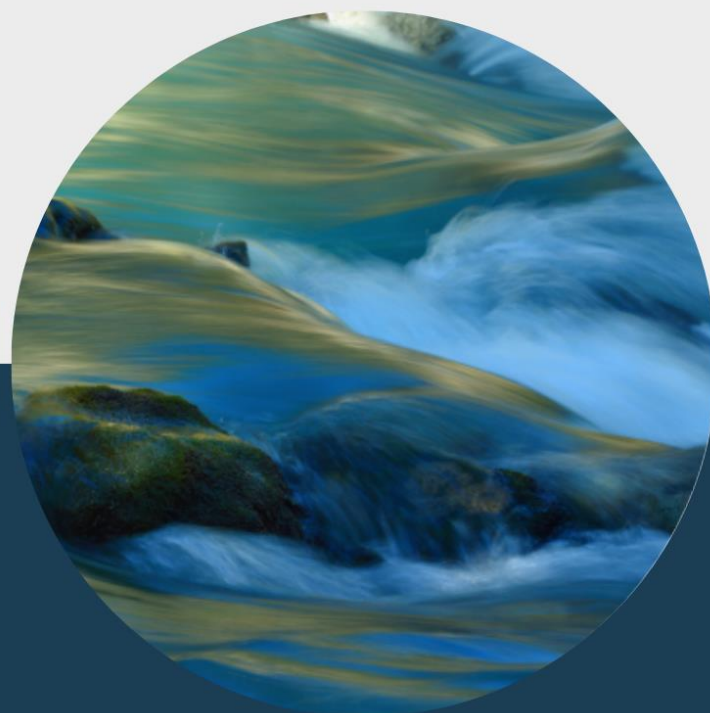


INQUIRY INTO THE ADMINISTRATION OF THE NATIONAL DISABILITY INSURANCE SCHEME. SUBMISSION



OTSi

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Inquiry into the Administration of the National Disability Insurance Scheme. Submission, 29 Jan 2026

EXECUTIVE SUMMARY

The Occupational Therapy Society for Hidden and Invisible Disabilities (OTSi) welcomes the opportunity to make a submission to the Inquiry into the Administration of the National Disability Insurance Scheme. OTSi's perspective is grounded in frontline practice and system-level experience, and reflects the cumulative impacts of administrative, evidentiary, and safeguarding arrangements on both participant outcomes and Scheme costs.

This submission addresses the Terms of Reference with a particular focus on NDIA decision-making, in relation to participant support needs, and how these decisions interact with the management of financial sustainability risks within the Scheme.

First, this submission examines the role of allied health reports and disability evidence, in informing NDIS funding decisions. Allied health evidence is a critical mechanism for translating functional capacity into recommendations for proportionate, reasonable, and necessary supports, both in Australia and internationally. Where such evidence is excluded, inconsistently weighted, or systematically discounted in decision-making, the result is not cost containment but increased downstream expenditure through plan breakdowns, crisis responses, reassessments, reviews, and appeals. This submission highlights that there has been evidence, spanning 5 years plus, that internal NDIS administrative processes, namely the process of utilising assessment scores to assign 'functional levels' and Typical Support Packages, have been key factors in participant plan inflation and contributed to avoidable cost escalation, and impacted Scheme sustainability. These processes have undermined individualised planning, embedded impairment-bias, side-lined health professional disability evidence, and increased distress and uncertainty for participants due to frequent unsuitable support packages. There is a very high risk that these same issues are on the brink of replication under NDIS New Framework Planning.

Secondly, the submission addresses the lack of adequate upstream safeguarding within NDIS administration, particularly at the points of access, assessment, and planning. OTSi observes that insufficient upstream safeguards, including unclear evidentiary standards and limited transparency in decision-making, have exacerbated financial sustainability risks while incurring significant human cost. These systemic gaps have increased the likelihood of participant harm, escalated support needs, and crisis-driven expenditure, placing pressure on both participants and the Scheme.

This submission concludes that current reform proposals risk repeating and entrenching past systemic mistakes. Administrative reliance on automated, impairment-based, assessment-score based or algorithmic decision making is not a proxy for triangulated, informed, participant provided disability evidence, including self-report, carer report, and occupational therapy evidence and reports. Combined with very tightly restricted appeal rights, this approach would constitute a safeguarding risk and perpetuate an administrative **failure of rationality** within the NDIS New Framework Planning.



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Summary of Recommendations

1. The Committee should recommend that the NDIA recommit to a contemporary social model of disability, consistent with the original intent and vision of the NDIS, and establish the administrative systems, workforce capability, and governance structures required to operationalise functional capacity and support need in planning and funding decisions, with the explicit objective of supporting an ordinary life for eligible Australians living with disability.

2. The Committee should scrutinise automation, algorithmic planning, Typical Support Packages, stated supports, funding periods, and impairment-based processes under the current and proposed New Planning Framework to assess their impact on decision making, funding accuracy, cost-effectiveness, participant safeguarding, transparency, and alignment with individual support needs, including the risks of substituting administrative proxies for evidence-based decision-making.

3. The Committee should recognise allied health expertise, particularly occupational therapy, as central to NDIS decision-making, and recommend that the NDIA formally embed this expertise in New Framework Planning, Support Needs Assessments, and evidentiary standards, acknowledging the person-centred, regulated, professional manner in which allied health evidence translates functional capacity into tailored support need recommendations.

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ABOUT THE OCCUPATIONAL THERAPY SOCIETY FOR HIDDEN AND INVISIBLE DISABILITIES

OTSi is a national society whose purpose is to enable occupational therapists who work alongside people with invisible and hidden disabilities, to reduce barriers to full participation as active citizens of Australia. OTSi has a strong voice in systemic advocacy and policy direction, as well as enabling individuals to build better lives. Currently, over 70% of OTSi members identify as having a disability and/or as carers. OTSi is a formalised organisation arising from the NDIS Occupational Therapy Community of Practice, a community comprised of over 11,000 occupational therapists. Occupational therapists play a fundamental role within the NDIS through disability evidentiary report provision, and are on the front-line delivering building capacity, therapeutic support, and working with participants towards their goals.

