2026

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

Physical Disability
AUSTRALIA

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ABOUT

Physical Disability Australia (PDA) is Australia's national peak Disabled People's Organisation representing people living with physical disability. Established in 1995, and governed and led by people with physical disability, we advocate for the rights, inclusion, and full participation of all people with physical disability across Australia.

At the heart of everything we do is a commitment to ensuring Australians with physical disability can realise their full potential and live with dignity, autonomy, and equal opportunity. Through systemic advocacy, meaningful policy engagement, and direct representation to government, we champion equality, inclusion, and accessibility — working to ensure the voices and lived experiences of people with physical disability shape the laws, policies, and decisions that affect their lives.

EXECUTIVE SUMMARY

Consultation is not a courtesy. It is essential.

While the need for a sustainable NDIS is undeniable, the way reform is pursued matters. For thousands of Australians with physical disability, the NDIS is not an abstract policy framework; it is the funding basis for wheelchairs, home modifications, essential therapies, personal care, and the assistive technology that makes employment and community participation possible.

In their present state, the reforms proposed by the Government risk narrowing access, reducing support, and forcing people into standardised categories that do not reflect the reality and complexity of physical disability. The reforms have been developed with minimal consultation from the disability community, and are now being rushed into Parliament without providing adequate opportunity for us to demonstrate how some of the reforms being proposed risk taking away the basic supports that thousands of people with physical disability rely on to live ordinary lives.

Any reform that affects the lives of people with disability must be co-designed with people with disability. That requires accessible, resourced, and timely consultation that shapes the policy before legislation is settled, not token consultation after key decisions have already been made.

In PDA’s view, this Bill would entrench the existing underrepresentation of people with physical disability in the NDIS by introducing new barriers to access, permitting exclusion where another system is said to be available, and recasting the reasonable and necessary test in a more restrictive form. It would also impose disproportionate administrative burdens through reassessment, renewal, information-gathering, and compliance processes, while creating instability in the funding of high-cost and long-lead supports such as custom wheelchairs and home modifications, particularly in thin regional markets.

For those reasons, Physical Disability Australia calls for substantial amendment of the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026, or for the Bill to be set aside pending further consultation. Although presented as a sustainability measure, the Bill would have a disproportionate and adverse impact on people with physical disability by tightening access, narrowing planning criteria, increasing reassessment and compliance burdens, and weakening practical safeguards in ways that do not reflect the nature of lifelong physical disability support needs, including attendant care, assistive technology, home modifications, continence supports, pressure care, and other supports essential to safe and independent community living.

"You cannot redesign a life you do not live. My NDIS plan is not an abstract policy. It is the essential funding for my wheelchair, home modifications, and the care that keeps me alive, yet these reforms would squeeze my complex needs into rigid categories without ever asking me how I survive. This impacts my very survival" John D

"How can it be that the Government accepts you need support to live a basic life, work, engage with the community, stay out of a nursing home one year; then threatens to take it all away the next when it is looking to save money. I just made do for years before even applying to become a NDIS participant; the seven hours of support a week that I now get has changed my life and I don't know if I can go back. The NDIS looks like it might have been nothing more than a cruel mirage" Paul W

THE SCALE OF UNDERREPRESENTATION: EVIDENCE OF SYSTEMIC EXCLUSION

The Australian Bureau of Statistics (ABS) reports that 5.5 million Australians were living with disability in 2022; just over three-quarters of that number reporting a physical condition as their main long-term health condition. Yet NDIS administrative data shows only 20–25% of participants list physical disability as their *primary* condition. Even after accounting for the well-documented age barrier, whereby Australians who acquire physical impairment after age 65 are excluded from the NDIS and funnelled into the aged care system, the disparity remains stark.

This gap suggests that hundreds of thousands of Australians of working age with significant physical impairments, including spinal cord injury, multiple sclerosis, muscular dystrophy, acquired brain injury with mobility loss, amputation, and degenerative arthritic conditions, are already either never entering the NDIS, or are being screened out during access and planning. The Bill's proposed changes risk codifying and accelerating this exclusion.ndirect Discrimination Through "Neutral" Assessment Methodology

The Bill's proposed changes to access and assessment methodology appearneutral but will have a disproportionately adverse effect on people with physical disability. This constitutes indirect discrimination under the *Disability Discrimination Act 1992* (Cth) and Article 2 of the UN Convention on the Rights of Persons with Disabilities (CRPD).

