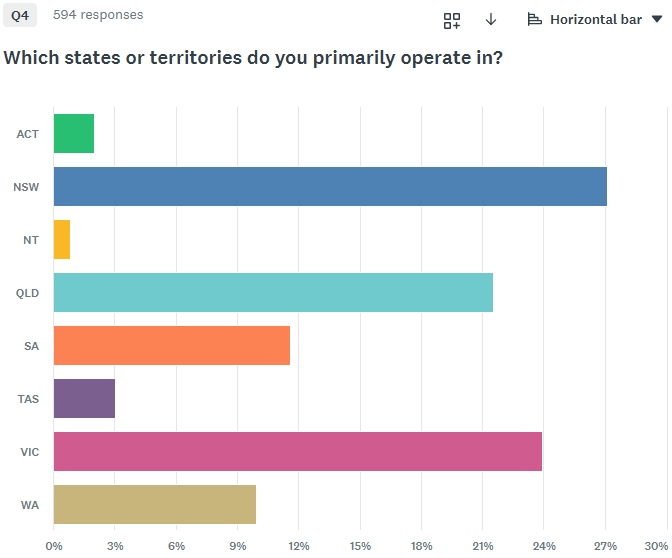
"Introducing differentiated pricing based on registration status would negatively impact our clinic as an unregistered NDIS provider. We provide the same high-quality, evidence-based physiotherapy services to NDIS participants as we do to all our patients. Our clinicians are fully qualified, registered with AHPRA and maintain the same professional standards regardless of NDIS registration status. Reducing reimbursement rates for unregistered providers would place additional financial pressure on smaller allied health businesses and potentially make it less viable to continue providing services to NDIS participants. I believe pricing should reflect the qualifications and experience of the practitioner, the complexity of the patient's needs and the quality of care provided, rather than simply whether an organisation is registered with the NDIS. Differentiated pricing could ultimately reduce participant choice and access to experienced allied health professionals. "

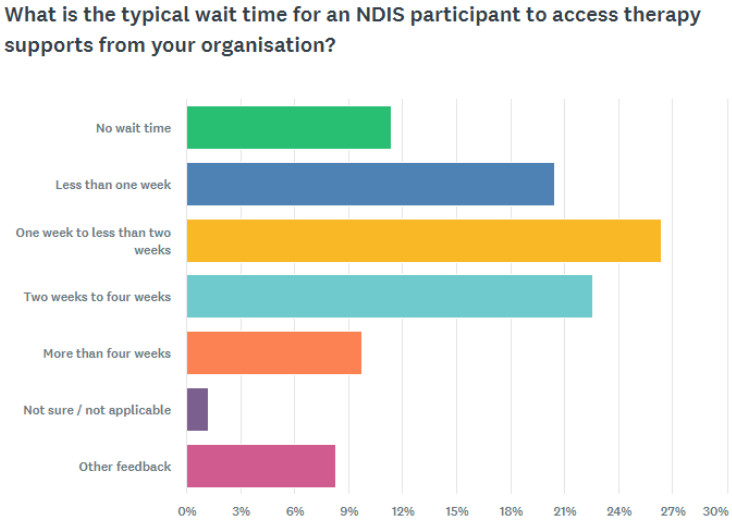
"Current registration is unreasonable and impractical for small business. If new registration is practical then I would consider registering. Particularly if it was aimed at improving the service delivered to clients"

"This is neither appropriate nor fair for either provider or client. The client should retain full choice as to their provider. The non-registered provider should retain full compensation for services. Often the unregistered provider offers specific niche services that help people with particular complex health problems."

Therapy operations

The survey was conducted for a week in October 26, findings reflect an established provider cohort operating across every Australian state and territory, with the largest groups based in New South Wales, Victoria and Queensland. Of 595 respondents, four in five work as sole traders or in organisations employing fewer than 20 staff. Owners and directors accounted for 61 per cent of respondents, employed physiotherapists for 27 per cent and contractors for 6.5 per cent. 62 per cent of respondents paid hours are billed to a funder. Most brought substantial experience of the scheme: 63 per cent reported that their organisation had delivered NDIS supports for more than five years, many noting engagement from scheme conception.





Respondents work across metropolitan, regional and rural areas, with remote and very remote services also represented. Caseloads ranged from fewer than 10 to more than 1,000 NDIS participants per organisation, with 10–50 participants the most common category at 43 per cent.

Both registered and unregistered organisations were represented, with 59 per cent of respondents working in unregistered organisations. Fee arrangements varied: 44 per cent reported charging different fees to NDIS and non-NDIS clients, while 23 per cent charged the same fees and 33% opted to provide other feedback largely concerning the gap between NDIS, private market and other funder fees.

Member insights include:

"NDIS fees do not cover our normal fees. Our fees are $250/hr generally ($125 for half an hour follow up). Seeing NDIS clients is not a smart business move for us, but because we care about our clients, who we have been seeing for a long time, we have taken the financial hit. Not sure how much longer that's sustainable for us though."

"We charge less for NDIS patients to stay in line with the price guide. Because NDIS rates are well below private market rate and appts typically need to be longer as they are more complex as a result lots of private practice refuse to have them on their books as it lowers their overall billing rates when they could see multiple private patients instead in the same time."

"Private, Support at Home, Workers Compensation, Motor Vehicle are all billed higher than NDIS rates."

Private clients incur a higher per hour charge ($183.99 for NDIS clients, $255-$280 for private paying clients)

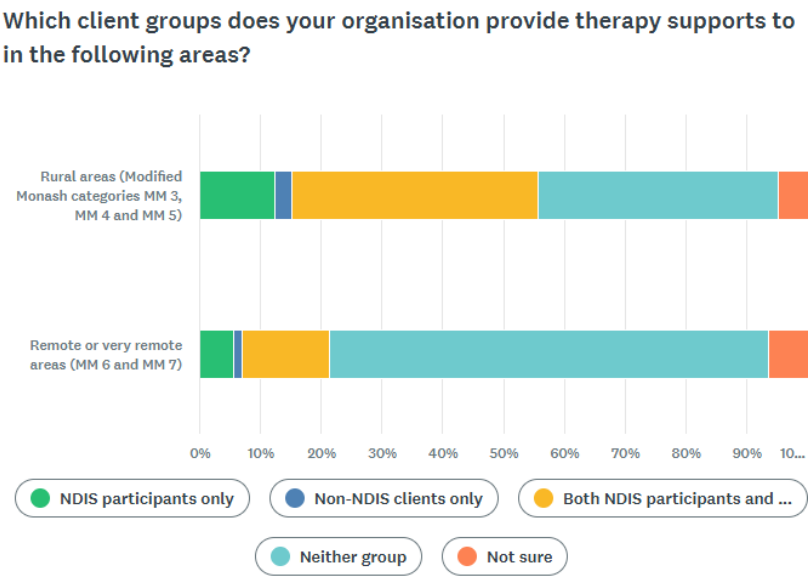
"NDIS rate is our lowest rate. Private, SIRA, aged care and LTCS are all higher."