1. Functional Capacity as a Foundational Construct of the NDIS

Functional capacity is a core construct underpinning both eligibility and support need within the NDIS. Its centrality reflects the Scheme's deliberate alignment with contemporary disability policy, particularly the World Health Organization's International Classification of Functioning, Disability and Health (ICF).

The ICF framework represents a non-medical, biopsychosocial model of disability that focuses on what a person can do in their real-world environment, rather than diagnosis alone. This intentional policy choice distinguished the NDIS internationally as a bold and progressive disability insurance scheme, moving beyond impairment-based and welfare models toward a functional, participation-focused approach.

This design choice should be commended. It positioned Australia as a global leader in disability reform and embedded the principle that public resources should be allocated based on individual functional impact of disability, and arising disability support need.

However, there has been long-term administrative challenges in operationalising the construct, which have had impact for NDIS participant access to support, safeguarding, and scheme sustainability. Further, legislation change implemented in 2024 and proposed administrative reforms through the NDIS New Planning Framework indicate a regression toward reductionist, impairment-based approaches. This departure from the original vision undermines both equity and efficiency, weakens the capacity to tailor supports, and diminishes the Scheme's ability to allocate funding fairly and cost-effectively.



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2. Systemic Challenges in Operationalising and Measuring Functional Capacity, and Arising Support Needs

Despite its centrality, the administration of the NDIS has frequently had difficulty in meaningfully engaging with, understanding, and operationalising the construct of functional capacity.

While the NDIS Act defines functional capacity broadly, Scheme administration has frequently relied on unsuitable proxy processes (e.g. Access lists, 'functional levels', and using assessment scores to calculate Typical Support Packages) rather than a standard approach to sourcing and evaluating evidentiary documentation on functional capacity, and arising disability support needs.

For example, the NDIS Access Lists are administrative lists of medical conditions that the NDIA has treated as automatic access lists. They represent an administrative shortcut that displaced, rather than resolved, functional assessment. While expedient, they undermined legislative intent, distorted cost modelling, weakened safeguarding, and contributed materially to Scheme sustainability concerns. They form diagnosis-based gateways to Scheme entry, enabled by internal policy and guidelines rather than the Act or legislative instruments. Combined with an absence of funded support to apply for the NDIS, they create inequity of access. The NDIS Review recommended "*Existing access lists should be removed and automatic access replaced with streamlined evidence requirements*" (see Action 3.8, p.91)¹.

Concerns regarding NDIS reliance on 'functional levels' generating Typical Support Packages as a proxy for tailored, individualised support plans, and the very significant implications for Scheme sustainability, are detailed in Section 7 and Appendix 2.

These administrative proxies have had direct implications for access decisions, funding precision, safeguarding, and overall Scheme sustainability. The long-term financial implications of this approach are significant. .

Further issues in administratively operationalising functional capacity as a construct include:

- reliance on unqualified or under-qualified workforces to make complex determinations around support needs arising from participation and function-focused disability evidence;
- limited Scheme infrastructure and information management systems capable of storing, interpreting, and applying disability evidence.

Further, many participants may now face eligibility reassessment due to the absence of defensible eligibility evidence. This may occur at a time when participants have limited flexibility within plan funding to source disability evidence, a consequence of the NDIS Amendment Act 2024 (Section 10, Section 33, combined with operational guidelines rendering therapy support 'stated' in plans²), creating further inequity.

The 2021 Independent Assessments proposal implicitly acknowledged these systemic weaknesses. However, the proposal was poorly designed and insufficiently co-designed with the disability and allied health sectors. Widespread concerns regarding validity, participant harm, and trauma led to its abandonment³. This failure does

¹ [Working together to deliver the NDIS | NDIS Review](#)

² [Letter NDIA CEO Stated Supports 08052025 \(1\) \(1\).pdf - Google Drive](#)

³ [Independent Assessments – Parliament of Australia](#)



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not negate the need for robust decision making based on solid evidence; rather, it demonstrates the risks of excluding sector expertise from policy design.

The NDIS Review repeatedly identifies that poor decision-making driven by inadequate assessment of functional capacity, and arising support needs, increases participant harm and drives higher Scheme costs, and recommends that assessment processes allow for evidence from a range of sources, including treating professionals (NDIS Review, pp. 90–105).

3. The Assessment of Functional Capacity, and Arising Support Needs

Both Australian and International evidence consistently demonstrates that robust health professional evidence is fundamental to accurately identifying disability support needs, and preventing risk of harm⁴. Across health and disability systems, health professional-led assessments are shown to improve detection of unmet needs, reduce avoidable adverse events, and support safer, more effective planning for people with disability⁵. Multidisciplinary health professional input is particularly critical for individuals with complex or fluctuating needs, enabling deep consideration of functional capacity, health risks, and environmental factors⁶. Frameworks such as the World Health Organization's International Classification of Functioning, Disability and Health (ICF) further reinforce the central role of trained health professionals in translating clinical and functional evidence into appropriate supports⁷. Without adequate professional assessment and evidence, systems risk underestimating need, misallocating supports, and increasing the likelihood of harm, preventable deterioration, or system failure⁸.

Disability evidence is provided by a broad range of contributors, including medical practitioners, allied health professionals, disability workers, advocates, and carers. The assessment of functional capacity and the translation of function into support need have, in practice, fallen predominantly to the profession of occupational therapy.

Functional Capacity Assessment reports, documenting both functional capacity and arising disability support needs, conducted by occupational therapists have been routinely requested by the NDIA since Scheme inception, both formally through participant plans and informally through planning interactions. This form of evidence has been consistently requested of participants as they prepare for plan reassessment, as well as at the point of access to the Scheme to test eligibility.

The assessment of function, functional ability, and functional capacity, and the translation of these findings into tailored support recommendations, is a core competency of occupational therapy. This reflects an internationally recognised profession holding established expertise in evaluating how individuals function within their environments and how supports can mitigate risk and promote participation⁹.

