

NDIS Evidence Advisory Committee Review into Exercise Physiology

Question 1 - support

Exercise physiology is an allied health profession that prescribes movement, exercise and physical activity to prevent and manage disease, injury and disability. Exercise physiologists are university-trained professionals. Exercise physiology aims to improve or maintain health status, function and independence.

Exercise physiology can include:

- *assessments of fitness, function and capacity*
- *supporting goal setting and creating exercise plans to help people with different*
- *health conditions when it is safe to do exercise checking what kind of exercise is best,*
- *making an exercise plan and making sure it is safe and works well for each person*
education in physical activity and lifestyle.

*Does the description above accurately describe what exercise physiology is and how it is used?
(please choose one)*

Yes

No, I want to change something (please say what you want to change and why):

The current description is overly generic and misrepresents the clinical nature of Exercise Physiology. It conflates therapeutic exercise prescription with general physical activity or lifestyle advice, failing to reflect the qualifications, governance, and evidence base that underpin Accredited Exercise Physiology practice.

Revised definition:

Exercise Physiology is a clinical allied-health profession that applies the science of human movement to assess, prescribe, and deliver structured, evidence-based exercise for the prevention and management of disease, injury, and disability. Within the NDIS, it focuses on building and maintaining functional capacity, independence, and participation through safe, measurable, and goal-directed interventions.

Accredited Exercise Physiologists (AEPs) are university-qualified, credentialed, and insured allied-health professionals who:

- Screen and assess physical capacity, functional status, and disability-related activity limitations;
- Prescribe and monitor exercise at appropriate frequency, intensity, and load to achieve safe physiological adaptation;
- Evaluate progress using objective outcome measures and adjust programs accordingly; and
- Provide education and behaviour-change support to promote long-term functional maintenance and independence.

AEPs are the only professionals qualified and insured to prescribe and deliver clinical exercise therapy for complex or high-risk populations. Their work directly supports the NDIS outcomes of capacity building, functional independence, and participation, consistent with Section 34 of the NDIS Act 2013 (reasonable and necessary supports).

Question 2 - disability group/population

Based on what we know so far, we think the people who might use exercise physiology in the context of the NDIS are:

- *Autistic people*
- *People with acquired brain injury*
- *People with cerebral palsy*
- *People with Down syndrome*
- *People with multiple sclerosis*
- *People with psychosocial disability*
- *People who have had a stroke*
- *People with spinal cord injury*
- *People with other neurological disabilities (i.e. Parkinson's Disease, brain injury, dementia).*

Both children and adults can access exercise physiology.

Do these groups cover all the people who may use exercise physiology in the context of the NDIS? (please choose one)

Yes

No, I want to change something (please say what you want to change and why)

The current list is incomplete and framed from a diagnostic rather than a functional perspective. Under the NDIS Act 2013, eligibility and funded supports are determined by functional impairment, not diagnosis. Grouping people by diagnostic category (e.g. “neurological disorders”) overlooks the diversity of functional limitations, exercise needs, and risk factors that require tailored clinical exercise prescription.

Exercise Physiology should be defined by functional need, not diagnostic label:

- Diagnostic information can assist with confirming the permanence of an impairment and guiding clinical risk management (for example, exercise precautions differ between multiple sclerosis, cerebral palsy, and spinal cord injury). However, diagnosis should inform how an Accredited Exercise Physiologist delivers therapy—not whether a person can access it.

Functional inclusion criteria:

- Exercise Physiology is clinically indicated whenever a participant's disability-related impairment limits one or more of the following domains:
 - Mobility, balance, or gait stability
 - Strength, endurance, or movement efficiency
 - Fatigue tolerance or autonomic regulation
 - Muscle tone regulation or coordination
 - Cardiometabolic health or exercise tolerance
 - Physical self-management capacity and participation in daily activities

This function-based approach ensures inclusion of all people with physical, neurological, musculoskeletal, metabolic, or psychosocial impairments—common or rare—whose functional capacity can be measurably improved or maintained through structured, clinically governed exercise therapy.

Such an approach aligns with Section 24 of the NDIS Act 2013 and upholds the Scheme's intent: to fund reasonable and necessary supports that build capacity, enhance participation, and deliver evidence-based outcomes.