"Due to the pricing model of the NDIS we lose money by treating these patients. Our clinic operates on $250/hr, however we have to charge the NDIS rate for those participants."

"We now charge non-NDIS clients more and other funding bodies agree to those rates. We prioritise other funding bodies ie LSA over NDIS now."

NDIS participants accounted for an average of 53 per cent of respondents' overall services. Around seven in 10 respondents reported organisations employing up to six full-time equivalent therapists. Services commonly included assessment, recommendation, therapy or training, alongside early childhood intervention and assistive technology and home modifications assessments.

Delivery extended across clinics (65 per cent), participants' homes (70 per cent), community settings (46 per cent), schools or education settings (33 per cent) and telehealth (19 per cent), demonstrating the importance of services beyond the clinic.

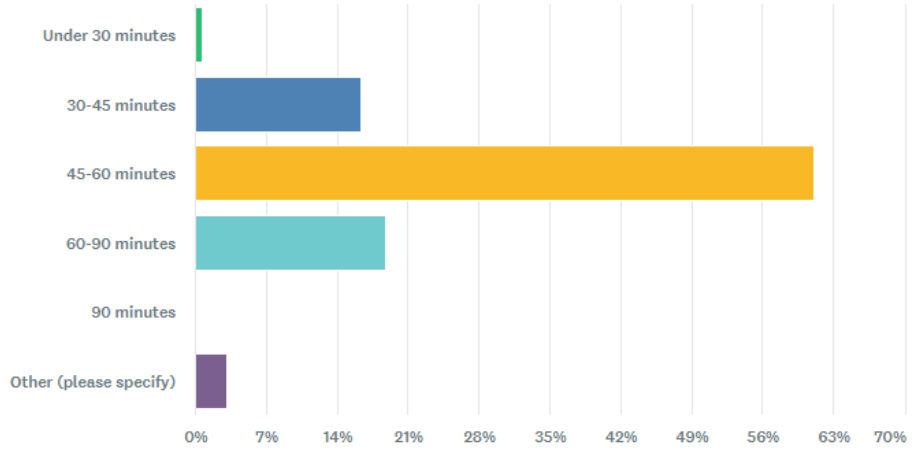


Among those answering the respective geographic questions, 40 per cent provided services to both NDIS and non-NDIS clients in rural areas, and 14 per cent did so in remote or very remote areas.

Reported waiting times varied: 11 per cent indicated no wait, 46 per cent a wait of less than two weeks, while 32 per cent reported waits of two weeks or longer, including 10 per cent reporting more than four weeks. Written responses also identified many providers who had closed their books to new NDIS participants, indicating that waiting times alone do not fully describe service availability.

Therapy pricing

Q.8 Please select the average face-to-face session length for NDIS participants.



Session length

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 an hour of direct therapeutic engagement. The NDIA's own data corroborates it: 62% of therapy claims were at the full-hour maximum price in Jul-Dec 2025 (NDIA 2026a, section 8.2.8).

This is reflected across providers in the APA's October survey (45-60 – 61 per cent | 60-90 – 19 per cent) and helps explain why session durations in the NDIS differ from those seen in non-disability funding environments which typically average 30 minutes.

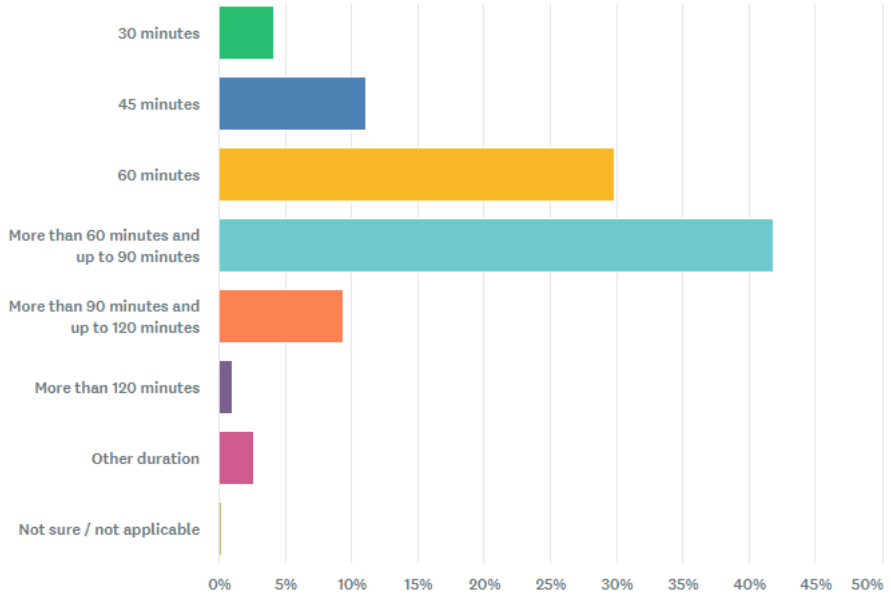
In practice, the total time required extends well beyond the direct contact period. Preparation, documentation, communication with families and support coordinators, and follow-up tasks are integral components of safe and effective disability care and cannot be compressed without compromising quality.