⁴ <https://www.health.vic.gov.au/allied-health-workforce/allied-health-capability-framework-disability-and-complex-support-needs>

⁵ <https://www.ndiscommission.gov.au/about-us/what-we-do/our-research>

⁶ <https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams>

⁷ Reed, G. Operationalizing the International Classification of Functioning, Disability and Health in Clinical Settings. <https://doi.org/10.1037/0090-5550.50.2.122>

⁸ Health Information and Quality Authority (2024) Scoping review to inform standards for assessment of need. Dublin, Ireland [Scoping review to inform standards for assessment of need](#)

⁹ [Homepage | WFOT](#)



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4. Lack of Engagement with the Sector Responsible for Providing Evidence on functional capacity and arising support needs

The NDIS has always relied on external disability evidence to understand the functional impact of disability for individuals, for both access decisions and decision making around funded reasonable and necessary supports, as part of an approach that aimed to individualise support packages. ANAO data citing 2021-2022 internal audit show that participant-provided disability evidence was reviewed by planners at 92% of participant plan reassessments¹⁰.

Despite this reliance, the NDIA has not meaningfully engaged with the allied health sector largely responsible for producing this evidence on how it can best be structured, standardised, and utilised to support Agency decision-making.

There has been:

- A lack of clarity on evidentiary expectations to inform critical decision making
- no consistent templates or decision-focused frameworks for functional capacity assessment;
- minimal feedback on functional capacity and support need evidentiary provision from the Agency routinely soliciting it and most participants undergoing functional capacity assessments;
- and no sustained effort to collaboratively improve consistency and standards.

This absence of engagement represents a significant governance gap. The Agency is making high-value public spending decisions without ensuring that the evidence it relies upon is optimised for accuracy, safeguarding, and financial accountability.

The overall cost of functional capacity assessment reports for existing participants to the NDIS budget cannot be calculated as they are funded from a broader funding category that includes funding for therapeutic support, capacity building, and nuanced assessment such as addressing reasonable and necessary criteria for home and living, and assistive technology or home modifications. However, there are efficiencies that could have been developed through collaboration with NDIA as the funding body. For example, agreements on currency of the reports (anecdotally, participants have told us that some planners have said the reports are no longer current beyond 3 months) and when and in what circumstances updates are required. This would prevent participants needing to undergo unnecessary assessment; preserve funds to address therapy and capacity building needs; and bring cost-efficiencies. In addition, strategies to address real or perceived conflict associated with treating therapists providing disability evidence, could be developed and standardised.

Despite repeated requests spanning many years, including as recently as 2025, the NDIA has not meaningfully engaged with the occupational therapy profession, its professional peak body, the NDIS occupational therapy community of practice, or recognised community leaders to build processes around consistent standards for evidentiary requirements.

¹⁰ Australian National Audit Office (2023) Effectiveness of the National Disability Insurance Agency's Management of Assistance with Daily Life Supports. Section 2.62, p.41. Available here: *Effectiveness of the National Disability Insurance Agency's Management of Assistance with Daily Life Supports*



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This lack of engagement has persisted despite the Agency's reliance on OT evidence and OT bodies repeated offers of collaboration to improve evidentiary consistency, safeguarding, and financial outcomes.

Following a statement by then NDIA CEO at Senate Estimates on Feb 27th 2025, disclosing that NDIS planners do not always read allied health reports, OTSi responded with a letter highlighting the decision-making and safeguarding risks associated with neglecting to read participant-provided evidentiary reports¹¹. The CEO response received in response on March 3rd explained. *“We understand the importance of thorough and comprehensive reports; however, it is crucial that the content of these reports aligns with the guidelines and funding criteria established by the NDIS Act. This will enable our planners to make informed decisions efficiently and effectively.”*

In the absence of Agency leadership, the responsibility for establishing best practice in functional capacity assessment and identification of arising NDIS support need has fallen to the occupational therapy community. Tailored templates, guidance and guidelines have been developed by the NDIS community of practice and OTSi¹², through engagement with the NDIS Act and Rules rather than Agency guidance. This reflects a strong professional commitment to consistency, safeguarding, by the occupational therapy profession.

Support needs assessment forms part of the overall functional assessment process, and changes due to the NDIS Amendment Act 2024, now mean that NDIS supports can only be funded if proven to 'arise' from particular impairments recognised by the NDIS, rather than the sum of the person's disability impact¹³. This change has fundamentally shifted how disability evidence, including therapy reports, identify support needs, and without a strong administrative process enabling the inclusion of participant-provided disability evidence in new Support Needs Assessments showing individual support needs 'arising from' impairments, these needs may be unrecognised and unmet¹⁴. As yet, there is no published information on how impairment-based inputs to funding decisions will work, in policy, New Framework Planning Rules, or administratively – despite these changes set to commence in June this year. There are already anecdotal reports that participants are experiencing impairments 'dropping off' NDIS systems meaning recommended supports cannot be funded^{15 16}- this issue urgently requires administrative scrutiny.

The occupational therapy profession has not been included of the NDIA co-design process for support needs assessments and new framework planning 2024-2026.

5. Agency Reliance on Occupational Therapy Evidence in Reviews and Appeals

The Agency's reliance on occupational therapy evidence is further demonstrated in merits review processes. When NDIA decisions are appealed through the Administrative Appeals Tribunal (AAT) and now the

¹¹ OTSi Letter NDIA CEO 20250302 <https://drive.google.com/file/d/11uM8jfOFr34MxRfmpbk7Z1ZthMtZlBvX/view?usp=sharing>

¹² [OTSi Practice Guideline Functional Capacity Assessment and Support Need Assessments for Psychosocial Disability and Autistic Adults.pdf - Google Drive](#)

¹³ [Calling for a 'Whole of Person' approach to NDIS funding - 2SER - 2SER](#)

¹⁴ [NDIS SNA- The Essential Role of Allied Health Evidence - Google Docs](#)

¹⁵ P.6 in document listed no. 5 response to Questions on Notice to the NDIS Joint Standing Committee, [Additional Documents – Parliament of Australia](#).

¹⁶ NDIS Joint Standing Committee, Submission no. 5, (Villamanta), p.11. [Submissions – Parliament of Australia](#)



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Administrative Review Tribunal (ART), the Agency routinely engages independently sourced occupational therapists to provide expert evidence of functional capacity¹⁷.

This practice underscores the current systemic reliance on occupational therapy expertise to resolve contested decisions.