Why the methodology discriminates:

Functional criteria bias: Standardised functional assessments often weight cognitive, behavioural, and communication domains more heavily than mobility, dexterity, continence, and chronic pain management. A person with profound mobility impairment but intact cognition may score as less "functionally impacted" than the assessment framework assumes.

Invisibility of environmental barriers: Physical disability support is fundamentally anchored in the social model of disability; wheelchairs, hoists, and home modifications are required because the built environment is inaccessible. If the new assessment methodology shifts toward "impairment severity" or "capacity to rehabilitate" without accounting for environmental intervention, it treats physical disability as a purely medical deficit rather than a barrier requiring capital supports.

The "primary condition" trap: Many physical disabilities involve complex, multi-system comorbidity (e.g., spasticity, pain, osteoporosis, pressure injury risk following spinal cord injury). Requiring a single "primary condition" obscures the cumulative functional burden and can lead to arbitrary categorisation that undervalues the need for assistive technology (AT) and personal care.

REASSESSMENT AND PLAN RENEWAL: A DISPROPORTIONATE BURDEN

People with physical disability often require stable, lifelong, or progressively increasing supports. The Bill's proposed changes to reassessment processes and plan renewal ignore the temporal reality of physical impairment:

Degenerative conditions: For people with motor neurone disease, multiple sclerosis, Parkinson's disease, or muscular dystrophy, frequent reassessment demands repeated proof of decline. This is not only administratively cruel but clinically redundant: the trajectory is known at diagnosis.

Energy and mobility costs of compliance: Reassessment requires attendance at appointments, travel, and sustained engagement with bureaucracy. For someone reliant on a powered wheelchair or full attendant care, this imposes a "disability tax" on time, energy, and personal support hours that Australians with other disability types may not face to the same degree.

Interruption of capital supports: Unlike consumable supports, Assistive Technology (AT) and home modifications (HM) operate on long lead times (months for custom wheelchairs, years for complex home builds). If reassessment creates even temporary funding uncertainty, supplier contracts are cancelled, builders withdraw, and participants are left without essential equipment or living in unsafe environments.

> *"I have been disabled for almost 45 years. It has not gone away, despite many treatments. I want to get on with my life, not go backwards. I manage the issues well, like incontinence, spasticity, pain, scoliosis. Yes some things have improved, but they haven't and are unlikely to make my fingers work or legs walk ever again." Tammy M*

FUNDING CERTAINTY AND THE DESTRUCTION OF ASSISTIVE TECHNOLOGY/HOME MODIFICATIONS MARKETS

The Bill's erosion of funding certainty is particularly discriminatory because people with physical disability are the principal consumers of high-cost capital supports. By introducing uncertainty at plan renewal or through administrative clawbacks, the Bill threatens the commercial viability of the very AT and HM providers on whom people with physical disability depend. In thin markets, particularly in regional and remote Australia, this will produce effective market withdrawal, leaving participants without access to specialised equipment or forced to accept generic, ill-fitting alternatives that increase risk of injury, pressure injuries, and hospitalisation.

REVIEW RIGHTS AND ADMINISTRATIVE ACCOUNTABILITY: BARRIERS TO JUSTICE

The proposed narrowing of review rights and administrative accountability disproportionately affects people with physical disability for several reasons:

Structural barriers to advocacy: Meritorious review before the Administrative Appeals Tribunal (AAT) requires legal representation, medical evidence, and digital or physical access to hearings. People with severe mobility limitations face compounded cost and access barriers in securing representation and attending proceedings.

Evidence asymmetry: The NDIA holds actuarial and medical procurement data that participants rarely see. Reducing accountability mechanisms entrenches this imbalance, particularly for participants whose needs are highly technical (e.g., level 4 pressure care seating, ceiling hoist tracking, complex bowel and bladder management).

Exhaustion and learned helplessness: Repeated adverse decisions and opaque review processes force participants with high physical support needs to choose between exhausting their limited energy on administrative combat or accepting dangerously inadequate plans. This is constructive denial of support.