It is important that NDIS pricing avoids repeating past methodological errors by importing assumptions from unrelated funding environments. A key issue in the 2024–25 APR was the assumption of a 45-minute session when converting PHI fees into hourly rates, despite evidence that real-world PHI sessions are typically closer to 30 minutes in the non-disability sector (NDIA 2025a; Nous Group 2025b). This inflates the assumed duration and leads to an underestimation of the true hourly rate required for physiotherapy under the NDIS. The APA notes this assumption was revised to 35 minutes this year however, it is unclear how this substantial reduction in average consultation duration translated into no change in the final pricing outcome (NDIA 2026a, section 8.6.2). Shorter consultation durations would be expected to result in a higher equivalent hourly benchmark. The explanation provided does not establish the adequacy of the price for NDIS delivery costs.

Member insights include:

"Our regular sessions are almost always 60 minutes face to face with an extra 10 minutes billed for non-contact time afterwards for note writing and treatment planning. Our intensive blocks of therapy have sessions that are 1-3 hours long, 3-5 days per week for 3 weeks and have 15minutes non-face-to-face time for notes and planning per session."

Q. 9-12 &14 For each therapy support your organisation provides (as answered in question 2), please select the average time billed for NDIS participants per session. This should include travel time, face-to-face therapy time and claimed time for report writing.



Total billed time and indirect clinical work

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, one provider responded in survey that f*or other healthcare patients approximately 85-90 per cent of time billed is face-to-face therapy.* Providers in this year's survey reported the following approximate breakdown of billed time:

- **Face-to-face therapy (including telehealth)**: 67 per cent*
- **Travelling to deliver therapy in either their homes or non-clinical settings:** 15 per cent
- **Writing reports (excluding billable travel hours)**: 10 per cent
- **Coordination, liaison or case conferencing**: 8 per cent

* The breakdown above describes billed time. Respondents also reported that, on average, 62.7 per cent of therapists' paid hours are billed to a funder. Taken together, only about 42 per cent of a clinician's paid time (0.627 × 0.67) is billed as face-to-face therapy. This is an approximation, as the figures are averages across different respondents. By comparison, one respondent reported billing 85–90 per cent of time for non-NDIS patients.

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 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 (Ability Roundtable 2025).

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:

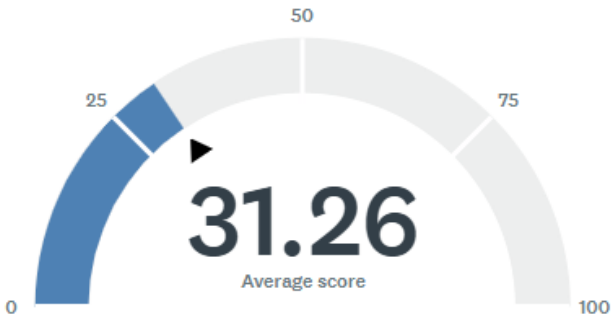
"70 minutes per session. 60 direct and 10 for planning and documentation. Quarterly 30 minutes set aside for tracking and recording progress and barriers towards goals. Other reporting (i.e. end of plans, equipment work, manual handling plans, mobility support plans. exercise programs) is separate to this and billed as such."

"Each client is different. Some clients will need notes etc. completed in non-face to face time, while others it can be completed in session. Each session is different depending on the needs of the client, and the goals."

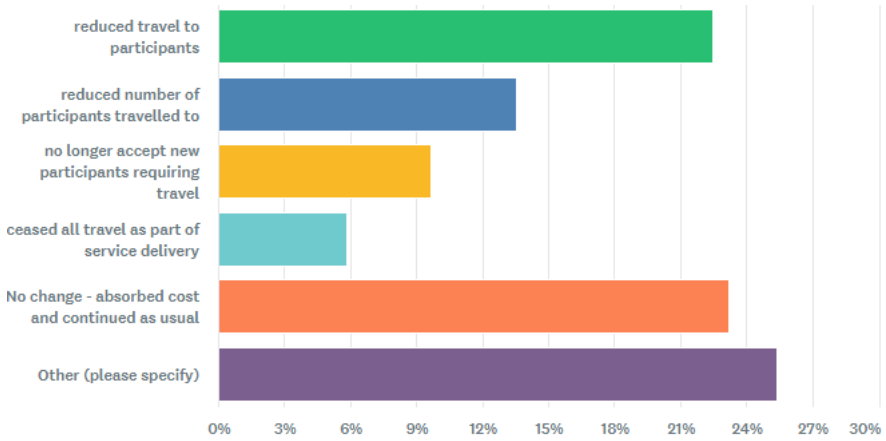
"That is so variable as there is no "typical" NDIS participants we see. Some who come in to the clinic will be almost all direct therapy. There are others, where I will spend more time on indirect with travel, coordination, reporting, manual handling plans, chasing up with other MDT, especially those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

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

Roughly what % of non-face-to-face work goes unbilled to preserve participant funding?



Q.13 Following updates to travel time provisions for therapists in the 2025–26 Pricing Arrangements and Price Limits, has your organisation's delivery model and billing practices changed? If so, how?



Changes to delivery model post changes to travel pricing

The 2024–25 NDIS Annual Pricing Review's abrupt reduction in travel reimbursement 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 (NDIA 2025a; NDIA 2025b). 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.

Reducing travel funding disincentives 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. As above, 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. Therapy-related travel payments were $49 million in July to December 2025, under 2 per cent of $2.67 billion in therapy payments and around 0.2 per cent of total Scheme payments (NDIA 2026a, Table 12). Despite its small share of expenditure, travel is fundamental to delivering therapy in natural environments. 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 policy 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.

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 (Massey et al 2024), 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 reported the necessary outreach across Groote Eylandt and five Homelands has ceased due to the unsustainable economics of travel under the new pricing structure.

APA surveys conducted since the changes, in February and October of 2026, have consistently shown approximately 50 per cent of providers responding had reduced or ceased travel outreach services because of the new pricing limits. In the October 2026 survey, 52 per cent of respondents reported reducing travel, visiting fewer participants, declining new participants requiring travel or ceasing travel following the changes. A further 23 per cent reported no change because they absorbed the cost.

These results identify restrictions within practices that remain operating. Absorbing a cost can temporarily preserve a service, but does not demonstrate that its price covers delivery. Monitoring should examine travel coverage, referral acceptance and continuity of support, including the effects on participants who cannot attend a clinic.

Without action to restore fair travel compensation, these cuts will continue to undermine the accessibility, quality, and equity of services under the NDIS.