Recent data indicates that approximately 70 per cent of NDIS-related decisions reviewed by the ART overturn original Agency determinations¹⁸, frequently relying on allied health evidence, particularly occupational therapy, to correct earlier decision-making errors. This high overturn rate represents a substantial and avoidable cost driver for the Scheme. There is growing concern that limited appeal rights under New Framework Planning Rules comes at a time when appeal rights are most needed¹⁹ i.e. during implementation of a new, unproven Support Needs Assessment charged with determining disability support need and funding.

6. Demonstrated Budget and Governance Risk Arising from the Translation of Assessment scores to Participant Budgets

6.1. Assessment scores informing participant budgets as a proxy for individualised budgets based primarily on participant-provided disability evidence

Since 2021, NDIS administrative processes that attempt to translate assessment scores into disability budgets have been demonstrated to lead to unreliable outcomes, and limited ability to tailor plans to support needs.

Longstanding concerns raised by allied health professional groups relate to:

- over-reliance on NDIS planner-delivered screening tools to generate scores informing support budgets/ Typical Support Packages (TSP's);
- Generic plans, not adequately tailored to individual need
- The evidence for, and implementation of, 'functional levels' to categorise participants and inform TSP's.
- the reduction of comprehensive occupational therapy functional capacity assessments to single scores or score sets used to generate TSP's.

Such approaches are not reliable proxies for individualised assessment and have been shown to produce both significant under- and over-funding [See Appendix 2]. From a public finance and governance perspective, this represents a material risk to Scheme sustainability and accountability.

¹⁷ [National Disability Insurance Agency v Sutherland \[2026\] FCA 3](#)

¹⁸ ART Caseload Report For the period 14 October 2024 to 31 December 2024 [ART Caseload Report 2024-25](#) Retrieved

¹⁹ [NDIS plans will be computer-generated, with human involvement dramatically cut under sweeping overhaul | National disability insurance scheme | The Guardian](#)



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6.2. Historic unreliability of funding decisions based on the translation of assessment scores to participant budget

The process of assigning a 'functional level' through the NDIS planning process, as disclosed in the NDIA's response to a question from the NDIS Joint Standing Committee in May 2021²⁰, is a source of inequity. This revealed that planners determine 'functional levels' based on assessment scores categorised through a table of assessment tools, for each disability type, with the score ranges (cut-off scores) determining high, medium and low levels of function that are used as an input to determine funding level, or 'Typical Support Package' (TSP) (NDIA, 2021).

While the assessment list was then made public, the evidence base underpinning the assessments, and score ranges that determine high, medium and low functionality, were not released. It appears that a participant's functional 'level' is determined in one of two ways. Either an NDIS delegate, an administrative officer, will define a 'level' by asking the participant questions from the generic self-report tool used internally (presumably, the WHODAS-2), or, if the participant's report provided by their known allied health professionals happen to include assessments matching those on the Planner's list, those assessment scores will be used to determine functional 'level'. Clearly, this is an inconsistent process.

There were many assessments on the disclosed Planner assessment list, but only the WHODAS-2 is administered by NDIS Planners for the adult population. So, the system was based on the assumption that some of the assessment scores will derive from participants' known allied health professional reports, presumably in many cases occupational therapy functional assessments. This lack of transparency in how allied health reports and assessments are used created risk that these reports could be used in ways that they were not intended and likely resulted in potentially unreliable or inaccurate conclusions being drawn.

The July 2021 Quarterly Report Addendum document titled 'Analysis of reported level of function trend' detailed the 'level of function trends', and indicated that factors such as who completed the assessment, and how they completed the assessment, were key to the determination of 'functional level' (2021, p. 9)²¹. It highlights a greater apparent trend towards functional decline over 5 years, when the functional level is determined by the internal, generic assessment tools (the WHODAS-2 and the PEDI-CAT). The proportion of participants assessed as 'low' functioning grew by 15% using the internal assessment tool administered by NDIS Planners/delegates. There was a significantly lesser trend towards functional decline over 5 years when the functional level was determined by external disability specific assessment tools (presumably, assessments completed externally by allied health professionals using consistent, tailored assessment strategies). The proportion of participants assessed as 'low' functioning grew by 4% using disability specific assessment tools (2021, p. 9). There is considerable difference between a 15% increase in participants showing functional decline, and a 4% increase in participants showing functional decline²². This discrepancy raised doubt as to the validity of funding decisions informed by the same internal assessment process. At scale and over time, this process of assigning functional levels, had major implications for Scheme budgets, particularly as participant numbers grew.

²⁰ National Disability Insurance Agency. (2021). Answers to questions on notice, 18 May 2021, received 29 June 2021. Parliament of Australia: ACT, Canberra. Retrieved from <https://www.aph.gov.au/DocumentStore.ashx?id=c8d10eba-03e3-4ea4-9ff9-dbee778bfb4f>

²¹ National Disability Insurance Scheme. (2021). Addendum 1, NDIS Quarterly Report to disability ministers 30 June 2021. Parliament of Australia: ACT, Canberra. Retrieved from <https://www.ndis.gov.au/media/3476/download?attachment>.



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Fast forward to 2026 - the consistency, reliability and validity of the NDIA's system of assigning functional 'levels', require careful re-examination, particularly if these 'functional levels' are currently in use and will transfer to the NDIS New Framework Plans. The assessment scores to determine 'functional levels' appear to have been historically fed through to the NDIS internal systems via the Person Environment Circumstance Questionnaire, and, together with the ICAN, this questionnaire will form part of the NDIS Support Needs Assessment due to commence in July 2026²³.

6.3 NDIS 'Functional level' calculation for psychosocial disability

These concerns regarding utilising assessment scores to assign 'functional levels' include the potential disproportionate impact on people with psychosocial disability, as the publicly shared assessment-score inputs regarding functional level to autogenerate a TSP have questionable relevance and accuracy. For example, LSP-16 is an assessment tool included in the Psychosocial Disability Evidence form for NDIS access²⁴. The use of LSP-16 scores to generate 'functional levels' and cut-off scores for Typical Support Packages for people with psychosocial disability, was made public through the parliamentary inquiry to independent assessments in 2021²⁵. The LSP-16 was developed over 30 years ago within the clinical mental health system, and measures aspects of life skills across four subscales - withdrawal, self-care, compliance (with clinical care and medication), and antisocial behaviour²⁶. It was not developed to assess functional capacity or identify disability support needs, as they are defined within the *NDIS Act 2013*. Utilizing the LSP-16 in the NDIS context, raises concerns regarding construct validity, as well as concerns regarding the tool's capacity to inform support and funding allocation. Concerns have been raised regarding the implications of using LSP-16 for NDIS participants with psychosocial disability²⁷. The LSP-16 continues to be listed on the NDIS website as the preferred 'functional' assessment tool for both access and plan re-assessment purposes²⁸.