Question 3 – Outcomes

Supports are used to achieve certain outcomes. These outcomes can be to improve people's life (provide benefit) or to reduce harm. We want to make sure the assessment examines outcomes that are important to people.

Based on what we know so far, we think exercise physiology aims to help with the following outcomes:

- *Physical function (mobility and gait, balance and coordination, reduced risk of falls)*
- *Physical health (fitness, strength, blood pressure, blood sugar levels)*
- *Spasticity and pain*
- *Stress, anxiety, mood and depressive symptoms*
- *Tiredness and sleep quality*
- *Cognitive performance, including memory, attention, and executive functioning*
- *Self-esteem and self-confidence*
- *Sense of autonomy and empowerment*
- *Physical activity*
- *Social participation*
- *Quality of life*
- *Support needs, such as decreased reliance on carers or reduced use of other funded supports.*

Are these the most important outcomes for people using exercise physiology? (please choose one)

Yes (you can provide additional comments if you want to, such as if some outcomes are more important to you)

No, I want to change the list (please tell us what you want to change and why, you could add something or remove something)

The listed outcomes are relevant but do not fully capture the measurable, long-term benefits of Exercise Physiology. Unlike many supports that aim to improve wellbeing indirectly, EP produces objective, evidence-based physiological adaptations that lead to sustained functional and psychosocial outcomes.

There is an overwhelming body of high-quality evidence across a wide range of disability presentations demonstrating that clinically prescribed exercise leads to measurable improvements in functional capacity, independence, and participation.

Exercise Physiology is a capacity-building therapy that uses structured, progressive, and load-managed exercise to achieve positive physiological adaptation—improvements in strength, endurance, balance, mobility, fatigue tolerance, and cardiometabolic health—which translate directly into gains in skills, independence, and participation. These changes are the foundation of capacity building and sustainable functional improvement.

AEPs deliver outcome-accountable therapy using validated, objective measures to quantify progress and refine programs in real time. This measurable, clinically governed approach

distinguishes EP from non-clinical or wellness-based interventions that lack standardisation, progression control, and accountability for outcomes.

In addition to the domains listed (physical, psychological, cognitive, and participation), EP delivers outcomes that directly support Scheme sustainability:

- Functional capacity and independence: measurable gains in mobility, daily-living performance, and community or vocational participation.
- Prevention of decline: maintaining function to delay reliance on higher-cost supports, hospitalisation, or aged-care transition.
- Self-management skills: improved exercise literacy, motivation, and adherence that promote lifelong functional maintenance.

In summary: Exercise Physiology is one of the most evidence-supported, measurable, and cost-effective capacity-building therapies within the NDIS. It builds and preserves functional capacity, supports independence and participation, and reduces future support needs—delivering outcomes that are quantifiable, durable, and aligned with the Scheme’s principles of sustainability and value for money.

Question 4 - Comparator

We will need to compare how well exercise physiology works alone, to how well it works in combination with other supports. Based on what we know so far, we think the most relevant supports to use with exercise physiology are:

- *Personal training*
- *Gym membership and access to exercise facilities*
- *Exercise classes*
- *Independent training*
- *Strength and conditioning coaches*
- *Using standard gym equipment*
- *Health, fitness or recreational activities in the community, other products and services (e.g. exergaming)*
- *Social/ community sports*
- *Other therapist or allied health professional.*

We chose these supports to compare with exercise physiology alone because they could be used to help carry out the exercise physiology plan.

If you have used or suggested something other than exercise physiology to achieve similar outcomes, please add it below. If exercise physiology was not available, are there other supports you would use or recommend? Please check if they are in the list above, and add them below if they are not in the list.

Are these the best supports to compare exercise physiology to? (please choose one)

Yes

No, I want to change something (please say what you want to change and why)

While the listed comparators provide context for activity-based supports, none deliver equivalent clinical scope, governance, or accountability to Exercise Physiology. The premise that other supports could “carry out” or substitute for EP is fundamentally flawed. Exercise Physiology is a stand-alone allied-health therapy—not a plan to be implemented by others.

Although some providers (e.g. personal trainers, strength and conditioning coaches, or allied health assistants) may deliver exercise, this is not clinical exercise prescription.