The NDIA should extend monitoring to capture changes in travel coverage, referral acceptance and continuity of support, including where providers remain active but restrict their services and meaningfully engage with the provider sector to gather feedback.

The APA supports the transparency objective of APR Recommendations 10 and 11, which address separate claiming for travel and non-face-to-face therapy work. Separate items for physiotherapy travel, non-face-to-face work and NDIA-requested reports now appear in the 2026–27 pricing schedule (NDIA 2026a; NDIA 2026b).

However, separate claiming codes don't create additional funding. Where therapy and travel are paid from Improved Daily Living, they draw on the same budget. Eligible non-labour costs can sometimes come from Core, but that still uses existing funding. Necessary travel must be adequately funded so as not to displace assessed therapy or other essential supports.

The APA's support is conditional on implementation preserving recovery of necessary service time. Separating items should not reduce total recoverable time or introduce new caps without evidence. The travel reimbursement limit should be reviewed alongside these arrangements, and providers should receive clear guidance, adequate notice and sufficient time for practice software changes.

Participants should receive clear explanations of the purpose and agreed cost of indirect clinical work. Greater visibility must not create an expectation that preparation, documentation or clinical coordination should be provided without payment. Respondents already estimate leaving an average of 31 per cent of non-face-to-face work unbilled to preserve participant funding.

The NDIA should use the new data to understand delivery costs and improve pricing. Monitoring should assess administrative burden, rejected claims, participant understanding and whether necessary work is being delivered and paid for.

Member insights include:

"The previous rates were below average prior to the price cut and changes to billing for travel. Most of my home visit clients don't have the capacity to travel 30-60min each way for clinically session due to their condition and I can only bill a total of $92 to travel to them to provide essential services. Most other clinicians have ceased working with these clients due to lost revenue. The main reason I continue to

see them is because they deserve support. Eventually the financial strain will force me to cease also which will be a travesty for both the participants function and wellbeing as well as my professional ethos."

"We have both reduced travel distance to participants and reduced the number of clients travelled to. We have cut travel as a percentage of billable NDIS hours from 15% to 10%. The business had a goal of reducing to 5% however this has only been partially achieved. Reducing travel has not been in our client's best interests (especially for our early intervention/paediatric population) however we have had to adopt to the framework put forward by NDIS to remain sustainable (just...)"

"I have not accepted clients requiring travel, I have reduced therapy to clients that require travel, I have group clients together as able to maximise travel, I have clients that now have reduced adjunct care, such as OT as none in our town (MMM - 5) and now therapists will not travel to our town to provide care. I have had to change care given. Not get correct functional assessments and equipment prescriptions for clients and compensate with a reduced care standard for clients. I have asked clients to travel to me and complete care in the local park near the clinic rooms and not charge my time in getting to the park and set-up/planning rather than in their own home and best therapy practice environment I have biased accepting other clients that pay for service delivery hours."

"Reduced travel to participants and reduced number of participants we travel to, preference to other funding types e.g. private, insured, WorkCover, support at home, where we have higher remuneration."

"Although till now we have absorbed costs, we have been moving more to clinic, and we will be hiring less people and prioritising non-NDIS participants and NDIS participants who can come into the clinic."

"Only accepting referrals who can attend majority of sessions in clinic or are within 15 minutes travel from clinic. Therapy assistant is no longer doing any home visits as it is not viable."

"1. Less clinician choice, it's not usually the most experienced person with the participants' condition, geography matters 2. Enforcing return travel and km travel 3. No flexibility with cancellations 4. Reduced time flexibility 5. Less supervision for junior staff, no unbilled shared clinician sessions for learning 6. Reduced new graduate education program - halved the number of ongoing education sessions."

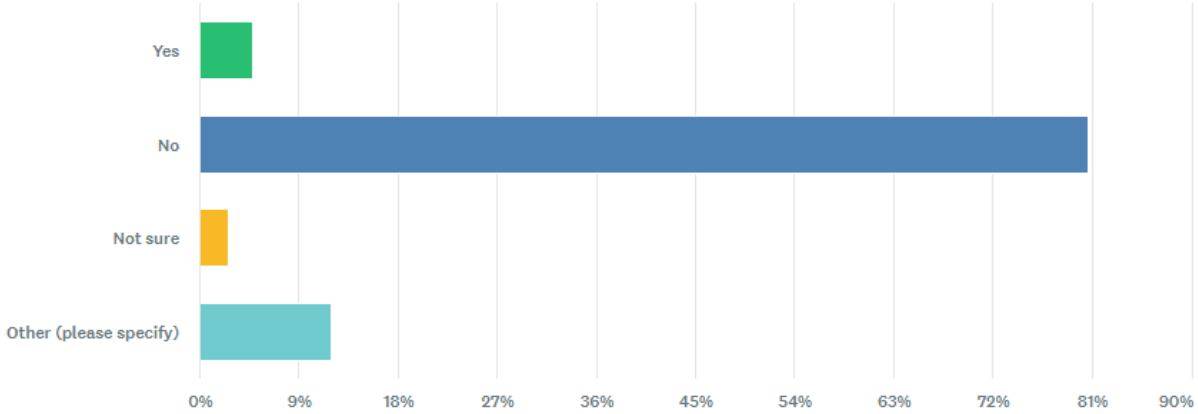
"I have had to continue business as usual as I provide the only cardio-respiratory service to regional areas of TAS so have had to absorb costs but making it less financially viable and running at a loss now to provide intervention in people's homes."

"In reality the first four apply, reduced travel, reduced number travelled to and no longer accept participants requiring travel. I have almost completely ceased travel as part of service delivery to only one client with occasional travel close by."

"We've limited the area we service and we have absorbed the rest. We are now on the brink and projected loss for this financial year."

"Absorbed cost but no longer sustainable with increases in fuel costs and reduction in travel billing. For some services only billing 30 minutes travel at half of standard hourly rate but travel is 1-1.5 hours. These clients will need to be handed over as not sustainable but nobody available to hand over to and cannot ethically leave participants without services or being added to long waitlists."

Q.15 Do you think NDIS price guidance reflects the cost of delivering therapy supports in your organisation?



