Response to NDIA Annual Pricing Review report released on 11/06/2025

Contents

Context:

Who has prepared this response?

- **My name is Dr Helen Nicholson and I am a physiotherapist with 29 years' experience. My family owns a small multidisciplinary allied health clinic in Western Sydney, where over 98% of the people we support are NDIS participants. As well as having a provider's perspective, I understand participants' needs because I have immediate family members who are NDIS participants. Done well, I've seen time and again how the NDIS can transform the lives of entire families. We started our service in a suburb that ranks in the 11% most disadvantaged in Australia because we are dedicated to helping families like ours live fair and equitable lives.**
- The recommendations in this year's Annual Pricing Review report perpetuate years of political grandstanding that NDIS providers are greedy fraudsters who apply a premium to their services so they can build decks on their holiday homes. This message has already burnt many therapists out and brought essential therapy services to their knees. We became therapists because we want to help people. When I began working with NDIS participants in 2015, I took a pay cut to do so – the price limit then was already below what my colleagues and I were charging privately. Every year since then, we have tried to pull off more and more miracles with fewer and fewer resources. The last therapy price limit changes (for all but psychology) took effect on 01/07/2019, i.e. therapy price limits have been frozen for 6 years. The proposed 01/07/2025 price limit reductions are simply not feasible and will result in

hundreds of thousands of NDIS participants experiencing functional decline, as their access to the therapy they rely on to live ordinary lives will be reduced or lost altogether.

- While the APR team highlights improvements in this year's pricing review methodology, those improvements remain insufficient to justify the recommendations made. I know this because I have research and statistics training to PhD level, and have peer reviewed a variety of research for leading academic journals. I have also checked my analysis of the APR report with my husband, whose autistic special interest includes statistics training to Master's degree level. The APR team has not made evidence-based recommendations; as such, **any recommendations to lower therapy prices should be delayed until the APR team's suggested therapy pricing review is completed**, a process they anticipate to take around 18 months.

What portion of NDIS expenditure do the APR therapy recommendations address?

- Using data presented on P53, at $222.7M per 6-month period, physiotherapy expenditure represents 9.2% of the $2.417B therapy expenditure. P51 states that total therapy payments account for "approximately 11% of all Scheme expenditure". **Physiotherapy expenditure is therefore approximately 9% of a subset of 11% of total NDIS expenditure.**
- P53 reports that total therapy travel expenditure was $26.1M covering 136,627 participants. This is an average of less than 1 hour of travel time per participant, and means that **therapist travel represents just 1% of therapy spending**.
- **As of December 2024, more than half of all NDIS participants, i.e. 412,945 Australians, were receiving essential therapy supports as part of their NDIS plans. The APR does not indicate how many participants were languishing on therapy waiting lists at that time; our clinic currently has 101 NDIS participants waiting for therapy and previously published NDIS data reported around only ¾ of therapy budgets being spent during participants' plans.**

What type of participants will be affected by the proposed therapy and travel price cuts?

- The **most common disabilities of NDIS participants** are **intellectual disability**, **autism spectrum disorders** and **developmental delay**.
- People with intellectual disability may struggle to use public transport independently or to obtain their driver license, making travel to therapy clinics challenging. If their therapists can't afford to travel to them, with less than 3 weeks' notice, continuity of care will be compromised and a range of participant outcomes reduced.
- Autistic people are typically very routine-based and struggle with change. It can take them months to adapt to what others might consider small changes in their routines. If their therapists can't afford to continue supporting them, either by travelling to them or providing therapy at lower cost, behaviours of concern related to these changes are likely to increase.
- Children with developmental delay can have quite complex needs, including multidisciplinary treatment teams that will be compromised if key therapists can no longer afford to provide services. Evidence-based early childhood intervention relies on therapists providing support in homes, preschools, etc; this will not happen if therapists can afford to travel, resulting in poorer outcomes and associated increased lifetime cost of care of these participants.