Accredited Exercise Physiologists (AEPs) operate under a recognised clinical governance framework, applying advanced understanding of anatomy, physiology, pathophysiology, pharmacology, and behavioural science to prescribe exercise that is safe, progressive, and targeted toward functional adaptation.

Non-clinical providers lack the expertise to assess and manage risk, interpret symptoms, or modify therapy based on medical or disability-related factors. When exercise for clinical populations is delivered outside AEP supervision, the result is predictable:

- Reduced therapeutic efficacy: sessions lack the load, progression, and individualisation required to achieve adaptation.
- Increased safety risk: absence of clinical screening and monitoring raises the likelihood of injury, fatigue, or adverse events.
- Higher cumulative cost: delayed or limited functional progress increases long-term support needs and healthcare utilisation.

Allied Health Assistants (AHAs) may support therapy under direct AEP supervision but cannot independently prescribe, progress, or monitor clinical exercise. Substituting AHAs or personal trainers for AEP-led services duplicates cost while reducing effectiveness and safety.

Community-based or recreational activities (e.g. gym access, classes, social sport) can promote participation but do not provide the clinical oversight, progression control, or outcome measurement required to produce capacity-building change. Relying on such supports in place of AEP-led therapy slows progress and increases long-term Scheme costs.

In summary: Exercise Physiology must remain a clinically accountable, stand-alone therapy within the NDIS. No other support offers the same combination of clinical reasoning, safety governance, and measurable outcomes. Substitution undermines both participant outcomes and the Scheme's value-for-money principles.

Use questions – the first question will be a branching question

Branching question

Do you use exercise physiology or provide it to someone else? (choose the most relevant)

I use exercise physiology myself

I have used exercise physiology, but I don't use it any more

I don't use exercise physiology, but I use something else to achieve the same goals

I have a family member who uses or has used exercise physiology

I care for someone who uses or has used exercise physiology

I provide or have provided exercise physiology to someone else or assist them to use it

I am a clinician or researcher who works in the field of exercise physiology

None of the above

Provider/clinician/researcher Role – these questions are shown if people answer that they provide the support, or are a clinician or researcher in the area of the support

Question 1 – length of use

How long should exercise physiology be used for? (please choose all that apply)

Less than 3 months

3-12 months

More than 12 months

Until a specific outcome is achieved (please specify)

Question 2– how often

How often should people who use exercise physiology receive direct or supervised services from an exercise physiologist and for how long each time for optimum results?

You could include things like:

- *The frequency with which exercise physiologists should provide direct support (for example to prescribe exercise and movement plans, monitor progress, support the implementation of exercise and movement plans)*
- *The frequency with which other trained or untrained people (for example, family members or carers) aim to help deliver the exercise and movement plan*
- *Typical session length.*

Please provide details.

It is not appropriate to prescribe a generic frequency or duration for Exercise Physiology.

The optimal therapy dose must be determined by the participant's functional presentation, capacity-building goals, and the specific physiological adaptations required—not by diagnosis or administrative limits.

Exercise Physiology is a clinical therapy, not an activity. Each program is individually prescribed and continuously adapted to elicit targeted physiological changes such as improvements in strength, endurance, mobility, balance, and fatigue tolerance. Achieving these outcomes requires repeated and progressive exposure to exercise at sufficient frequency, intensity, and volume to induce adaptation.

Because many participants have multiple concurrent goals targeting different physiological domains, therapy frequency must be scaled accordingly. The required dose therefore varies substantially between individuals and may involve multiple supervised sessions per week when clinically indicated.

Therapy frequency and duration are determined through clinical reasoning, guided by the following principles:

- The exercise dose must be sufficient to induce and sustain physiological adaptation—not merely maintain participation.
- Sessions must allow time for assessment, execution, monitoring, and adjustment to ensure safety and achieve measurable outcomes.

Reducing AEP involvement or substituting with non-clinical supports undermines effectiveness, delays progress, and increases overall Scheme costs.

Non-face-to-face time is integral for program design, data interpretation, provider communication, and documentation, ensuring therapy remains clinically accountable and outcome-driven.