INTERSECTIONAL DISCRIMINATION: AGE, GENDER, AND GEOGRAPHY

The discrimination is compounded by intersectional factors:

The age-65 cliff: Because physical disability prevalence rises sharply with age (52.3% of Australians aged 65 and over live with disability), the NDIS age gateway already diverts many older Australians into the aged care system. This system is structurally oriented toward residential care rather than independent living, assistive technology, and home modifications. The Bill’s tightening of NDIS access offers no equivalent safeguard, meaning a person who acquires a spinal cord injury at 64 may have only a narrow window in which to access the NDIS before turning 65, and may face a severe support cliff shortly thereafter.

Gendered impact: Older women, who live longer and have higher rates of age-related physical disability, are disproportionately affected by both the age gateway and the devaluation of in-home support.

Regional thin markets: People with physical disability in regional areas already face prohibitive travel costs for AT assessments. Any additional administrative hurdle multiplies that burden exponentially.

“I was diagnosed with Chordoma at age 60. It had already impacted my ability to walk and do basic household chores but had been misdiagnosed. I was not considered ‘disabled enough’ to gain access to the NDIS so could not afford many essential items and had to make do. By the time I was considered ‘disabled enough’ to be considered for the NDIS system at age 64, I was told I was too old and would need to apply under the aged care system when I reached 65. I live in a rural location so when I did hit 65 and applied I was told there are no services in my area that have capacity to take me on – not even to help around the house or take me to my treatments. I am a widow with no children so have no help. I feel like giving up, clearly no one cares” Sue T

VIOLATION OF HUMAN RIGHTS OBLIGATIONS

Under the CRPD, Australia is obligated to ensure equal right to live independently in the community (Article 19) and to provide disability-specific supports aimed at independence (Article 26). The Bill’s suite of changes, particularly to assessment, funding certainty, and review, threatens to make the NDIS a scheme that, in practice, prioritises supports for which eligibility is easily administrated, rather than supports that are essential for the largest population of people with disability.

This is not merely a policy gap. When a neutral-looking regulatory framework produces outcomes where 75% of the disability population receives 20 - 25% of scheme representation, and where proposed reforms further narrow the pipeline for AT, HM, and personal support, the effect is discriminatory in both intention and impact.

THE IMPACT OF THE BILL ON PEOPLE WITH PHYSICAL DISABILITY

Schedule 1, Part 1 — Defining "Functional Capacity" (s 9B)

The new “whole activity” assessment raises the threshold for people with physical disability who can complete some self-care sub-tasks but not others, penalising those with partial or fluctuating function. When combined with the requirement to assess capacity without assistive technology, it creates a perverse contradiction: a person may qualify when assessed without their wheelchair but fail when assessed with it. This creates scope for inconsistent assessor judgment and a postcode-based variation in outcomes. While the new recognition of cumulative impairments benefits people with complex physical conditions, it applies only to early intervention, not the main disability access test.

> *“Given that I have Cerebral Palsy, am wheelchair bound but live independently, I believe I am likely to be classified as having a moderate disability and therefore face dramatic funding cuts and be forced onto a Medicare system that will not cover the cost of certain critical funding or equipment. Also, in no instance does Medicare cover the full cost of any service that the NDIS currently covers so we are not dealing with like for like systems.” Emily E*

Schedule 1, Part 3 — Strengthening the Impairment-to-Support Link

If supports must be tied to impairments that themselves meet s 24 or s 25, the question becomes: does the secondary condition itself meet the disability requirements? For example:

- My shoulder injury from 20 years of manual wheelchair propulsion is clearly a consequence of my spinal injury, but is it "permanent" in its own right? Is it "significant"? Will I have to prove this all over again to ensure that I can fund the shoulder physiotherapy that allows me to maintain the ability to independently transfer in and out of my wheelchair?
- A child with cerebral palsy may need swallowing therapy, but if "dysphagia" isn't itemised as a qualifying impairment, will the funding for Occupational Therapy feeding strategies and support be cut?

The risk is that planners adopt a narrow reading and refuse to fund supports that address secondary conditions, even when the secondary conditions are entirely caused by the primary disability.