6.4 ANAO audit demonstrates extreme cost-variance linked to methodology utilising assessment scores to inform budgets

The Australian National Audit Office report *on the Effectiveness of the NDIA's Management of Assistance with Daily Life Supports* demonstrates substantial cost variance linked to planner-delivered assessment (WHODAS 2) methodology where they translate assessment scores to budget values²⁹. This budget-setting methodology has been demonstrated through ANAO analysis, as unreliable and likely frequently unreflective of participant support need. Further analysis of ANAO data suggests that the provision of external allied health disability evidence contributed to an estimated \$1.5 billion reduction in core support costs in 2022–23, by comparison to NDIA reliance on planner-delivered WHODAS. Analysis of ANAO evidence of extreme cost-variance linked to flawed methodology utilising assessment scores to inform budgets, is detailed in Appendix 2. The variances appear

²³ [Assessments and Budgeting co-design working group meeting July 2025 | NDIS](#)

²⁴ [National disability insurance scheme access: What evidence do you need to provide for psychosocial disability? - Tania Shelby-James, Amy Duncan, Megan Rattray, Richard Reed, 2023](#)

²⁵ National Disability Insurance Scheme. (2021). Addendum 1, NDIS Quarterly Report to disability ministers 30 June 2021. Parliament of Australia: ACT, Canberra. Retrieved from <https://www.ndis.gov.au/media/3476/download?attachment>.

²⁶ [Abbreviated Life Skills Profile \(LSP-16\)](#)

²⁷ Submission no. 28, and Supplementary Sub 28 (page 3), to the Inquiry to NDIA Capability & Culture here [Submissions – Parliament of Australia \(aph.gov.au\)](#)

²⁸ [Types of disability evidence | NDIS](#) Retrieved 29 Jan 2026

²⁹ [Effectiveness of the National Disability Insurance Agency's Management of Assistance with Daily Life Supports | Australian National Audit Office \(ANAO\)](#)



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attributable to the manner in which the assessment scores are utilised by the NDIS to determine 'functional levels and TSP's, and do not represent an actual variance in participant support need. This variance represents a high-risk budgetary inaccuracy that threatened the sustainability of the NDIS, and risks individual participant access to NDIS support tailored to their needs.

7. Evidentiary Exclusion as both a Safeguarding and Cost-Escalation Issue

The failure to meaningfully consider participant-provided allied health evidence raises significant safeguarding concerns. Decisions made without proper regard to disability evidence, including that provided by known allied health professionals increase the likelihood of:

- inappropriate or unsafe support models;
- under- or over-funding;
- exposure to exploitation and fraud; and
- deterioration in participant wellbeing.

Policy settings that limit access to allied health expertise, devalue professional evidence, or substitute standardised or algorithmic administrative processes for professional judgement undermine safeguarding objectives, particularly for people with psychosocial, hidden and invisible disabilities. For participants with psychosocial disability, cognitive impairment, or impaired decision-making capacity, allied health reports frequently identify foreseeable risks and recommend proportionate and preventative support and safeguards. When these warnings are not acted upon, harm is not accidental but predictable.

These risks are illustrated in the case of 'Jason' (see Appendix 1, Case Study 'Jason'), where repeated occupational therapy recommendations regarding support needs, decision-making support requirements, exploitation risk, and the need for safeguards were documented and escalated but not reflected in NDIA planning decisions.

From a financial sustainability perspective, the absence of upstream safeguards in disability evidentiary use does not reduce risk, instead it displaces and amplifies it.

Poorly informed planning decisions create predictable downstream consequences, including:

- rapid depletion of plan budgets;
- increased complaints, reviews, and appeals;
- crisis-driven plan variations;
- reliance on acute health, housing, and statutory systems; and
- heightened exposure to fraud and/or exploitation.

As demonstrated in the case study, these dynamics can result in higher lifetime Scheme costs despite increased expenditure, fundamentally undermining the insurance logic of early, preventative investment.

Fraud prevention must be considered from an upstream safeguarding perspective. Lack of regard for participant-provided disability evidence including allied health reports, is one factor that escalates the risk of participant



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exploitation. A further factor that is of relevance to this Committee, is broader policy decisions that create both human and administrative risk once operationalised. For example, in late 2021, the NDIA published a new SIL Operational Guideline. The NDIA maintained this was not a change of policy, just “clarification” of existing policy. However, a number of clear changes were noted by the disability sector. Following release of the OG, the pattern of SIL funding by the NDIA dramatically changed and this was evidenced by data from consecutive Quarterly Reports. The changes led to safeguarding implications for participants. The combined change in policy and resulting funding patterns, disproportionately (sometimes catastrophically) impacted participants with psychosocial disability³⁰. Consecutive NDIA Quarterly reports, since Q3 2021-2022 through to currently available data, have shown a clear drop in funded SIL across all disability types, and most significantly for psychosocial disability – where there has been significantly reduced access to (more costly) formal SIL. While not clearly captured in the data, there was a shift to ‘flexible core’ funding being funded in lieu of formal SIL funding. This meant many participant’ plans included large sums of ‘flexible core’ funds to cover home and living supports, in lieu of more regulated (and costly) formal SIL funding. Predictably, a lack of accompanying upstream safeguarding process made them a target for unscrupulous providers. This policy change was likely a significant factor in the surge of participant exploitation and fraud seen from 2022-2025. In case study ‘Jason’, this is precisely what occurred. This same cohort, utilising ‘flexible core’ funds to cover home and living solutions, are now at extremely high risk of housing loss, and homelessness, due to the very high rates of NDIS funding cuts taking place at the same time as Section 33 funding periods are applied to participant plans³¹.