In summary: Frequency and duration of EP must be guided solely by participant function, goals, and evidence-based practice, not arbitrary benchmarks. Exercise Physiology is a stand-alone, clinically governed therapy, and therapeutic dose must remain under the discretion of the treating Accredited Exercise Physiologist to ensure effective, safe, and sustainable outcomes.

Question 3 – Alternative q only for providers/clinicians/researchers on recommending the support.

In what circumstances would you recommend exercise physiology and why?

Exercise Physiology should not be limited to narrow circumstances. It is clinically indicated whenever a participant's disability, injury, or health condition restricts their ability to safely or effectively engage in exercise without professional supervision.

In these circumstances, an Accredited Exercise Physiologist provides the clinical expertise required to translate NDIS goals into structured, evidence-based programs that build or maintain physical capacity, functional skills, and independence.

EP should be recommended when a participant's goals involve:

- Improving or maintaining mobility and transfers (e.g. standing, walking, or functional movement);
- Building strength, endurance, or balance to enhance independence in self-care, community access, or employment;
- Preventing decline or secondary complications (e.g. deconditioning, fatigue, falls, contractures, or weight change);
- Increasing confidence and participation through structured, goal-directed exercise in a safe and clinically supervised setting.

Functional improvement in these domains requires individualised assessment, targeted prescription, and clinical monitoring—factors that can only be delivered under AEP supervision. Without this structured, capacity-building intervention, participants are at risk of functional regression, loss of independence, and increased long-term support needs, which undermines both participant outcomes and Scheme sustainability.

Question 4 – only for providers/clinicians/researchers – not recommend?

In what circumstances would you not recommend exercise physiology and why? (free text)

Exercise Physiology would not be recommended only in rare circumstances where a participant demonstrates full functional independence, clinical stability, and the ability to self-manage physical activity safely and effectively without supervision. In these cases, exercise participation is recreational rather than therapeutic, and measurable functional improvement has already been achieved and sustained.

Such participants no longer experience disability-related barriers to safe exercise and can maintain activity independently without risk of regression or injury. In these situations,

engagement in general community fitness or recreation settings may be appropriate, provided it does not replace or duplicate clinical therapy.

However, if there is any risk of decline, symptom fluctuation, or loss of capacity, or where unstructured activity fails to maintain outcomes, re-engagement with an Accredited Exercise Physiologist becomes clinically necessary to restore safety and prevent secondary complications.

This approach preserves the integrity of EP as a targeted, outcome-driven allied-health service—applied when disability-related impairments require clinical intervention, and concluded only once independence is safely achieved and sustainable.

Question 5 – who provides/assists

How should exercise physiology support be delivered (including prescription and delivery of the exercise and movement plan)? (choose all that apply)

By a qualified exercise physiologist only (they both prescribe and deliver the exercise and movement plan)

A qualified exercise physiologist should prescribe the exercise and movement plan, and the plan could be undertaken independently

A qualified exercise physiologist should prescribe the exercise and movement plan, and family members or carers could help to undertake the plan

A qualified exercise physiologist should prescribe the exercise and movement plan, and a different allied health professional could supervise the plan (for example, a therapy assistant)

A qualified exercise physiologist should prescribe the exercise and movement plan, and a different trained professional could supervise the plan (for example, a personal trainer)

I don't know

Other (please specify)

The level and mode of Exercise Physiology support must always be determined by the participant's clinical presentation, functional capacity, and safety requirements—not by cost or administrative preference.

For participants with complex, unstable, or high-risk presentations, an Accredited Exercise Physiologist must both prescribe and deliver the intervention directly. These presentations require real-time clinical decision-making, symptom monitoring, and load modification to ensure safety and measurable progress.

All exercise-based therapy for people with disability must remain under AEP supervision and accountability. Allied-health assistants, personal trainers, or other facilitators lack the qualifications, insurance coverage, and clinical reasoning to prescribe, progress, or monitor therapeutic exercise safely. Their role, where appropriate, is limited to supporting participation, not implementing or adapting the clinical plan.

The AEP retains full clinical responsibility for assessment, prescription, progression, and review. This governance ensures that all interventions are evidence-based, safe, and effective, and align with the participant's goals and disability-related needs.