> *"After two decades of pushing my wheelchair my shoulders are wearing out, but they're wearing out because of my disability, not separate from it. If I have to prove all over again that this pain is permanent enough or significant enough to deserve support, I'll lose everything the NDIS was designed to protect." Matt W*

Schedule 1, Part 4 — Support Determinations (Commences 1 October 2026)

For physical disability participants, support worker hours are existential. A reduction in funding for "personal care" hours doesn't reduce a person’s need to be transferred, showered, repositioned, or assisted at toileting, it just means they have to find that care elsewhere, ration it, or go without. "Going without" personal care is not an inconvenience; it is a medical event that brings with it the risk of serious complications, including potentially Hospitalisation..

The mechanism is also concerning because it operates across the NDIS, not on an individual participant basis. That means an entire cohort can lose funding at once, without individual review.

> *“So if they reduce my personal care hours, what would they like me to give up? Hygiene? Clean equipment? Essential hospital treatments? Or perhaps they want me to stay home and never see another living person – a reduction in any of these leads to the same thing. One less on the NDIS system because I’ll likely be dead.” David M*

Schedule 1, Part 5 — Plan Renewal (Commences 1 February 2027)

Plan continuations have, in practice, been the mechanism that kept participants funded while awaiting reassessment. Many participants with physical disability have remained on rolling continuations for more than a year because the NDIA has been unable to complete reassessments within expected timeframes.

The new "renewal" mechanism legislates this, which is good in principle, but with the catch that renewed plans must comply with the new s 33 requirements: total funding amounts, funding component amounts, and funding periods.

This means a renewal is not a continuation of the old plan; it is a recalculation under the new framework. For participants whose old-framework plans were generous, a renewal may actually be a reduction.

The interaction with Schedule 1 Part 4 (support determinations) is particularly worrying: renewals will be calculated using whatever reduced funding the Minister has determined for those support categories. Existing participants will be migrated to lower budgets at renewal.

> *“Living with a physical disability is hard enough. Every delay feels like I’m being left to drift without the support that keeps me afloat, and the idea that a renewal could quietly shrink my funding is terrifying. What the system calls continuity to me feels like survival on borrowed time, because if my needs are reassessed into a lower budget it doesn’t just change my plan it changes whether I can live with some sense of self-worth and be safe.” Kevin T*

Schedule 1, Part 6 — Reasonable and Necessary Supports (Commences 1 February 2027)

High-cost AT is precisely where actuarial pressure will land. A $40,000 power chair lasts a person seven to ten years; the temptation for the Agency to push lower-cost options that wear out faster, fit poorly, and cause secondary injury is enormous.

Two-worker transfers are clinically necessary for many people but expensive. Pressure to use mechanical hoists with single workers risks worker injury and participant injury alike.

Complex bowel care, ventilation support, and tracheostomy care are life-and-death supports that should never be subject to cost-driven tightening.

> *"Reducing my survival to being a solution to fix your budget is a direct threat to my safety. When balancing a budget is allowed to dictate my only mode of moving around and how I manage my complex bowel care needs, this is no longer about balancing a budget, it is a terrifying calculation of whether I am too expensive to keep alive." Lisa M*

Schedule 1, Part 7 — Plan Suspension (Commences 1 October 2026)

This is more dangerous than it first appears. Physical disability participants who are at highest risk of non-contact are often the participants who most need their supports:

Hospitalised participants: physical disability participants are hospitalised more often than the general population. Long admissions (months for spinal injury, ABI, complex pressure injury treatment) can mean missed correspondence.

Participants who have lost their primary carer: the carer may have been managing all correspondence. Their death or departure leaves the participant unable to engage with the NDIA.

Participants in regional areas: with intermittent postal and phone service.

Participants whose communication is significantly impaired: by stroke, ABI, MND, or advanced MS - they may not be able to respond to standard NDIA correspondence at all.

Participants in crisis: (mental health, family violence, housing instability) where engaging with bureaucracy is the lowest priority.

A plan suspension during a hospital admission, followed by revocation at 90 days, could mean that a participant comes home from hospital to find they have no NDIS plan: no support workers, no equipment maintenance, no plan manager.