The NDIS Review final report explained that *Poor planning decisions can lead to increased costs over time.*” (p. 104) and *“Reactive responses to crises are more expensive than early, well-targeted support.”* (p. 105) and *“The Scheme is currently bearing costs that could be reduced through better assessment and planning.”* (p. 105) and *“Improving decision-making quality is essential to the long-term sustainability of the Scheme.”* (p. 103).³²

8. Conclusion - Implications for Scheme Sustainability and Reform

The evidence indicates that many of the NDIS’s current administrative and financial challenges stem from barriers to solid decision-making, that is grounded in high-quality disability evidence identifying foreseeable risk for individual participants. Practices such as reliance on assessment scores and TSPs to generate budgets, substituting professional judgement with proxy tools, narrowing supports by impairment category, and inconsistently considering allied health and occupational therapy evidence have already been shown in many instances to undermine participant safety, inflate long-term Scheme costs, and contribute to poor planning decisions, crisis-driven expenditure, and cost-shifting into health, housing, and justice systems.

Recent consultations with disability representative and carer organisations between October and December 2025 highlight widespread concern among disability representative and carer organisations regarding the New Planning Framework, particularly the proposed Support Needs Assessments and use of the I-CAN tool. Organisations reported a lack of clarity about assessment processes, assessor qualifications, applicability, timelines, and trauma- and communication-informed approaches. They questioned the suitability of I-CAN for funding decisions, citing concerns about validation, cultural safety, age appropriateness, ethics, and its ability to

³⁰ [NDIS participants 'kidnapped' and financially abused in boarding homes for people with disability, report finds - ABC News](#)

³¹ [Exclusive: One third of reassessed NDIS plans see cuts to funding | The Saturday Paper](#)

³² [Working together to deliver the NDIS | NDIS Review](#)



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recognise complex, progressive, or rare conditions. There were additional fears that reform could reduce transparency, bias budgeting decisions, displace allied health evidence, and weaken participant rights, including informed consent, access to reports, and appeal mechanisms. Many groups described the consultation process as tokenistic and called for genuine co-design, clearer rules, and a slower, safer implementation to prevent harm³³.

OTSi is particularly concerned that proposed reforms risk re-embedding the structural weaknesses that have already undermined Scheme sustainability. Standardised or algorithmic translation of assessment outputs into budgets³⁴, exclusion of longitudinal allied health evidence, rigid impairment-based funding, and reduced participant appeal rights³⁵ would not constitute reform but consolidation of known barriers to effective support need identification. For this reason, NDIS reform must proceed cautiously and deliberately. Notably, allied health professionals must be included in NDIS New Framework Planning co-design, going forward.³⁶ OTSi has proposed an alternative NDIS Support Needs Assessment model that would uphold participant choice of provider, ensure individualised assessment of support needs, reduce administrative complexity, and enhance cost-effectiveness³⁷.

OTSi urges the Committee to ensure that reforms strengthen the evidentiary foundations of decision-making, preserve a whole-of-person understanding of disability, and avoid repeating mistakes that have already compromised participant outcomes and Scheme sustainability. OTSi stands ready to contribute constructively to co-design processes that improve safeguarding, funding precision, and long-term outcomes for participants, the administration of the Scheme, and the broader public interest.

APPENDIX 1 Case Study: “Jason” (name changed) -when foreseeable risk goes unmanaged

Jason’s story

Jason is a man in his mid-30s living in metropolitan Victoria. He lives with severe and enduring psychosocial disability alongside cognitive impairment that affects his memory, insight, judgment and ability to make safe decisions. Day to day, this means Jason struggles to organise his life, understand complex information, and recognise when situations or people are unsafe. Navigating systems, contracts, budgets and money is overwhelming for him.

Jason wants stability. He wants to live safely, feel supported, and avoid hospital. He requires support to make decisions. Without this, he is at risk of exploitation, misinformation and poor-quality services. These risks are

³³ [NDIS new framework planning: what we heard summary report | Australian Government Department of Health, Disability and Ageing](#)

³⁴ [Did we learn nothing from robodebt? NDIS automation will put vulnerable lives at the mercy of machines | Georgia Van Toorn | The Guardian](#)

³⁵ [Most NDIS participants will lose external avenue to appeal funding amounts under new system, Senate estimates told | National disability insurance scheme | The Guardian](#)

³⁶ [NDIS SNA- The Essential Role of Allied Health Evidence - Google Docs](#)

³⁷ [Best-Practices-Support-Needs-Assessment-for-the-NDIS-OTSi-31012025-FINAL.pdf](#)



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well-documented, long-standing, and recognised by health professionals across mental health and disability systems.

Despite this, Jason was placed into an NDIS environment that assumed a level of autonomy and decision-making capacity he simply did not have.

What the evidence said, and why it mattered

Over several years, Jason's treating occupational therapist provided multiple functional capacity assessments and written risk reports. They clearly explained how Jason's cognitive impairment affected his ability to self-manage, understand provider roles, give informed consent, and protect himself from harm.

The OT repeatedly warned that without safeguards, Jason was at high risk of:

- misuse or rapid depletion of NDIS funds
- unsafe or inappropriate living arrangements
- provider-induced demand and coercion
- mental health deterioration and crisis
- escalation into hospital and statutory intervention

The recommendations were practical and preventative: Agency-managed funding, specialist support coordination, a structured housing solution, and clear separation of provider roles. Taken together, they formed a coherent plan to stabilise Jason's life, protect him from harm, and reduce long-term system costs.

This was foreseeable risk, clearly articulated, and preventable.

What happened instead

Despite this consistent allied health evidence, NDIA planning decisions did not implement the recommended safeguards. Jason was issued a plan with significant flexible funding and complex arrangements that he did not understand and could not safely manage.

Rather than relying on the detailed evidence already available, the NDIA substituted this with a planner-administered WHODAS assessment. This tool did not capture Jason's cognitive disability, impaired decision-making, or safeguarding needs. As a result, his capacity was overestimated and risk was underestimated.

The outcome was predictable. Flexibility without protective structure became a liability rather than a support.