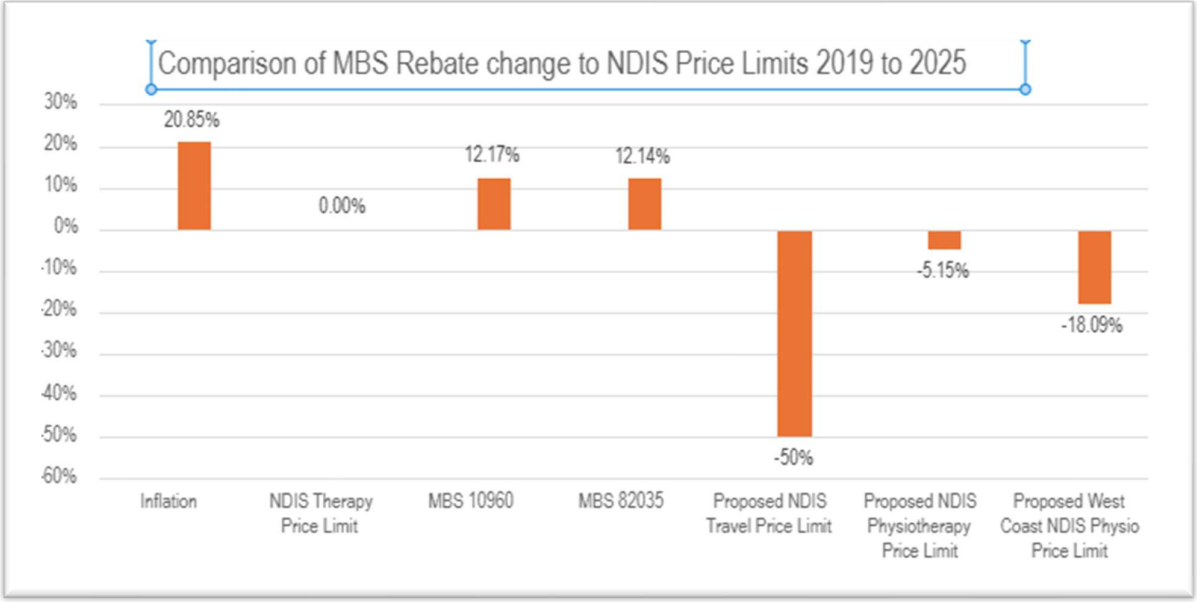
Regarding the APR Methodology:

- There are extensive issues with this year's APR methodology. With limited turn-around time and lack of access to raw data, not all issues will be addressed in this response. Any way the report is analysed, the conclusions remain the same: there is insufficient evidence to lower specific therapy price limits; the recommendation to halve therapist travel price limits shows a lack of understanding of the importance of travel in delivering safe and effective supports; and there is no valid evidence to continue the freeze of therapy price limits for the 7th year in a row.
- A specific example of flawed methodology is found on P68 – Benchmarking Data Coverage: "*The MBS data offer the best coverage in terms of pricing of the general population… The NDIA prioritised transparent assumptions and used triangulation across sources to mitigate data gaps where possible.*
  The benchmarking results in this chapter are informed by this multi-source comparison and provide the evidence base for the Annual Pricing Review's recommendations for therapy support price limits."
    - Although multiple sources of data were used, and the weighting of website scraped pricing data was reduced in this year's APR, the benchmarking those sources inform gives an **incorrect evidence base on which to base therapy price limits from 01/07/2025**. Examples include:
        - Most physiotherapy clients funded by **MBS Item 10960** or **PHI** do not have disability.
        - Most physiotherapy clients funded by **other government schemes** do not have autism, intellectual disability or developmental delay, even when they do have similar physical presentations.
        - No comparison of change between 2019 and 2025 prices was made, despite freely available, overwhelming evidence of high inflation and changes to business practices as a result of the pandemic.
    - The APR team **demonstrates limited understanding of the therapy sector** by also drawing incorrect conclusions about the effect price limit reductions will have on the accessibility of therapy for participants and does not consider the legislative requirement of the NDIS to fund safe reasonable and necessary supports.

Regarding Physiotherapy – MBS Item 10960:

- **Estimating Hourly Rates from Session Based Pricing**
    - P66 – The statistical methodology to extrapolate equivalent hourly prices is sound, however, the use of 2024 data, when the rebate for item 10960 was $58.30, skews results lower than the current market prices (the 2025 rebate is $60.35).
        - This is consistent with the previous APR, in which the MBS rate used in the justification of keeping the price limit the same was increased on July 1st, but the NDIS price was not adjusted accordingly post-July 1st.
    - P68 – although 3,148,452 MBS transactions is an excellent sample size, the difference between a rebate of $58.30 and $60.35 over that many transactions is a total of $6,454,326.60.
    - P132 Appendix B – Physiotherapy NSW/VIC/QLD/ACT MBS
        - 25th percentile and median both equal $58.30, indicating the outdated rebate rate was used. The correct figure (pending release of 2025-2026 financial year MBS rebates) for the 25th percentile should be $60.35. It is not possible to

estimate the correct median without access to the raw data, but it should be at least $60.35.
        - Demonstrates the majority of MBS physiotherapy sessions are bulk-billed.
        - The correct hourly rate for the 25th percentile and median session times, both of which were 30mins should be $120.70, not $116.60.
        - $90 for 34mins equates to $158.83/hr, not the published $158.70. Although the report notes rounding has been applied, rounding to a reasonable number of decimal places does not account for the discrepancy. The difference over the sample size is $409,298.76 in 2024.
    - P79 – the statement "For physiotherapy, the equivalent hourly averages are $76 and $71 respectively" is statistically impossible, given the data presented in the rest of the report. I.e. a national hourly average of $158 (Appendix B) cannot possibly be split into an Eastern average of $71 and a Western average of $76.
- **None of the above factors in percentage change of MBS rebates since the NDIS price limits were frozen in 2019**. As seen in the below graph, even the incorrectly selected MBS item 10960 has risen by over 12% over the last 6 years:



- **It is essential to understand that the population treated under MBS item 10960 differs substantially from that treated under equivalent NDIS therapy line items.** I.e., as per the above context section of this response and the detailed explanations below, physiotherapy for the general population is NOT the same as physiotherapy for NDIS participants. **The APR does not compare apples with apples**.
    - MBS item 10960 covers chronic conditions that are not disabilities, i.e. do not permanently impair a person's ability to participate economically or in the community. Common conditions covered include chronic low back pain, osteoarthritis, bursitis, adhesive capsulitis, chronic neck pain, and plantar fasciitis.
    - The limit of five sessions per year makes it less unaffordable for therapists to bulk-bill, because there is a limit to the financial loss of treating that person. This is equivalent to a "loss leader":
        - While a supermarket may sell bread at a loss to get shoppers into the store, hoping they will buy other products priced profitably while they are there, physiotherapists may bulk-bill 5 MBS 10960 sessions, hoping those clients will also purchase complementary products or services (e.g. a foam roller or

enrolment in balance classes) or drive word of mouth attendance of fee-paying clients.
        - Because the bulk-billed sessions are shorter in duration, the physiotherapist's time spent working at a loss is minimised.
        - It is also common for clients to make meaningful progress during the five bulk-billed sessions, even if they are not fully 'cured'. As a result, many choose to continue attending and pay out of pocket to maintain and build on their progress.
- **The physiotherapists providing MBS Item 10960 differ from most of those providing NDIS physiotherapy sessions**.
    - Bulk-billed MBS sessions are often held by new graduate physiotherapists, who are paid less and whose university training makes them fit-for-purpose to work with these chronic conditions immediately upon graduating.
    - The "bread and butter" or "run of the mill" conditions covered by MBS sessions do not require the physiotherapist to have the same intensity of supervision and professional development as those working with the conditions covered by the NDIS and other government schemes.
        - This further lowers the provider's loss from running them as bulk-billed sessions.
    - Practices that bulk-bill sessions typically have a broad range of funding sources, including private-paying clients. Physiotherapists working in the NDIS, especially with paediatric participants, can have upwards of 90% of their caseload consisting of NDIS participants.
- **Inaccurate selection and use of MBS data:**
    - The MBS item 10960 prices are outdated by at least $2.05 per transaction for at least 50% of the 3,148,452 transactions. This is because the 2024 bulk-billed rebate of $58.30 has been used instead of the **2025 rebate of $60.35**, with **potential for further rebate increase from 01/07/2025**.
    - **MBS item 82035 would have been a better comparison item;** it is for a minimum of 30 minutes of physiotherapy for children with autism, i.e. one of the most common services performed by physiotherapists working in the NDIS. The current scheduled fee for MBS item 82035 is the equivalent of $200.40 per hour. This is not a price limit.
- **Physiotherapists can charge a gap fee** for MBS sessions of any item number; many therapists charge their full private rates for these sessions.
- Conclusions:
    - **Before adopting any price reductions, the APR should release figures on the frequency of use of MBS item 82035 (and equivalent items for other allied health disciplines), as well as the session lengths and transaction prices of these sessions.**
    - **The APR should also conduct these transaction analyses using the 85% rebate price current at the time of the analysis and adjust for indexation, to prevent continued misrepresentation of MBS rebates in comparison to NDIS price limits.**