> *"I often have to be in hospital for long periods. If I got home and found my (NDIS) plan was revoked I would be left without support workers to help me with equipment including my ventilator, suction machine and feeding pump. Without these things working properly, I face immediate life threatening problems including not being able to breathe. Would they prefer I just use up a hospital bed for the rest of my life?" Adrian B*

Schedule 1, Part 8 — Tightening Permanence: "All Appropriate Treatment" (Commences 1 January 2028)

The "all appropriate treatment" concept is a major shift. Currently, an impairment is "permanent" if it is unlikely to substantially improve. The new test apparently requires that all appropriate treatment has been undertaken (or considered) first. This is a significant problem for several physical disability cohorts:

- Post-traumatic injury (spinal cord, brain, amputation)
- Chronic pain conditions (CRPS, fibromyalgia, post-surgical pain)
- Conditions managed (not cured) by medication or surgery
- MS and other relapsing-remitting conditions

Does the existence of a treatment that might slow progression mean the underlying disability is no longer "permanent"?

There is also a coercive dimension. If access depends on having had "all appropriate treatment," participants may be pressured into treatments they do not want, cannot afford, cannot access (long public waitlists), or that have unacceptable side effects.

The CRPD Article 25(d) requires that health professionals provide care to people with disabilities based on free and informed consent. A scheme that conditions disability support on accepting treatment risks crossing that line.

Schedule 1, Part 9 — Eligibility based on access to other services

The EM acknowledges the sustainability rationale but provides no mechanism for cases where the alternative support is demonstrably inferior. The 90-day revocation process under the amended section 30 also gives participants little time to challenge a finding that they “meet the alternative support requirements.”

Real-world risks include:

- A person with paraplegia from a car accident receives a lump-sum CTP payment that runs out after 10 years; no ongoing NDIS access despite lifelong needs
- Long-standing NDIS participants with work-related spinal injuries could have their status revoked once the Rules declare workers’ compensation as an alternative support
- Future legislative instruments can deem entire service systems (e.g., aged care, veterans’ affairs, or state disability programs) as “alternative supports” without parliamentary scrutiny
- A state compensation scheme collapses, becomes insolvent, or changes its rules, and affected participants have no automatic pathway back into the NDIS
- Younger people injured at work or in accidents are most likely to have decades of support needs that exceed typical compensation scheme caps

> *“After my accident I fought for years to piece together a life worth living. The NDIS was finally the stable ground I could stand on. The thought that my small lump-sum payment, which will be spent with the next essential upgrade to manage my degrading condition, could be used to permanently close the door on my support is a sentence handed down on the rest of my life. The 90 days appeals process doesn’t provide any comfort if you are depressed and busy just trying to manage." Terry P*

Schedule 2, Part 3C — Compliance and Enforcement in relation to Agency Functions

This Part matters because it is the point at which the Agency’s power becomes visible in everyday life. The problem is not monitoring as such. A scheme that pays billions of dollars in public funds should be monitorable. The problem is how much discretion the Agency will have when deciding whose records, premises, systems, or conduct to scrutinise, and whether that scrutiny is tempered by real safeguards for participants with disability.

If the powers are used primarily against providers, they may improve system integrity. If they are used expansively and without restraint, they may create a compliance atmosphere that is difficult for participants with physical disability to navigate.

That means the regulatory gaze may extend into highly personal and operational aspects of a participant’s life.

> *“So are they saying that they are giving themselves the power to do a deep dive into my records, my home, and my personal routines? If the focus stays with providers then maybe that’s a good thing, but if it is used without boundaries, it will crowd my disabled life with invasive oversight that will chip away my independence and dignity. Would a non-disabled member of the community think this was reasonable if for example they were receiving a pension or unemployment benefits?” Joe M*

Schedule 2, Part 4 — Information Gathering, Record Retention and Claims Integrity

This part is one of the clearest examples of the Bill's integrity agenda reaching directly into participant life. The Government's case is simple: if the NDIS is vulnerable to fraud, the Agency needs better information. That is fair. But the practical reality is that people with physical disability are not all equally capable of acting as compliant record-keepers or prompt respondents to formal notices.

Many participants with physical disability experience:

- fatigue,
- pain,
- upper limb impairment,
- sensory impairment,
- cognitive load from chronic illness,
- intermittent hospitalisation,
- and dependence on carers or family to manage paperwork.

That means a request for information is not a neutral administrative step. It may impose a substantial functional burden.

