OTSi Response to Nous Consulting Group

NDIS Early Childhood Intervention Market Consultation

Introduction

OTSi welcomes the opportunity to contribute to the Nous Consulting Group project to develop an evidence-based view of the current NDIS Early Childhood Intervention (ECI) market composition and analyse the implications of related reforms on this market.

OTSi supports the objectives of strengthening early identification, community-based supports and collaboration across health, education, disability and community systems. However, we are concerned that market reform is progressing at considerable speed without sufficiently robust modelling of the population need it will be required to meet. Broad sweeping 10% cuts to NDIS therapy budgets by Ministerial Support Determination due to commence in October, have not been modelled for participant nor market impact.

This is particularly important in the current environment. Families are experiencing significant cost-of-living pressures, while schools, early childhood services, health and mental health systems are already under considerable strain. At the same time, substantial numbers of children with autism, developmental delay and other disabilities are expected to experience changes to their access to the NDIS and supports funded under NDIS.

In this context, it is critical that reform does not begin from the question of what services can be commissioned within a constrained funding envelope, but from the question of what children and families need, and what system is required to meet that need. The threshold for NDIS access is central to the conversation around market reform, and must be defined before markets can be accordingly stewarded.

OTSi's response is informed by four interconnected principles applicable to the NDIS and broader ECI system: **population need must come before market design; equitable access to targeted intervention must be protected; Australia's existing specialist workforce and ECI ecosystem must be retained; and quality must remain the organising principle of reform.**

1. High-quality ECI

What does high-quality ECI service delivery look like in practice, and what factors currently support or constrain your ability to deliver it?

High-quality ECI is individualised, family-centred, trauma-informed, neurodiversity-affirming and developmentally appropriate. It is grounded in the child's real life and recognises that disability may have different functional impacts across environments, relationships and contexts.

The National Best Practice Framework for Early Childhood Intervention (Moore et al., 2025) provides an important foundation, describing high-quality intervention as family-centred and strengths-based, delivered in everyday settings, coordinated around the child and family, provided by appropriately qualified and experienced practitioners, and evidence-informed with embedded outcome measurement.

High-quality ECI should not be understood as making a child "more compliant". Its purpose should be to support children's autonomy, participation, communication, safety, development and quality of life, while supporting families to understand their child's needs and respond effectively as those needs change.

Early intervention should help parents and caregivers understand not only their child's current presentation, but how their needs may develop and change, and how the child and family can be supported across developmental stages. This should occur in a neurodiversity-affirming way, enabling caregivers to provide evidence-informed support while supporting longer-term growth, development, autonomy and participation.

This requires practitioners to understand the whole child, including their sensory and interoceptive profile, communication style and communication access needs, emotional and co-regulation needs, executive functioning, developmental profile, routines and daily occupations, physical and social environments, interests, strengths and preferences, and family circumstances and capacity.

Occupational therapy and other allied health are central to this work within the NDIS, and beyond

ECI is broader than therapy, and OTSi does not suggest that every child requires allied health intervention. However, children who require targeted intervention need access to appropriately qualified allied health professionals.

Occupational therapy is particularly relevant because it addresses the interaction between a child's capacities, their environment and their ability to participate in everyday occupations, including play, learning, self-care, family routines and community participation. Occupational therapists also contribute expertise in sensory processing and regulation, functional assessment, environmental modification and, where appropriate, assistive technology.

Speech pathology, physiotherapy, psychology, developmental education and other allied health professions similarly provide essential discipline-specific expertise.

There is a legitimate role for allied health assistants, therapy assistants, educators, peer workers and parent-mediated intervention within a well-designed ECI system. However, these approaches are not substitutes for specialist clinical intervention where it is required. Assistants and families require appropriate training, clinical oversight and supervision, and some children will continue to require direct intervention from specialist practitioners. Workforce substitution must not become a mechanism for responding to inadequate pricing or workforce shortages.

Individualisation is fundamental

No two families receiving ECI are the same. Children may have similar diagnoses or developmental profiles but very different functional needs, family circumstances, environments and goals.