80.6 per cent reported that NDIS price guidance did not reflect the cost of delivering therapy in their organisation. A further 4.5 per cent answered yes, 2.4 per cent were unsure and 12.5 per cent provided other feedback.

Written responses described pressure from clinician remuneration, travel, indirect clinical work, administration and other operating costs. Some respondents reported cross-subsidising NDIS services with private or other funded work.

Member insights include:

"Due to the NDIS price cap, we are unable to charge our NDIS participants our full fee. NDIS fees are below our standard fees by between $32-$54 per hour. This is made significantly worse again when making community visits where a 1hr consultation with 30mins travel time (15mins each direction) is discounted by $94-$127. Therapist attrition is significant. We had planned to invest in additional disability equipment during our recent expansion; however, this was no longer able to go ahead due to the significantly reduced funding and instead we have focused our clinical spaces towards non disability clients/participants. We have also reduced our overall capacity to see NDIS participants due to reducing our disability service provision. The NDIS price guidelines do not in any way consider the additional costs associated with providing this service. No other patient/participant group requires a dedicated senior administrator, an accounts manager, the absorption of significant unpaid invoices due to changes in participant funding and/or funding period changes."

"Increased travel costs for rural clients with reduced travel funding from the NDIS. Significant increase in report writing, evidence collection and justification to secure NDIS funding for complex neurological clients (often unpaid). Significant reduction in allocation of physiotherapy hours. Duty of care to provide therapy services, often above (therefore not billed) the minimal allocated hours."
"Not at all. 9 years of rate freezes, in SA the hourly rate reduced by more than $40 an hour and then travel was halved! Meanwhile CPI and the recent increase of the award has left me as the director on

Centrelink benefits to absorb the cost to increase staff wages. This is NOT sustainable and we now have a redundancy plan."

"Absolutely not. After more than 10 years working in the NDIS, it has become so demoralising that I am leaving my business at the end of this calendar year."
"I have been doing this job for 40 years and never has a 30-minute session been possible with my client group. We take on private clients who have EPC plans but there is an out-of-pocket cost of course unlike musculoskeletal physios who provide a 20–30-minute service and bulk bill EPC plans. This needs to stop as it undermines and devalues our services. This distinction between rehab and musculoskeletal physio sessions needs to be acknowledged by NDIS as TAC have done. NDIS does not even acknowledge award pay increases and CPI increases to accommodate our costs and overheads."

"Having not had a rate increase and actually receiving a $10 cut for physiotherapists is totally inadequate. The rising cost of rent, wage increases, superannuation increases, insurance costs, utilities costs, training costs, administrative costs, travel costs etc. without the ability to raise fees is totally unacceptable and wouldn't be accepted in any other business or industry."

"Absolutely not. Therapy rates do not reflect the cost of providing high-quality care-team, training and reinvestment into equipment and service delivery and supporting participants to navigate scheme. Administration costs are through the roof dealing with debt chasing (when plans are exhausted but therapist has not been notified, despite signed treatment plan), onboarding admin, complaints management (typically of scheme, but clinician cops it) and registration and compliance demands."

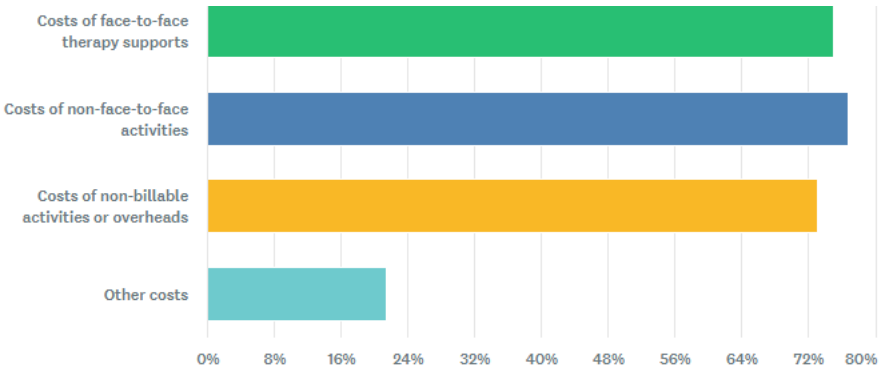
"Absolutely not. As a large, registered organisation the level of compliance we need to ensure to satisfy the NDIS standards is ten times that of providing service to a private client. We have had to keep lower than CPI increases over the past 5+ years and now we are no longer able to provide a comparative salary to public sector wages (the primary competitor for neurological physiotherapists). With the gender based undervaluation reassessment of award wages and re-classifications we now have minimal margin between award rate and our salary rate - we will not be able to make ends meet from 1 July 2027 when the well above CPI increase will occur for all staff."

"No NDIS price guide does not reflect the cost of delivering therapy supports - cost of commercial property rental has skyrocketed x4 times since 2020, we purchased a commercial space in 2025, the bank interest rates have gone up significantly, so mortgage cost has increased, therapist salaries have gone up and recently with the new therapist classification salaries have gone up, electricity costs and all operational costs have gone up, but NDIS rates for physiotherapy services have not increased and in fact decreased to $183.99 from $193.99/hour. The $193.99 rate wasn't even sufficient to sustain a business to begin with."

"I fail to see how Physiotherapy input is not seen as being as essential as the other Allied Health therapies such as OT and SLP, and as a consequence is awarded a lower rate of remuneration."

"Reduction in hourly rate and travel rates have led to loss of approx. $400 per day. Unable to employ contractor/staff to support caseload because their hourly rate plus super etc. is not sustainable with risk of further hourly rate cuts and travel times. Case management, emails, phone calls, meetings are rarely billed as this will reduce available funding for therapy services."

Q.16 If you answered no to question 15, please detail which costs NDIS prices don't cover.



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.

Complexity classifications may fail to capture the interaction between a participant's condition, functional goals, environment and support arrangements. Needs can also change during a plan period. A tiered model risks delayed access while classifications are reviewed, incentives to select participants according to remuneration, and reduced access to experienced clinicians for people assigned a lower tier. Concentrating demanding caseloads without adequate supervision and workload support may also increase workforce stress and burnout.

Complexity is best associated with a need for additional services (i.e., more time, more intensive service delivery) and improved capacity to engage with other services, supports or formal and informal caregivers. Assessment and funding processes need to accurately identify and fund need.