Regarding Physiotherapy – PHI:

- **There are errors in the PHI information published**, for example, p73:
    - Incorrect: West coast 75th percentile hourly rate is $133.40 vs East coast $150.50.
    - **Correct:** West coast 75th percentile hourly rate is $133.33 vs East coast $150.70.
        - $118/47min = $150.50 should be $150.70
        - $104/46.8min = $133.40 should be $133.33

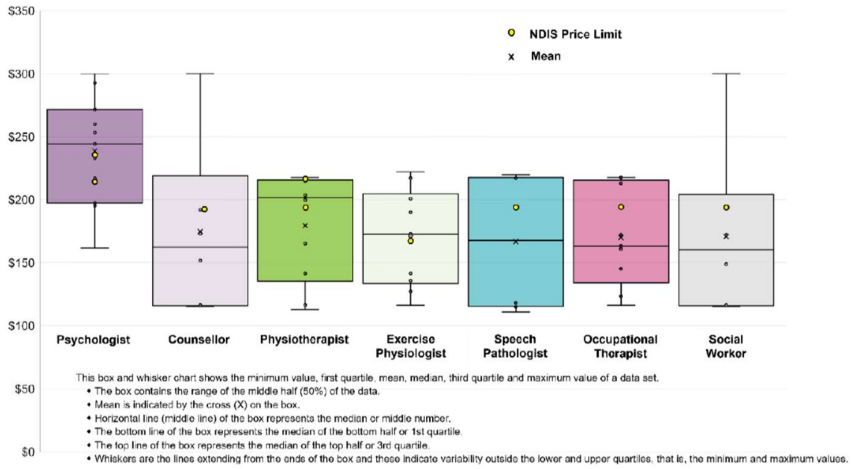
    - Incorrect: NDIS price limit is $224.62 West coast (68.4% above MBS) vs $193.99 East coast (28.9% above)
    - Correct: NDIS price limit is $224.62 West coast (68.5% above MBS) vs $193.99 East coast (28.7% above)
- While these errors are minor and do not affect the outcome of the PHI comparisons in this case, they **undermine confidence in the integrity of the report's recommendations**.
- The 830,021 physiotherapy PHI transactions is an excellent sample size, but is only from one insurer. **No information has been provided about key considerations** such as whether this insurer is typical of the PHI industry or offers 'preferred provider' programs that fairly compensate therapists for their work. For example, **if this insurer has a higher proportion of therapists on 'preferred provider' agreements that are set below market rates, the resulting transaction information will be unreliable to base NDIS price limit decisions on**.
- **The population treated under PHI differs substantially from that treated under equivalent NDIS therapy line items.**
    - Conditions managed in these sessions typically include sprained ankles, sports injuries, post-operative rehabilitation of cruciate ligament surgery or joint replacements; it is not common for PHI clients to have co-existing disability.
    - It is also common for clients who previously used MBS item 10960 for five sessions and who have disposable income, to use their private health insurance to make further progress.
    - These clients will often have multiple physiotherapy sessions a week for the duration of their treatment course.
    - Because these clients are paying out-of-pocket gap fees, therapists can run them profitably and therefore afford to spend more of their time providing these sessions.
    - The longer session length gives therapists time to provide safe, evidence-based therapy, even though the conditions may not be very complex.
    - After their acute or primary episode is managed, clients may also enrol in therapy groups, which improves the financial feasibility of the therapist's service over time.
    - For example, paediatric clients who attend PHI sessions typically don't have a disability, so it is quicker for the therapist to collect their history information. These clients tend to cooperate better with the therapist than children with disabilities, which means assessments can be completed quicker and more therapy activities completed within each session.
    - Standard assessments can usually be completed with PHI clients of all ages, i.e. little customisation is required, compared to NDIS participants.
- **The physiotherapists providing PHI therapy sessions differ from most of those providing equivalent NDIS therapy sessions**.
    - New graduate and early career physiotherapists are fit-for-purpose to provide the majority of these sessions.
    - These physiotherapists also require less supervision and professional development compared to those working with the conditions covered by the NDIS and other government schemes.
    - These physiotherapists can typically rely on standardised treatment protocols, which reduces the cognitive load on the therapist, enabling them to see a higher volume of clients in the same working hours.
- **Physiotherapists set their own fees** for PHI sessions and the equivalent of "bulk-billing" or "no gap" services is not possible.
- **Conclusions:**
    - **The APR should not rely on data from a single health insurer, as it is unlikely to be representative of the equivalent NDIS services.**

- When the APR performs their proposed therapy pricing review, the raw (deidentified) data should be made publicly available so that independent verification of results can occur.