Effective intervention therefore requires clinical assessment and reasoning. Strategies, programs and interventions may overlap, but their application, timing, intensity, grading and fading will differ substantially between children.

A highly standardised model may appear efficient, but risks failing precisely those children whose needs are more complex, less visible or less readily accommodated by generic programs.

ECI must also recognise family capacity

The NDIS and broader ECI system must not assume unlimited capacity within families to implement intensive intervention.

ABS data indicate that 84.3% of primary carers of children and young people with disability are female, while 61.6% provide an average of 20 or more hours of care each week[1]. This reinforces the importance of designing ECI systems that do not simply transfer additional coordination, care and intervention responsibilities onto families, particularly mothers.

Many families are balancing multiple children, disability-related needs, employment, medical appointments and significant costs not covered by disability funding. In this environment, expecting families to undertake intensive skills practice without adequate practical support is unrealistic. Appropriately funded NDIS support workers and other implementation supports can therefore play an important role in helping families generalise skills and reduce the burden of care.

2. Responding to reform

How is your organisation responding, or likely to respond, to disability ecosystem reforms, and what factors are shaping these decisions?

Reform must begin with population need

OTSi's principal concern is the **sequencing of reform**.

There is considerable merit in strengthening universal and community-based supports. However, Australia does not yet have a sufficiently clear picture of the population of children requiring ECI, the proportion requiring targeted intervention, the existing workforce, or the service infrastructure required to meet future demand.

[1] Australian Bureau of Statistics. (2024). Children and young people with disability, 2022. Australian Bureau of Statistics.

The appropriate sequence should be:

Population need → service need → workforce and infrastructure → funding → market design.

There is a significant risk that the current sequence is instead being driven by NDIS expenditure constraints, changes to eligibility and a transition of responsibility between governments.

This is particularly concerning given the pressure already experienced by mainstream systems. Schools, early childhood settings, health services and child and adolescent mental health services are all operating within constrained environments. It is not realistic to assume that these systems can absorb large numbers of children exiting the NDIS, who have specialised developmental needs, without substantial additional investment and specialist capacity.

Universal supports and targeted intervention are **complementary to a functioning. Accessible NDIS, not interchangeable**.

Equity of access to allied health is a fundamental issue

OTSi is particularly concerned about the risk of creating a two-tier ECI system.

If access to occupational therapy, speech pathology, physiotherapy, psychology and other specialised interventions becomes increasingly dependent on private payment, children from families with financial resources will be able to maintain access while children from families experiencing financial hardship will not.

This is not simply a market issue. **It is an equity issue.**

A child's access to developmentally important intervention should not depend on whether their parents can afford private fees.

The current cost-of-living crisis makes this particularly urgent. Families are already making difficult decisions about housing, food, education, health care and other essential costs. Requiring families to privately purchase specialist intervention risks embedding socioeconomic inequality into children's developmental opportunities.

Reform must also consider children outside both the NDIS and future Thriving Kids pathways

The reforms have largely proceeded independently of a broader review of early childhood health and developmental service delivery.

This creates a further risk for children who do not meet NDIS eligibility requirements but may also fall outside future Thriving Kids eligibility or service pathways/environments.

Population planning must therefore consider the whole population of children requiring developmental support, not simply the children eligible for one particular program.

3. Workforce

What workforce changes do you anticipate as reforms are implemented?

Australia's current ECI workforce is a substantial national asset.

The NDIS has contributed to a major shift of allied health professionals into private and community-based practice. As a result, Australia now has extensive local infrastructure and a significant pool of occupational therapists and other allied health professionals with specialist expertise in ECI.

This workforce cannot simply be assumed to remain available through reform – particularly when this reform proceeds without adequate inclusion of this workforce in consultation and market-focused reform.

Market design can determine which clinicians remain in ECI

A market may appear well supplied based on provider numbers while remaining functionally inaccessible to families seeking an appropriately skilled clinician who can respond to complexity and provide continuity.

Conversely, highly standardised programs, restrictive service specifications, inadequate pricing, excessive administrative requirements or commissioning arrangements accessible primarily to very large organisations may cause smaller specialist providers to reduce or cease their ECI involvement.