Question 6 – safety

Are there any problems, safety issues or adverse events related to using exercise physiology that you have observed or know about? These could be short-term problems or long-term problems.

No

Yes (please provide details)

If this question has raised concerns please see the list of help lines and services on the last page..

No.

Exercise Physiology is a low-risk, clinically governed therapy when delivered by an Accredited Exercise Physiologist. AEPs are university-qualified allied-health professionals trained to apply evidence-based exercise safely for people with chronic health conditions and disability.

Through structured screening, assessment, and continuous monitoring, they identify and mitigate risk before and during therapy.

Adverse events are rare and typically minor, often related to pre-existing impairments, fatigue, or overexertion. These are minimised through progressive prescription, clinical reasoning, and adherence to professional standards of practice. AEPs operate under a national clinical governance framework, including mandatory insurance, documentation, and ethical accountability through Exercise & Sports Science Australia (ESSA)—consistent with the safety expectations of all regulated allied health professions.

In contrast, unqualified or unregulated providers (e.g. personal trainers, coaches, or support staff) operate without clinical oversight, contraindication screening, or liability protection, which significantly increases participant risk. Such providers lack the expertise to manage medical complexity, adjust for symptom fluctuations, or respond safely to fatigue, pain, or behavioural changes.

By maintaining direct AEP oversight, Exercise Physiology provides a safe, evidence-based, and accountable model of care that meets the NDIS requirement for supports to be effective, beneficial, and consistent with current good practice. Delegating or substituting EP with non-clinical supports increases the likelihood of injury, regression, and preventable hospitalisation—leading to poorer participant outcomes and higher long-term Scheme costs.

Question 7 – alternative supports

What other supports would you recommend if exercise physiology was unavailable, or instead of exercise physiology?

There are no true substitutes for EP-led therapy. When Exercise Physiology is unavailable, in-person allied health services remain the most clinically appropriate alternative, as they provide direct observation, load management, and safety oversight—all essential for people with disability or complex medical conditions.

Where unqualified or indirect supports attempt to replace AEP involvement, there is a significant increase in safety risk and a reduction in measurable outcomes. Unregulated providers cannot identify warning signs, monitor physiological response, or modify programs based on clinical presentation, exposing participants to preventable injury, regression, or medical complications.

Importantly, the push toward “alternative supports” often reflects insufficient NDIS funding for therapeutic exercise, rather than a lack of clinical options. Underfunding limits access to evidence-based therapy, leading to functional decline, higher care needs, and increased downstream Scheme costs through greater hospitalisation and loss of independence.

Question 8 - general context question

If there are specific circumstances where exercise physiology is or is not suitable for people, please describe them.

This could include things like

- *access to exercise physiology*
- *access to supports that aim to achieve similar goals*
- *access to other allied health professionals*
- *access to other exercise professionals*
- *cost factors (such as ongoing costs)*
- *where exercise physiology takes place (such as, at home, in a clinic or in a gym)*
- *how exercise physiology fits into a therapy or exercise plan, supervised or unsupervised*
- *how exercise physiology works alongside other supports, such as personal trainers*
- *age, gender, ethnicity or cultural factors*
- *who the person lives with or where they live, such as in a city or a remote area.*

You can tell us anything you think is relevant for the Evidence Advisory Committee to understand the support.

Exercise Physiology is suitable whenever a person’s disability, injury, or chronic health condition limits their ability to safely or effectively engage in physical activity without clinical supervision or tailored prescription. This includes people with complex mobility needs, neurological or musculoskeletal impairments, chronic pain, fatigue, cognitive or behavioural challenges, or mental-health-related barriers to participation.

EP is most effective when delivered face-to-face in a safe, accessible, and clinically governed environment. Direct supervision by an Accredited Exercise Physiologist enables real-time monitoring, feedback, and load adjustment, ensuring measurable, goal-driven outcomes while minimising risk of injury or regression.

EP is less suitable only where a participant demonstrates full functional independence and can safely self-manage exercise without risk of decline or injury. In these rare cases, community-based fitness or recreation may be appropriate but remain non-clinical and outside the NDIS therapy framework.