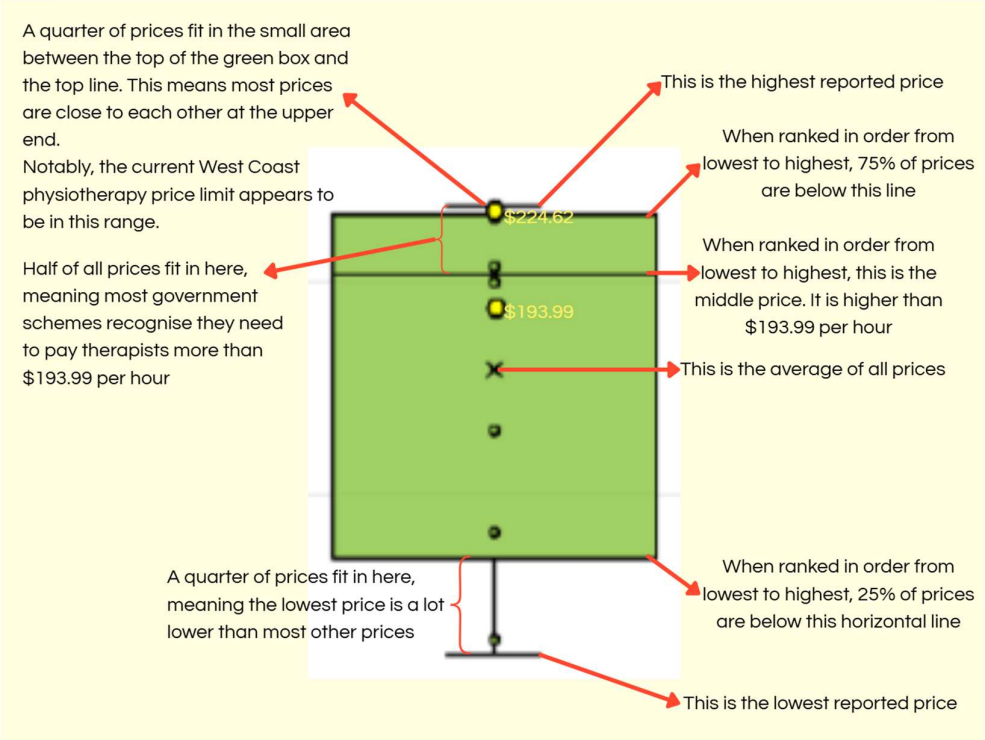
Regarding Physiotherapy – Other Schemes:

- The interpretation of the physiotherapy section (p81) is wrong.

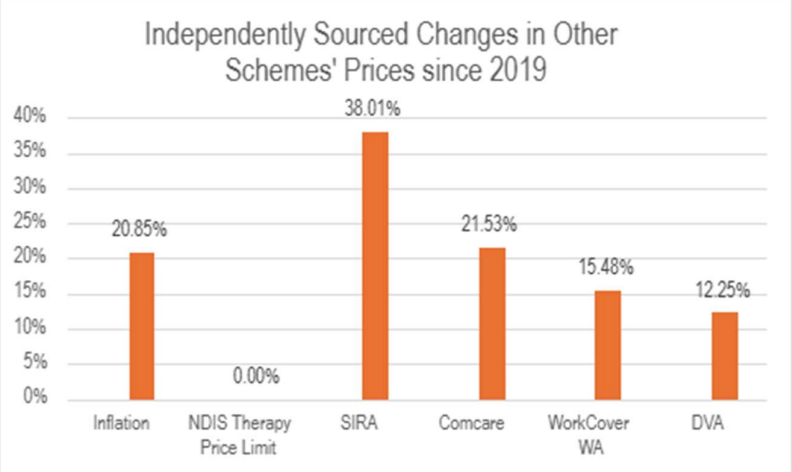
Figure 22: Comparison of NDIS Price Limits to other Government Schemes