Providers will understandably move clinicians towards populations and funding streams where skilled work can be sustainably delivered.

The result could be that a reform intended to expand early support **actually reduces the number of experienced clinicians willing to work in ECI**.

The issue is therefore not simply service sustainability. It is the potential loss of clinicians who provide highly specialised intervention and who are also essential to supervising, mentoring and developing the next generation of practitioners.

Senior clinicians are essential workforce infrastructure

ECI requires skilled clinicians. Working effectively with a three-, four- or five-year-old autistic child with complex sensory, communication and regulation needs is not simply generic developmental support. It requires clinical reasoning, developmental expertise, disability knowledge and the ability to work relationally with the child, family, educators and broader team.

We must also develop the next generation of ECI clinicians.

A system that rewards only face-to-face billable activity while failing to recognise supervision, clinical preparation, collaboration, travel and professional development creates the wrong workforce incentives.

OTSi is concerned that poorly designed NDIS market reform could result in loss of experienced clinicians, reduced willingness of practices to employ graduates, increased productivity expectations and burnout, less family and educator collaboration, greater centralisation of services, reduced outreach and mobile intervention, and movement of clinicians into private-fee or other health sectors.

It could also progressively replace discipline-specific expertise with cheaper, more generic service models. Skill-substitution and the impact on both quality and outcomes for ECI, is a major risk in the current reform context.

A personal history of the workforce transition illustrates the risk

The experience of experienced occupational therapists is relevant to understanding this risk. Clinicians who have worked under earlier block-funded models have experienced systems where high clinical caseloads, limited senior supervision and organisational structures did not always support best-practice clinical practice.

Many experienced therapists subsequently established community-based practices following the transition to the NDIS, creating more flexible models of practice, stronger continuity for families, specialist clinical supervision and greater capacity to respond to individual need. These clinicians are not necessarily willing to return to highly management-heavy models that they have previously experienced as limiting clinical autonomy and quality.

Once this specialist workforce is lost, it is very difficult and time-consuming to rebuild.

4. Supporting the transition

What actions should governments prioritise to support market stability, continuity of supports and high-quality ECI services through transition?

Population modelling must come first

Government should undertake comprehensive population modelling of children requiring ECI, within NDIS and Thriving Kids, and establish transparent thresholds for access to both systems. This modelling ust explicitly include children with developmental delay, autism, neurodivergence and other disability.

This should establish not only the number of children requiring NDIS and ‘Thriving Kids’ support, but the proportion requiring targeted and specialised intervention, geographic distribution, workforce requirements and existing service capacity.

Existing infrastructure must be recognised

Government should map the existing ECI ecosystem, including occupational therapy and other allied health practices, their geographic distribution, specialist expertise, multidisciplinary capacity and relationships with families, education and other services.

The objective should not be to preserve every existing provider. It should be to ensure that reform decisions are based on an accurate understanding of what skilled capacity currently exists and what could be lost.

Market reform should not unintentionally (or intentionally) consolidate ECI

Small community-based providers often hold specialised knowledge, strong local relationships, niche neurodevelopmental expertise and continuity of care that larger organisations may not replicate.

Small organisations are not inherently less sophisticated than large NGOs. Many of Australia's highly experienced clinicians established community based practices following the decommissioning of state-based and block-funded services precisely because these models enabled more responsive and clinically appropriate practice.

Commissioning should therefore avoid unnecessarily high administrative thresholds, financial requirements or service-volume expectations that exclude high-quality small and medium providers.

Market consolidation should not be confused with quality. Nor should government assume existing providers will simply reshape themselves around whatever funding architecture emerges. Some will reduce services, diversify away from disability, or leave ECI altogether.

Maintain continuity across the NDIS and Thriving Kids

OTSi is concerned about fragmentation between the NDIS and Thriving Kids.

Where appropriate, providers should be able to work across both systems. A child should not have to change a trusted occupational therapist, speech pathologist or other clinician simply because the funding mechanism supporting the intervention has changed.

Continuity of clinician is particularly important for children with complex needs and for families who have already invested substantial time establishing therapeutic relationships.