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.

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 (Department of Health, Disability and Ageing 2025).

Evidence from the Nous review confirms that current pricing assumptions underestimate the skill intensity required to deliver physiotherapy supports under the Scheme (Nous Group 2025b).

Feedback from APA members and Ability Roundtable data consistently demonstrates that allied health assistants and support workers cannot safely substitute for physiotherapists in assessment, prescription and management of complex presentations.

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.

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:

“If our organisation was 100% NDIS we'd be out of business by next week...”

“I often (nearly 80% of time) don't bill my time for notes, prep and planning for any session. I just bill face to face therapy time.”

“The current NDIS price cap fails to account for the heavy burden of non-billable overheads required to run a safe, high-quality practice. Specifically, it does not cover the extensive clinical supervision and mentoring required for early-career graduates, the soaring costs of NDIS registration audits (we have commenced this process), and general administrative demands such as intake coordination and waitlist

management. Furthermore, the travel caps do not offset the wear-and-tear costs of operating a mobile workforce, and regular unbillable time allocated for professional development severely compresses our net operating margins. In addition, it does acknowledge changes to Health Professional Award which will result insignificant increases in staff wages in coming years."

"F2F supports does not reflect the level of experience required to deliver services to complex neurological patients including spasticity management, high falls risk, behavioural challenges, cognitive challenges, impaired motor learning, complex AT prescriptions, complex home mods, complex SIL and SDA reporting requirements. Can NOT be done by new graduate therapists. Even with support of more experienced therapists (which isn't covered in the NDIS pricing) a large amount of time is spent on case coordination, liaison and report writing that we don't bill for a lot of the time because the participants don't have enough funding for therapy so we try and save funding for F2F therapy. Report writing would be so much better and streamlined if the NDIS provided us with a template similar to those provided by WorkCover and other insurance bodies. We allocate report writing hours to fit within the participants budget and then spend on average double the time (and don't bill this) and then "when" funding is cut (which it is 100% of the time) there are no funded hours left for the argument against the cuts. This is despite thorough and justified reasons for reasonable and necessary therapy in complex neurological conditions. Other non-billable activities such as providing service agreements, working out case budgets, invoicing, chasing outstanding invoices, compliance requirements, organising appointments in the community to try and limit travel time all of which is not billable. We can only bill for 50% of our therapists day for NDIS by the time you factor in all of these activities."

"There is far more admin work, service agreements writing, chasing unpaid accounts, chasing plan dates than for other funding or private patients. In a solo practice a physio may do all of this. In a bigger practice an admin person will do a lot of it. However, we need far more admin hours with the advent of NDIS than before and they tell you, you can't charge for admin."

"A lot of my clients are at school and are complex clients. I work to support the child's SSO and teaching staff so that they can deliver exercises outside of the child's therapy with me, the physiotherapist. Additional support work to deliver services to complex children at school, such as team meetings (Team Around the Child TAC meetings) are often not able to be billed for as the child doesn't have enough funding. I do a 'community service' to attend such meetings free of charge, but it is not sustainable and I will have to either not attend in the future, or reduce therapy hours. Verbal hand over to teachers and parents at the end of a session is never billable and extremely time consuming. We are no longer able to provide hydrotherapy because we cannot cover the cost of entry fee, pool hire, and additional time it takes for the therapist to shower, dress etc. involved in a pool session. The NDIS do not cover these supports. Often clients are unable to cover the entry fee for the session."

"Significantly more administration time than non-NDIS clients, arranging servicing agreements, following these up when they are not returned, time with the calculator working out schedules of supports and dollars allocated to funding blocks, again following up schedules of supports that are not

returned signed. Participants plans are so lean on hours it is very difficult to justify billing for all the time we spend communicating with family members, house managers, support coordinators, other therapists on the participant's team, there would be nothing left for delivering actual therapy, which is what we are trained to do. In addition to this, the NDIS fee limit for physiotherapy does not reflect market rate in Victoria, and we are funding NDIS participants and support coordinators are increasingly very overtly lying to us at intake stage about whether or not home visits are required, so that we will accept the client then just do the home visits anyway at a loss to our business. Sessions involving travel are no longer viable, and we cannot continue to carry this loss, especially with the new HPSS award rates."

"The main costs that are not adequately reflected in NDIS pricing include:

Experienced clinician remuneration: *The cost of employing highly experienced and qualified physiotherapists, including ongoing professional development and training.*

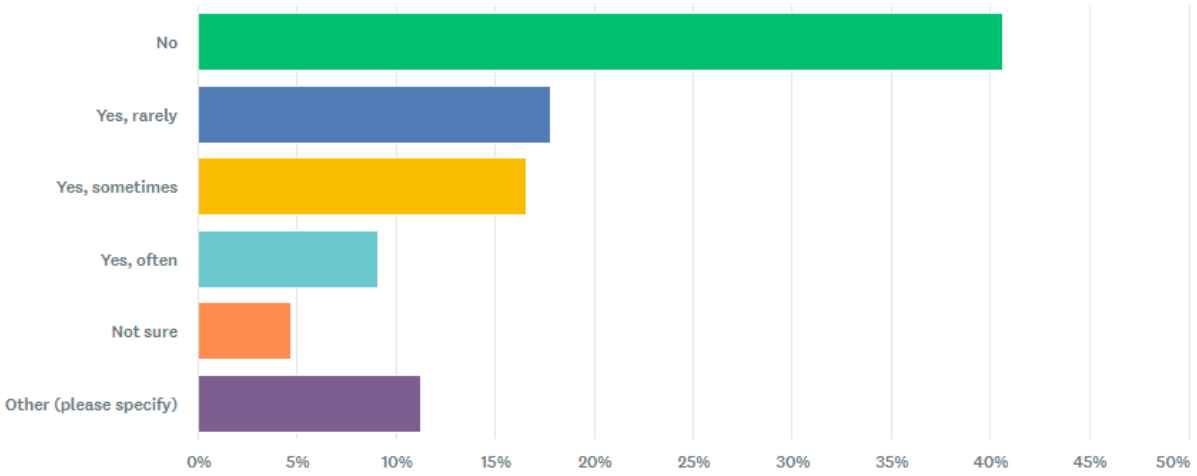
Longer consultation times*: Our clinic provides extended appointments to allow for comprehensive assessment, treatment, education and individualised rehabilitation planning.*

Administration and documentation: *Time spent on clinical notes, report writing, communication with support coordinators and other healthcare professionals, and managing NDIS-related requirements.*

Business overheads: *Increasing costs associated with rent, utilities, insurance, clinical software, equipment and administrative support.*

Complex patient presentations*: Additional clinical reasoning, care coordination and preparation required for participants with complex or multiple health conditions. As a small, independent physiotherapy clinic, we believe NDIS pricing needs to better recognise the actual costs of delivering high-quality, individualised therapy, particularly when working with participants who have complex needs."*

Q.17 Has your organisation ever not provided therapy supports to an NDIS participant due to the NDIS price for that support?