When risk becomes harm

Without safeguards in place, Jason's situation deteriorated. He was placed in unsuitable and unsafe living arrangements. He experienced confusion about who was supporting him and why. He was exposed to restrictive practices without appropriate authorisation. His mental health declined.

Eventually, Jason was involuntarily hospitalised and placed on a Community Treatment Order. He ultimately required very intensive NDIS supports to restore functional capacity and stabilise his living situation.

This was not an unexpected crisis. It was the realisation of risks that had been clearly identified years earlier.



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Policy implications

Jason's experience highlights a critical policy failure: when allied health evidence identifying foreseeable risk is ignored or overridden, the NDIS shifts from prevention to crisis response. This does not save money. It escalates NDIS costs, harms participants, and pushes pressure onto hospitals, mental health services and statutory systems. These are the failures to act early, when intervention is most effective and least costly.

Jason's case shows that individualised funding only works when it is risk-adjusted, evidence-led and safeguarded; and supported-decision-making supports are in place when needed. Ignoring allied health evidence did not preserve Jason's autonomy - it removed his safety net. And the harm that followed was both foreseeable and preventable.

Appendix 2: ANAO Evidence of Cost Variance Linked to Assessment Methodology

This example highlights the limitations of both the use of planner-delivered functional screening tools, and the reduction of functional capacity and support needs assessments to single scores as 'inputs' to generate functional levels informing Typical Support Packages (TSP) for NDIS participants.

Evidence that the use of (largely NDIS planner delivered) World Health Organisation Disability Assessment Scale 2 (WHODAS) assessments pose risks to the financial sustainability of the NDIS, has been identified by the recent ANAO audit-report to the Australian Auditor General on *Effectiveness of the NDIA's management of assistance with daily life supports report* (June 2023)

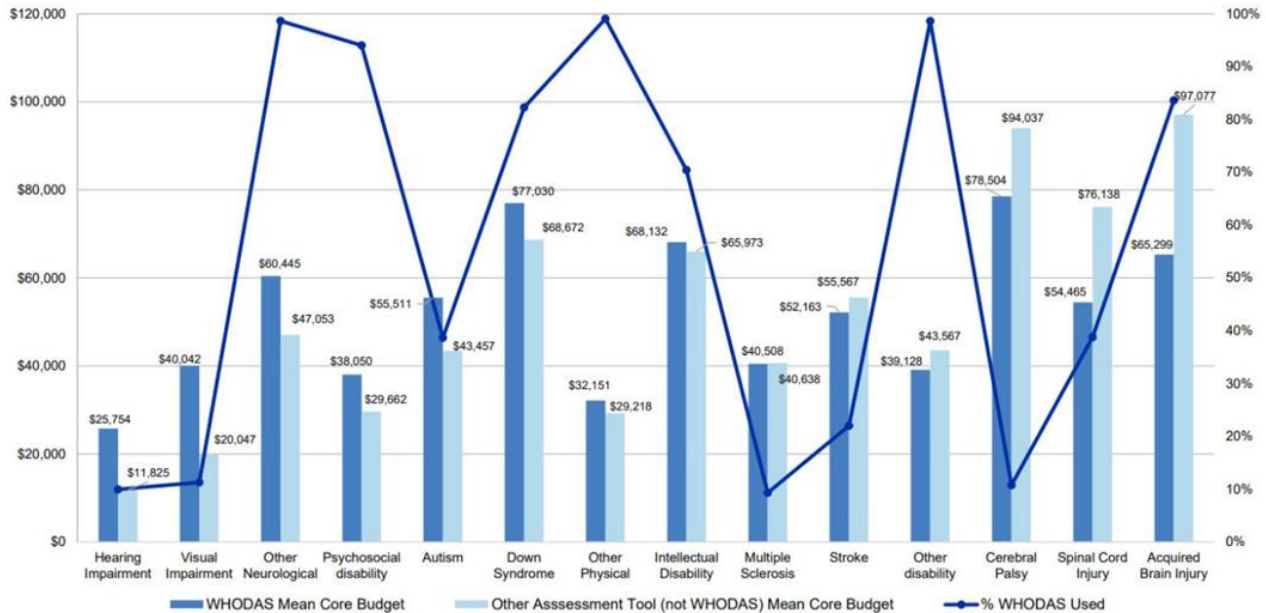
The ANAO report evidences the funding variances between using (largely planner delivered) WHODAS, and occupational therapy functional capacity assessments (OT FCA)/health professional reports*, respectively. The variances appear attributable to the manner in which the assessment tools scores are utilised by the NDIS, and do not represent an actual variance in participant support need. [See ANAO analysis of NDIA data, June 2023 Fig 2.1, p. 39 & copied below in Fig 1].



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Fig 1: ANAO analysis of NDIA data, June 2023 Fig 2.1, p. 39 [7]

Figure 2.1: Assistance with Daily Life (ADL): WHODAS assessment tool usage and average core supports budget 2021–22, relative to other assessment tool, by disability



Note: ADL is included in core supports budget (see paragraph 1.7). Analysis includes plans for participants aged 17 years or older approved in 2020–21 and 2021–22, and expenditure greater than zero. Excludes plans less than one month duration and groups with less than 1000 plans: Development Delay, Global Development Delay and Other Sensory/Speech. High usage of WHODAS is expected as the preferred tool for Other Neurological, Other Physical and Other Disability (see Appendix 3).

Source: ANAO analysis of NDIA data.

Using the average core support budgets identified by ANAO (Fig 1) and applying these to current Scheme numbers and assuming every participant had a plan re-assessment within the financial year, a 100% use of WHODAS would lead to an estimated total core-support cost of \$28 billion and 100% 'other' assessment tool (OT FCA/health professional) would lead to an estimated total core-support cost of \$25 billion, for the financial year 2022–2023. This is an estimated cost-variance of approximately \$3 billion for the FY (Fig 2) attributable to assessment score method**, **with no actual difference in participant support-need**. This figure represents an 11% variance within the then overall NDIS support budget of \$35.1 billion, and is an average variance of \$6111 per participant (Fig 2). Note this is for core-support budget alone, not total support budget, as the ANAO focused only on core-support funding within their 'assistance with daily life supports' scope.