- **Understanding the physiotherapy section correctly is impossible without the raw data.** The lowest price is unexpectedly low, and this combined with the above-mentioned errors and the below incorrect interpretation raises concerns that the APR team has made an error when calculating or presenting the data:



- P81 – "*Besides for one NDIS physiotherapy price limit, NDIS therapist price limits are generally between the 50th and 75th percentiles in the calculated bands from the available therapy data received from other schemes.*"
    - This is incorrect. Neither physiotherapy NDIS price limit is between the 50th and 75th percentiles. The West coast limit appears to be just above the 75th percentile, while the East coast limit is below the median and the mean of other government schemes.
    - **With this in mind and the likely indexation of other schemes' rates on July 1st, the new national NDIS price limit would be better aligned with the 75th percentile of other schemes if it was raised to the current West coast limit ($224.62 per hour).**
- P81 – "*Physiotherapy… (is) priced consistently lower under these schemes, with most falling between $140 to $190 per hour*".
    - This is incorrect. Without the raw data, it can only be estimated that less than a quarter of other schemes' physiotherapy prices are between $140 and $190 per hour.
    - Instead, most other schemes' (50%) physiotherapy prices fall between around $200 (approximately the median) and $225 per hour (approximately the maximum).
    - The high position of the middle line in the green physiotherapy box indicates that the physiotherapy prices are clustered at the high end of the price range (skewed). Compare this to the blue speech pathology box, which has the median and mean approximately equal and in the middle of the box and much more similarly sized whiskers (indicating it is "normally distributed", i.e. like a bell curve).
    - The correct statement should have been "Physiotherapy is priced consistently higher under these schemes, with most falling between ~$200 to ~$225 per hour, compared to $193.99-$224.62 per hour (state and territory special price limit) under the NDIS."
    - **The other schemes information supports setting the national NDIS price limit for physiotherapy at the current West coast geographic loading limit of $224.62 per hour, which is close to the benchmark of the 75th percentile of other schemes' prices.**
    - **Independently sourced data on other government schemes tells a very different story:**



- **The population treated under other schemes is the most similar to that treated under equivalent NDIS therapy line items than any other comparison group.**
    - Many of these clients have severe or permanent impairments that limit their ability to participate socially and economically.
    - However, very few of these clients have autism, intellectual disability or developmental delay.
    - This means that, although the work is more complex, standard treatment protocols can still often be used. For example, a client from this population may have an amputation following a road accident. There is a standard progression of treatment

for amputations, including wound care protocols, temporary prosthesis construction, etc.
    - Many clients funded through other schemes have multidisciplinary teams, but they often have fewer members than NDIS participants' teams do.
- **The physiotherapists providing sessions through other schemes are the most similar (but not necessarily identical) to those providing equivalent NDIS therapy sessions**.
    - These therapists require additional experience and training than what new graduate physiotherapists have.
    - However, despite requiring a similar skillset to treat the complex conditions both NDIS and other scheme clients may present with, these therapists typically don't have experience with or the skills to work with complex conditions in people with comorbid intellectual, developmental or neurodevelopmental disabilities.
    - **Additional requirements for physiotherapists working with NDIS participants include**:
        - The ability to customise every session, every time, in real time. An example is working with identical twins with the same disability; each twin has different sensory preferences, strengths, learning needs, etc.
        - The ability to build rapport with clients who may not have typical social interactions.
        - The ability to manage clients who may have behaviour support plans and modify session plans dependent on the client's regulation and presenting behaviours on the day.
        - Skills to obtain objective measures when compliance or other disability-related factors prevent the use of standard measures.
        - The ability to re-engage clients who can't "sit still and do exercises" for 30 minutes at a time (like the typical MBS and PHI, and even most other scheme clients can).
        - Skills to adapt techniques so clients understand what we're asking of them. Examples include:
            - NDIS participants with intellectual disability take longer to learn new skills. They also take longer to complete activities in therapy, which results in slower progress, requiring the therapist to be more creative to prevent boredom.
            - NDIS participants with autism typically have poor proprioception and interoception that makes it hard for them to learn to position their bodies correctly and perform movements with appropriate force and coordination.
            - NDIS participants may also take longer to identify that they have pain and may require their physiotherapist to have skills in using AAC devices to able to communicate.
        - Working with NDIS participants, especially when they have large multidisciplinary teams with high staff turnover amongst providers, increases the cognitive demand on physiotherapists.
            - This results in increased work health and safety risks and associated burnout and loss from the profession.
- **Physiotherapists typically can't charge more than the rate set by the other schemes**. (Some allow gap payments; most don't.)
    - These rates effectively operate like the NDIS price limits – this is the **closest the APR comes to comparing apples with apples.**