> *"I've experienced firsthand how a simple request for information can become a significant burden due to my reliance on carers to manage my paperwork. During a recent hospitalisation, I missed a crucial deadline for responding to an NDIS notice and had to fight to get everything reinstated before it had terrible knock-on effects that risked more hospitalisations. I come into this with a university level education to guide my carers through the process and still found it incredibly challenging. How does anyone who does not have the same educational privilege manage?" Mike G*

OUR RECOMMENDATIONS

Primary Recommendations

Physical Disability Australia considers the Bill, in its current form, unworkable and likely to cause significant harm to people with physical disability. We recommend that the Bill be withdrawn and that a genuine, accessible consultation process be undertaken before any further legislative reform proceeds.

During that consultation period, reform efforts should prioritise cost reduction through provider oversight, market stewardship, and administrative efficiency rather than by shifting additional burden onto participants.

If the Bill is not withdrawn, it should be substantially amended to ensure proper representation, procedural fairness, and strong protections for people with physical disability.

Specific Recommendations on the Bill

Part 8 of the Bill

Part 8 should be opposed on the basis that it introduces a threshold likely to exclude or delay access for people with physical disability by linking permanence too closely to the exhaustion of treatment options. For many people with spinal cord injury, multiple sclerosis, neuromuscular conditions, acquired brain injury with mobility loss, amputation, chronic pain conditions, or other significant physical impairment, treatment may manage symptoms, slow deterioration, or prevent secondary complications without altering the permanence of the underlying disability or the ongoing need for personal care, assistive technology, home modifications, pressure care, and transfer assistance. The provision would create uncertainty, increase the scope for inconsistent decision-making, and risk exerting pressure on participants to undergo treatment that is unavailable, unsuitable, or inconsistent with free and informed consent. Part 8 raises defects of principle and operation that cannot be cured by minor amendment and should be omitted in its entirety.

Other Available Support Systems (Access)

Schedule 1, Part 9 should be removed on the basis that it would permit exclusion from the Scheme of participants with lifelong physical disability support needs by reason only of the notional availability of another service system, including where that system is time-limited, inferior, uncertain, or incapable of providing equivalent support. For people who require ongoing attendant care, continence support, complex bowel or bladder care, pressure management, wheelchair replacement, vehicle or home modifications, and other long-term physical disability supports, the existence of a compensation, health, or aged care pathway does not ensure equivalence of access, continuity, or adequacy. The provision would create a real risk of displacing people with physical disability from the NDIS without any reliable safeguard that substitute supports will be available in practice over the course of their lives. Schedule 1, Part 9 should therefore be omitted.

If Part 9 is retained, the rule-making power in proposed section 25B should, at a minimum, be removed because it would allow substantial restrictions on NDIS access to be effected by delegated legislation rather than by amendment to the primary Act subject to full parliamentary scrutiny. That presents a particular risk for people with physical disability, whose long-term reliance on attendant care, assistive technology, home modifications, consumables, and complex daily living supports may be displaced by broad assumptions that another service system is available. Changes of that kind go to the substance of entitlement and should not be left to future rules capable of materially altering access without the same degree of debate, transparency, and accountability. If Part 9 is retained, the rule-making power in proposed section 25B should be omitted and any such reform should be made, if at all, by amendment to the NDIS Act itself.

'Reasonable and Necessary' Criteria (Planning)

Proposed ***subsection 34(1A)*** should be removed because it introduces a constraining threshold at the threshold stage of the reasonable and necessary test, with the effect of narrowing access to supports for participants with physical disability whose needs are substantial, ongoing, and highly individualised. For this cohort, essential supports commonly include personal care, transfers, pressure care, continence supports, assistive technology, and home modifications, none of which can be appropriately assessed through broad statutory framing divorced from the participant’s actual functional circumstances. The provision would create a material risk that supports critical to health, safety, and community living are excluded by abstraction rather than assessed by reference to their necessity and functional purpose. Proposed subsection 34(1A) should therefore be omitted, while proposed subsections 34(1B) and (1C) may remain.