The ANAO report cites the following examples (p.38):

- “for adult participants with autism as a primary diagnosis, WHODAS was used for 39 per cent of plans, resulting in 28 per cent higher average funding for core supports of \$55,511, compared to \$43,457 where another tool was used.”
- “Conversely, for participants with an acquired brain injury, WHODAS was used 84 per cent of the time, but resulted in average core supports funding of two thirds of that based on another tool, in most instances being the Care and Needs Scale (CANS).”

A further example, for psychosocial disability, the ANAO report highlights an average variance of \$8388 for core-support per participant plan, depending on which input is used – (largely planner delivered) WHODAS or OT FCA/health professional report (Fig 1). This potential absolute variance could amount to \$520,056,000 p.a., over half a billion dollars, when estimated for the 62,000 participants living with psychosocial disability - **with no actual difference in participant support-need**. For autism, the average variance per plan is \$12,504. For spinal cord injury, the average variance for core-support is a whopping \$21,673, per participant plan (Fig 1).



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Further attempts to extrapolate data from the ANAO graph (fig 2.1 p.39) (See Fig 2), examining net variance, reveals that OT FCA/health professional reports offering assessments other than WHODAS, were utilised in approx 45% of total plan re-assessments during FY21-22. Applying the variances identified in the ANAO audit to current Scheme participant numbers & FY22-23, the average core support plan value when (largely planner delivered) WHODAS was utilised as an input to TSP, by comparison to OT FCA/health-professional assessment, would be \$53,879 compared to \$47,768, an average difference of \$6,111 per participant plan for core-support across all disability types.

In other words, the provision of OT FCA/health professional reports for plan-reassessment, preventing the need for reliance on WHODAS for 45% of participants, likely led to an estimated NDIS core-support cost-‘saving’ of \$1,446,022,708, a figure close to \$1.5 billion, for the financial year 22-23. While this is a budgetary ‘cost-saving’, it is not a true ‘saving’ as in some cases, it may represent an inappropriate reduction of needed daily living supports for some participants. It is unknown whether there was an overall plan-reduction for these participants, as the impact on other budget categories, such as capacity building, was not analysed by ANAO.

**OT FCA is the main source of functional assessment submitted by NDIS participants at plan re-assessments, while other allied health and medical reports may comprise a small proportion also. ** The estimates does not include additional factors used to generate TSP’s as this information is not in the public domain e.g. variables, such as age and geographical location, which may contribute to the differences. Also, the estimate does not consider variables introduced by use of Paediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT) for children up to age 16, as this was not published within the ANAO report.*

Fig 2: Core Support net variance, assuming current scheme numbers and variance as per ANAO calculation FY21-22 - WHODAS compared ‘other’ i.e. OT FCA/health professional

Disability	Number of Participants	Budget		Total Budget		% WHODAS Used		Budget
		WHODAS	Other Tool (not WHODAS)	WHODAS	Other Tool (not WHODAS)	WHODAS	Other Tool (not WHODAS)	WHODAS by % Used
Hearing Impairment	26,507	\$ 25,754	\$ 11,825	\$ 682,661,278	\$ 313,445,275	15%	85%	\$ 368,827,675
Visual Impairment	10,158	\$ 40,042	\$ 20,047	\$ 406,746,636	\$ 203,637,426	15%	85%	\$ 234,103,808
Other Neurological	22,442	\$ 60,445	\$ 47,053	\$ 1,356,506,690	\$ 1,055,963,426	98%	2%	\$ 1,350,495,825
Psychosocial disability	62,011	\$ 38,050	\$ 29,662	\$ 2,359,518,550	\$ 1,839,370,282	94%	6%	\$ 2,328,309,654
Autism	214,800	\$ 55,511	\$ 43,457	\$ 11,923,762,800	\$ 9,334,563,600	39%	61%	\$ 10,344,351,288
Down Syndrome	no data	\$ 77,030	\$ 68,672	\$ -	\$ -	82%	18%	\$ -
Other Physical	19,961	\$ 32,151	\$ 29,218	\$ 641,766,111	\$ 583,220,498	99%	1%	\$ 641,180,655
Intellectual Disability	100,692	\$ 68,132	\$ 65,973	\$ 6,860,347,344	\$ 6,642,953,316	70%	30%	\$ 6,795,129,136
Multiple Sclerosis	10,337	\$ 40,508	\$ 40,638	\$ 418,731,196	\$ 420,075,006	10%	90%	\$ 419,940,625
Stroke	8,967	\$ 52,163	\$ 55,567	\$ 467,745,621	\$ 498,269,289	22%	78%	\$ 491,554,082
Other disability	8,341	\$ 39,128	\$ 43,567	\$ 326,366,648	\$ 363,392,347	97%	3%	\$ 327,477,419
Cerebral Palsy	17,680	\$ 78,504	\$ 94,037	\$ 1,387,950,720	\$ 1,662,574,160	10%	90%	\$ 1,635,111,816
Spinal Cord Injury	5,895	\$ 54,465	\$ 76,138	\$ 321,071,175	\$ 448,833,510	38%	62%	\$ 400,283,823
Acquired Brain Injury	18,045	\$ 65,299	\$ 97,077	\$ 1,178,320,455	\$ 1,751,754,465	84%	16%	\$ 1,270,069,897
	525,836			\$ 28,331,495,224	\$ 25,118,052,600	Av 55%	Av 45%	\$ 26,606,835,701
		Variance						
excludes:		Per person		\$ 53,879	\$ 47,768			\$ 50,599
Global developmental	14,926	Avg per person var			\$ 6,111			
Other sensory/speech	2,072							
Developmental delay	67,558							
Total	610,392							
Variance	110							1,446,022,708

While the cost-‘saving’ attributable to OT FCA/health professional assessment is no doubt viewed favourably from an NDIS budget perspective, the practice of minimizing comprehensive health-professional reports by extrapolating a single assessment score from a particular tool as an input to a TSP system to inform plan-budget, is highly inappropriate and represents a misuse of health and allied health reports, including occupational therapy functional capacity assessments (OT FCA).



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The ANAO audit report states that the NDIA had not assessed the impact of its over-reliance on WHODAS, including whether it may be distorting plan funding outcomes for participants overall, or for certain participant cohorts.