Ensure outreach and natural-environment intervention remain viable

Intervention in natural environments is invaluable, but only if funding settings make it economically possible for skilled clinicians to deliver it.

Current pressures around travel reimbursement, pricing, administration and increasing non-billable workload can already make outreach difficult to sustain. There is a genuine danger that reforms intended to improve efficiency will instead drive therapy back into clinics because that becomes the only financially viable model.

That would be contrary to contemporary ECI principles.

Service viability affects whether providers can undertake home, childcare and kindergarten visits, accept families living further away, maintain lower-productivity early intervention caseloads, undertake multidisciplinary consultation, supervise new graduates and liaise with educators and other professionals.

These are part of delivering high-quality ECI.

A brief example: children with complex and less visible needs

The importance of specialist expertise is particularly evident for children with complex presentations involving combinations of generalised joint hypermobility or hypermobility spectrum disorders, developmental delay, hypotonia, ataxia, gastroparesis requiring partial or full enteral feeding, chronic fatigue, POTS, anxiety and twice exceptionality.

For these children, timely access to appropriately skilled clinicians is critical. Specialist expertise may be geographically dispersed, meaning families routinely access different professionals across multiple jurisdictions.

For example, a child living in Western Australia may see a local physiotherapist and psychologist face-to-face, an occupational therapist in New South Wales by telehealth, an exercise physiologist in Victoria by telehealth and a rehabilitation specialist in NSW annually. Another child living rurally in Queensland may access a local dietitian and physiotherapist, an occupational therapist interstate by telehealth and specialist services involving a five-hour round trip.

These examples demonstrate that provider numbers alone are a poor measure of market access. A market can appear well supplied while families cannot access the particular expertise their child requires.

Much of the specialist expertise in some complex and relatively low-prevalence conditions is concentrated in private practice, with only limited public specialist teams and lengthy waiting lists. Reform that privileges standardised or highly centralised models risks removing access to the very expertise required by these children.

Quality and outcomes must remain central

Reform should not design ECI around what is easiest to commission, administer and standardise.

The question should be what actually works for children and families, particularly children with complex, neurodivergent, hidden or invisible disabilities.

Meaningful ECI outcomes should extend beyond attendance, therapy hours, standardised scores or developmental milestones. They should include participation, autonomy, communication access, safety, regulation, functional independence where appropriate, family capacity, environmental fit, inclusion, relationships and the child's ability to participate in everyday life without unreasonable physiological or emotional cost.

This requires sufficient flexibility for clinicians to tailor intervention to the child rather than fitting children into predetermined service models.

Conclusion

OTSi supports the development of a stronger, more accessible and integrated ECI system. However, reform must be grounded in a realistic understanding of population need and the capacity required to meet it.

The central risk is that Australia designs an ECI market around what is easiest to fund, commission and administer rather than what children and families actually require.

There is an urgent need to model population demand before substantial market restructuring occurs; protect equitable access to targeted occupational therapy and other allied health; retain the specialist workforce and existing community-based infrastructure; and ensure that future models reflect contemporary evidence about high-quality, neurodiversity-affirming ECI.

Universal and community-based supports have an important role. They cannot, however, replace specialised intervention for children who require it.

Nor should the financial circumstances of a child's family determine whether they can access that expertise.

The objective of reform should be to ensure that every child can access the level and type of support their functional needs require - not simply the level of support that is easiest or cheapest for the system to provide.

A successful transition will therefore require population modelling, workforce planning, protection of continuity, equitable access to specialist allied health, preservation of diverse provider capacity and robust monitoring of outcomes and emerging unmet need.

Most importantly, government should monitor the market **during** transition, not wait until problems emerge. This should include provider exits and closures, waiting times, regional availability, workforce turnover, senior clinician retention, availability of appropriately skilled practitioners, continuity of clinicians, access for children with complex or less visible disability, family experience and functional and participation outcomes.

Provider numbers or headline workforce figures alone will not reveal whether children are receiving the right intervention from the right professionals at the right time.

The measure of a successful ECI reform is ultimately not the size or efficiency of the market. It is whether children and families can access high-quality, timely and equitable intervention that improves their participation, autonomy and lives.