Proposed subsections ***34(1E) and (1F)*** should be removed because they risk recasting the existing ‘effective and beneficial’ inquiry in a manner that is narrower, more rigid, and less responsive to the practical realities of physical disability support. For people with physical disability, a support may be effective and beneficial because it prevents pressure injuries, preserves transfer safety, reduces hospitalisation risk, maintains wheelchair access, sustains continence management, or enables community living, even where it does not produce measurable improvement in impairment. The current Supports Rules already provide an appropriate framework for that inquiry and should not be displaced by provisions likely to invite a more restrictive interpretation. Proposed subsections 34(1E) and (1F) should therefore be omitted.

Proposed subsection ***34(1G)*** should be clarified to ensure that the treatment of parental responsibility remains anchored to the additional care burden arising from disability, and is not used to normalise the transfer of disability-specific supports to families. That is of particular importance for children with physical disability who may require lifting, transfers, positioning, feeding assistance, respiratory support, pressure management, continence care, or mobility-related supervision beyond what would ordinarily be expected of a parent of a child of similar age. The objective should be to preserve a clear distinction between ordinary parental responsibility and materially increased care needs arising from physical disability.

Amend proposed subsection 34(1G) to read:

For the purposes of paragraph (1)(e) so far as it applies in relation to a participant who is a child, the CEO must take into account:

a. that it is commonly expected that parents are responsible for providing care and support for their children; and
b. whether, because of the child's disability, the child's care needs are substantially greater than those of other children of a similar age.

Proposed subsection ***34(1H)*** should be removed because it risks importing assumptions about ordinary family functioning that do not reflect the complexity, intensity, and sustainability limits of physical disability-related care. For participants with physical disability, those assumptions may understate the labour involved in lifting, showering, dressing, toileting, repositioning, supervision during transfers, equipment management, and night-time care, and may shift essential care obligations to family members without adequate statutory protection. Proposed subsection 34(1H) should therefore be omitted.

Proposed subsection ***34(1J)*** should be amended to ensure that reductions in parental burden or gains in household efficiency are not treated as reasons to refuse supports that are otherwise necessary by reason of physical disability. In the context of physical disability, supports such as hoists, showering assistance, toileting support, mealtime assistance, home modifications, and mobility equipment may also reduce household strain; however, that incidental effect should not be used to characterise them as ordinary family supports rather than disability-specific necessities. The subsection should make clear that disability-related supports are not to be excluded merely because they also produce practical benefits within the home.

Amend proposed subsection 34(1J) to read:

For the purposes of paragraph 1(e) so far as it applies in relation to a participant who is a child, the CEO must disregard the extent to which the support would:

a. reduce burdens on parental time below what is reasonably expected of a parent of a child with disability; and
b. improve household efficiency.

Proposed subsection ***34(1K)*** should be amended to ensure that reliance on family, carers, informal networks, or community supports is not treated as inherently available, safe, or sustainable. For people with physical disability, informal support may involve high-intensity manual handling, continence assistance, pressure care, transport, equipment set-up, or night-time attendance, and should not be assumed without consideration of carer fatigue, injury risk, burnout, and the participant’s safety and dignity. The provision should require express consideration of risk and wellbeing so that informal supports are strengthened where appropriate, but are not assumed in circumstances where such reliance would create harm, instability, or unmet need.

Amend proposed subsection 34(1K) to read:

For the purposes of paragraph 1(e), the CEO must consider:

a. whether relying on family, carers, informal networks or the community would expose the participant or another person to any risk to their wellbeing that cannot be reasonably mitigated; and

b. the desirability of supporting, maintaining and strengthening informal supports and community networks in preference to replacing those supports and networks with funded supports.

CONCLUSION

This Bill is presented as a measure to secure the future of the NDIS, but for people with physical disability it risks producing the opposite result: even further reduced access, less certainty, greater administrative burden, and weaker practical safeguards. A sustainable NDIS must also be fair. Reform cannot be durable if it is built on processes that exclude the people most affected and on legal settings that fail to reflect the realities of lifelong physical disability support.

Physical Disability Australia therefore urges the withdrawal of the Bill, or at minimum its substantial amendment following genuine consultation and co-design with people with disability. Without those changes, the Bill risks entrenching structural exclusion rather than securing the NDIS for future generations.

Submission Details

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We sincerely thank our association members and the wider physical disability community who responded to our call for comments. The sheer volume of emails and calls we received shows how important this legislation is and how strongly people feel about it. We have considered all feedback in preparing this response, and any quotes not included here will be collated and provided to the Ministers as a separate document.

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