Context Example: Enable Fitness Centre (South Australia)

Enable Fitness Centre was established to address the absence of accessible, clinically safe environments for people with disability. Most mainstream gyms lack adaptive equipment, transfer space, hoists, or staff trained in complex-needs support. Specialised facilities such as Enable provide inclusive, disability-specific environments where participants can access evidence-based, outcome-driven therapy that promotes independence and participation.

Hundreds of participants use Enable’s EP services each year, consistently reporting measurable improvements in strength, mobility, confidence, and quality of life. Without NDIS funding for EP,

facilities like Enable would become unsustainable, leaving participants reliant on unsafe or ineffective alternatives such as community fitness programs or personal trainers.

The consequences of restricting EP access are predictable: functional decline, reduced participation, greater care dependency, and higher long-term Scheme costs. If the purpose of the NDIS is to fund supports that reduce future dependency and build capacity, then ongoing and adequate funding for Accredited Exercise Physiology is essential.

Exercise Physiology is a cost-effective, preventative, and capacity-building intervention that meets all criteria for a reasonable and necessary support under Section 34 of the NDIS Act 2013—delivering measurable functional improvements, promoting social and economic participation, and ensuring equitable access to safe, effective, and clinically governed exercise environments for people with disability.

Question 9 – for providers/clinicians and researchers only, grey lit question

A systematic review will be conducted to inform the Evidence Advisory Committee's work. It will include peer reviewed research as well as key sources of grey literature. Are there other sources of evidence in your area, such as professional journals or conferences, that we should be checking for evidence on exercise physiology?

Please provide details below if they are publicly available. If you have specific articles or papers that you think the Evidence Advisory Committee should be aware of, you may also send them via email to disabilityevidence@health.gov.au.

- *professional journals (free text for titles etc.)*
- *conference publications (free text)*
- *technical documents (free text)*
- *policy or guidelines documents (free text)*

Given the findings of the Victorian Allied Health Workforce Project (Department of Health & Human Services, 2016) highlighting ongoing confusion around the scope, utilisation, and role of Accredited Exercise Physiologists (AEPs) within the allied health system, it is imperative that at least one AEP is appointed to the Evidence Advisory Committee (EAC) Panel.

Without AEP representation, there is a significant risk that decisions regarding exercise-based supports will be made without accurate understanding of AEP qualifications, governance, or scope of practice, leading to inappropriate comparisons with non-clinical providers and erosion of evidence-based, outcome-driven disability supports.

Executive-level representation of an AEP on the EAC is essential to ensure that funding and policy decisions accurately reflect the unique clinical contribution of AEPs within the NDIS and broader health system—safeguarding participant outcomes, professional integrity, and Scheme sustainability.

Professional and Economic Evidence:

- *Deloitte Access Economics & Exercise & Sports Science Australia. (2016). The value of accredited exercise physiologists to consumers in Australia [Report]. <https://www.essa.org.au/Common/Uploaded%20files/Reports/value-of-aep-report-2016.pdf>*

- Found that every \$1 invested in AEP services delivers between \$5 and \$10 in economic and health benefits.
 - Identified direct benefits (reduced disease burden, improved function, prevention of decline) and indirect benefits (productivity, reduced hospitalisation and pharmaceutical use).
 - Estimated potential annual economic benefit exceeding \$11 billion if AEP services were more widely adopted.
 - Reinforced AEPs as distinct and complementary to other allied health professions—bridging the gap between medicine, physiotherapy, and community exercise.
 - Provided a strong economic case for expanded AEP access under Medicare, NDIS, DVA, and other public schemes.
- *Department of Health & Human Services (Victoria). (2016). Victorian Allied Health Workforce Project: Exercise Physiology Workforce Report. <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/v/victorian-allied-health-workforce-project-2016/exercise-physiology-workforce-report.pdf>*
- Found that the AEP workforce is under-recognised and under-utilised compared to physiotherapy and occupational therapy.
 - Identified widespread scope confusion among referrers and consumers regarding AEPs versus physiotherapists and personal trainers.
 - Clarified that AEPs focus on long-term capacity building and functional improvement, distinct from physiotherapists, who address acute diagnosis and short-term treatment.
 - Concluded that exercise physiology is a critical but under-utilised component of the allied health system with high potential to improve outcomes and reduce chronic disease costs.