Member insights include:

"Yes often, parents with insufficient NDIS funding cannot even access our services, and often existing clients have to stop existing services when they run out of funding - for some families they stop all therapy services for their child due to insufficient NDIS funding."

"I have never withdrawn service due to price but I certainly decline new referrals. I have done the maths on a fairly standard consult, which for me as a specialist AT provider (let's say I am at the trial stage) usually takes at minimum 1.5 hours face to face with the client, plus another hour to do the clinical follow-up, and an hour travel (although NDIS will only pay 30 minutes). I have also factored in the usual minimum 3 hours to do a complex AT report. NDIS at $183.99/hour and won't pay more than 30 mins travel. WC at $231/hour clinical and $171 for travel (all paid). The difference between the two schemes for this ONE CLIENT amounts to $361, which if I repeat even four times a week is equivalent to a loss of almost $1450 in revenue per week, so it's no wonder that providers cannot financially sustain NDIS clients. I would also note that the private state schemes are somewhat self-selecting in terms of the fact that you generally do not get the work unless experienced and competent.

"I have declined referrals as the travel costs would not be compensated adequately."

"I am no longer taking on new participants since the price guide freeze/cuts last year."

"This has increased in the past 2 years. We no longer take on NDIS participants."

Yes as we have to change their therapy schedule to have less time with us. OR we do not charge if we feel that no therapy or decreased therapy will lead to negative consequences for the child/adult

Q.18 Is there anything else you'd like to tell us about pricing for therapy supports

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.

To restore coherence, the pricing framework must be structurally reframed. Plans must reflect the true breakdown of required supports and reform must be grounded in actual expenditure data, not projections or assumptions. 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.

While the Independent Pricing Committee 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) (Independent Pricing Committee 2025; IHACPA 2025; NDIA 2026c).

The APA's position is that the NDIS imposes materially greater non-face-to-face 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 (NDIA 2023, pp. 83–84).

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 (Ability Roundtable 2025).

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.

Member insights include:

"The price set for physiotherapy therapy supports is substantially below the prevailing private market rate. The NDIS pays $184 per hour, which is only 68% of the $270 per hour charged by a typical, non-specialised private physiotherapist. Specialists, such as neurological physiotherapists, commonly charge in excess of $300 per hour, yet the NDIS pays them no more than the standard $184. Private patients are paying these fees, so the market has demonstrated what the service is worth. Specialist physiotherapists, despite their additional training and complexity of practice, receive no recognition of that expertise in the NDIS price. The requirement to claim provider travel at 50% of the standard rate compounds this shortfall. Travel is unproductive, non-billable time for the clinician, and the reduced rate does not cover it. Many NDIS participants find attending a clinic difficult or impossible, or would require specialised transport and support to do so, which would carry comparable costs. Mobile services are therefore frequently the most practical and cost-effective option for participants, yet the current pricing penalises providers for delivering them."

"It is inappropriate for an occupational therapist and physiotherapist to be directed to charge different rate (per the price guide) for the same activity e.g. wheelchair prescription, manual handling assessment/recommendations, early intervention supports."

"Hourly physio rate needs to be increase. Currently, after overheads - I can only afford to pay a senior clinician $50 per hour before tax, which is significantly lower than senior physiotherapist working in NSW Health (starting at $65 per hour)."

"Most NDIS providers are highly skilled professionals with years of experience in disability and/or paediatrics. Our 'award rate' is not the same as what you would pay a new graduate physio. Pricing needs to reflect this before skilled professionals leave the profession or cease support to anyone who is not self-managed."

"I spend approximately 40% of my working hours providing unpaid work. This is not admin time or business related unpaid work. This is time spent advocating and liaising in complex case management for people with complex care needs and the most vulnerable people in our community."

"The underhanded and insidious issue currently is also budget cuts that are occurring that are significant and even late notice, not just fee rates, which are historically outdated and unchanged from previous years. There is also a major issue with timing of release, as mere week or so before 1 July is not appropriate for business operations."

"I work in prescribing and assessing AT and have significantly more training/education than many therapists (30yrs experience, further qualifications etc.). I work in complex equipment and complex disability and am often employed due to the fact that participants existing therapy team do not have the skills needed. I provide a 'state-wide' equipment service, providing assistance to people from melb metro to Mildura, Caroline springs to Frankston but can charge less than the therapists requesting my assistance and cannot charge for travel as clients are 'metro' even though they are unable to find services in their local area."

"The NDIS does not understand or value the expertise of experienced neurological physiotherapists. They think that physiotherapy treatment can be delegated to untrained support workers to implement complex physiotherapy intervention. Physiotherapy should be equally valued compared with other allied health professions. You cannot directly compare a traditional musculoskeletal private practice model (time per appointment or cost of appointment) with physio's working with complex neurological or disability clients. The time to deliver services (hoist transfers, slower movement and communication, communication with care teams, cancellation of appointments due to illness,

communication regarding manual handling and complex AT implementation etc.) is not directly comparable. It is unrealistic to expect that services can be delivered in 30 min time frames. "

"I will be exiting the NDIS space once my current registration expires. The cost and time cost of an audit for a sole practitioner is enormous relative to the income generated from the 1 - 2 clients per week I see."

"If providers are further disadvantaged due to not being registered, or if self-managed is removed as an option I would not provide NDIS services, and a whole region of children would be unserviced."

"If I could afford to do my job under stagnant and reducing price limits, I would continue to do so, but I can't, and it will be an enormous relief not to have to deal with the NDIS anymore!"

"If something doesn't change to increase pricing for therapy supports, the entire paediatric therapy private sector will collapse. Small businesses like ours produce the highest quality service and intervention but with therapist wage expectations and such poor NDIS pricing, it's not sustainable and participants will be the ones who suffer most."

"Things have to change as many of us are very close to closing. I have never felt so disempowered as a physiotherapist as I have now and I have been in the profession for 28 years. I am considering completely leaving the profession."

"We have created a new strategic plan for our business which guides our business to completely exit the NDIS market as the pricing system is creating a loss in our business, and preventing us from attracting high quality therapists. I very much hope this can be rectified so that we can resume offering a service to NDIS participants."

"Without a significant increase to all allied health service pricing providers like us that do meet all registration standards and train early career therapists to be able to handle the complexity seen in this cohort will collapse - we have nothing left we can absorb."

"The drop in pay rates for therapists and no growth means that therapists feel really undervalued. It makes me want to leave the profession and stop delivering therapy to NDIS clients. This is work that I love and I am passionate about. I have extensive clinical experience and a Masters degree and I feel cheated and devalued by NDIS price changes.

"Reduction in travel for therapists has resulted in many clients living remotely not being able to access supports they previously have resulting in functional deterioration. Short term solution on saving cost as those participants will be at higher risk of being hospitalised and increased cost."

"I had to borrow over $300,000 last year after the pricing changes to remain solvent. I can no longer take that risk."

"Therapy supports in the NDIS space cannot be compared to Medicare or private health funding. NDIS space is for complex care and higher needs than the standard session. This needs to be taken into account especially when working with participants who have a significant amount of persons in their care team."

"Therapy actually builds capacity which reduces need for funding. Therapists are in the most part highly ethical. Cutting therapy funding does not make logical sense from a financial perspective by any argument that I can imagine."

"Physiotherapy is undervalued by NDIS as a whole (not by the clients receiving it who know and understand out value) and I feel like we are being pushed out of NDIS. Not specific to therapy costings per se however I prescribe complex AT- AT suppliers are increasing their rates up to and above physio rates for simply delivering equipment for trial. This is incredibly frustrating and an area that has been overlooked when it comes to monitoring of where funds are going. Greater monitoring of this sector is required."

"The government has done an excellent job in allowing and perpetuating the idea that the NDIS is full of frauds. We are not. I work 80 hours per week to ensure that our business can survive. We do not have admin and other staff to keep our expenses as low as possible. We are highly experienced and have had our business for > 20 years. Despite this, there is every chance we will lose the business to thriving kids and ongoing pricing limits."

"NDIS packages are not being supplied with enough funds to cover the cost of treatment and non-billable time that is provided to NDIS participants. 1 participant who had funding for 1x per fortnight, had no funding for therapy hours included in current plan. Currently fighting for the inclusion through ART which they have agreed to include now but the participant has gone without for over 12 months. I am being paid more as a support worker than a physiotherapist for my time. So the importance of physiotherapy also needs to be advocated to the NDIS. I am not willing to take on any more NDIS clients because I am not willing to take on the extra burden that NDIS is causing in cut backs everywhere. I end up working for nothing. 1 hour billed equates to 5 hours working for no payment that is how bad it has become."

"The NDIS funding 3-monthly funding periods have created a lot of non-billable work - creating service agreements & creating budgets that need checking every 3 months for every participant It is becoming less sustainable for the business to take on NDIS clients and more sustainable to switch to aged care or TAC clients Therapists have less time for research or PD as business KPIs have risen with the price reduction and threat to business sustainability. The NDIS pressures (price reduction, client reduced funded hours and functional deterioration) are affecting job satisfaction and will mean physios leave NDIS to work in public health."

"By pricing all services at the same level, NDIS providers are penalised for hiring more experienced and higher trained therapists, which ultimately means that those with specialised needs are under serviced."

"The amount of post session emails, feedback, follow up advice for clients with severe disability, especially living in SDA and not with family is huge. If I billed for all the time I spend on this there would be little funding for the necessary face to face support."

6. Conclusion

Physiotherapy helps NDIS participants maintain and build the capacity to move safely, manage everyday activities and participate in the lives they choose. Protecting access to these services requires pricing that recognises the full work involved in delivering safe, effective care.

The evidence presented in this submission identifies pressures that provider numbers alone cannot reveal. Providers report restricting referrals and travel, absorbing necessary work without payment and making difficult decisions about the services they can sustain. Continued participation in the Scheme does not establish that current prices are adequate or that participants can access the support they need.

The APA therefore calls on the NDIA to recommend to the Minister a correction to the physiotherapy price limit for 2027–28 (at minimum restoring the pre-July 2025 rate of $193.99 in addition to appropriate geographical loadings and recurring indexation that reflects the HPSS Award wage increases. The APA's indexed sustainable hourly rate guidance of $273 per hour, based on the Nous methodology, shows the scale of the gap between current pricing and the cost of sustainable practice (APA 2026a). Future reviews, including the 2027 Therapy Pricing Review, should be informed by independent bottom-up costing. This correction must be supported by recurring indexation that recognises relevant workforce and operating costs, and travel arrangements that enable providers to reach participants who depend on outreach services.

Reform must also protect recovery of necessary indirect clinical work. Changes to billing arrangements should improve transparency while preserving payment for the time required to deliver appropriate services. Registration-based pricing differentiation must be grounded in validated costs and safeguards for access. Participants with complex needs require funding for the time, intensity and coordination their care demands.

The APA supports independent bottom-up costing, meaningful consultation and stronger monitoring of participant access. It will provide further independent economic analysis to the Agency when complete. That work should strengthen future pricing decisions; it should not delay the correction sought in this review.

Physiotherapists want to continue supporting NDIS participants. The 2027–28 pricing decision must give them a sustainable basis to do so, so participants can rely on the services that support their independence, participation and wellbeing.

Finally, monitoring must examine referral acceptance, waiting times, travel coverage and continuity of support alongside provider numbers. These measures would help ensure that ongoing provider participation translates into services participants can actually access.

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Appendix

Nous Group Review of the 2024-25 APR with respect to physiotherapy