    - **The 75th percentile of other scheme fees is therefore the most reasonable benchmark to compare NDIS price limits with.**
    - That said, most physiotherapists working in other schemes have a broad range of clients funded by a variety of sources; physiotherapists working in the NDIS, especially with paediatric participants, usually have a primarily NDIS caseload and are therefore more impacted by NDIS price limit stagnancy and reductions.
- **Conclusions:**
    - **The APR should release the raw data used in this analysis, so it can be independently verified.**
    - **The only evidence for changes to the NDIS physiotherapy price limit is for it to be increased to at least the current West coast limit of $224.62 and indexed in line with other government schemes.**

Regarding Removal of the West coast (geographic) loading for physiotherapy & psychology:

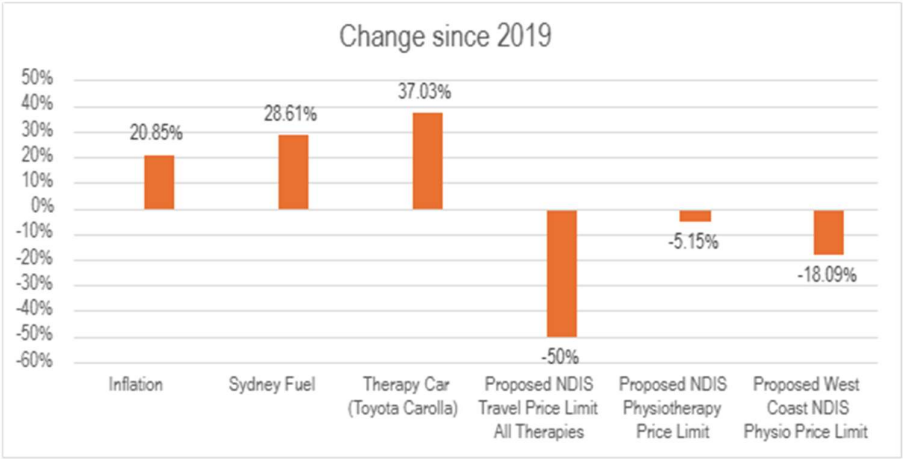
While the APR physiotherapy analysis is based on flawed selection of data, incorrect maths, outdated MBS data, and incorrect statistical interpretation, the values that can be corrected without access to the raw data do not significantly alter the justification for removing the geographic loading from physiotherapy. (Please note that this is a separate matter to what rate the new national physiotherapy price limit should be.)

By contrast, the psychology analysis is based on correct maths (it is irrelevant for psychology that the MBS rebate has changed, as published statistics show bulk billing in psychology is uncommon). However, given the benchmark of NDIS rates being around the 75th percentile of other schemes, the analysis does not support removing the geographic loading for psychology. It also supports an increase in the (currently East coast) NDIS price limit to around the current West coast price limit.

- **Conclusions:**
    - **The APR's evidence does not support removing the geographical loading for psychology price limits.**
    - **Using the APR's stated benchmarking aim of 75th percentile of other schemes, there is evidence that both the physiotherapy and psychology national NDIS price limits should be around the current West coast price limits.**

Regarding Halving of Therapist Travel Price Limit:

- The APR gives no evidence-based reasoning for halving therapist travel price limits.
- The APR ignores the increased cost of therapist travel since price limits were last set in 2019:



  - **Reduction of travel price limits alone makes therapist travel unaffordable, but combined with proposed reductions in therapy price limits**, the reduction of travel price limits simply **makes many providers completely unviable**.
  - As mentioned earlier, **therapist travel is essential for safe, best-practice** provision of therapy to NDIS participants.
  - **Therapists are already efficiently scheduling travel**, as evidenced by the average participant spend is less than 1 hour per 6 months. Also mentioned earlier is that
- **Conclusions:**
  - **The NDIA has a legislated obligation to provide safe, best-practice supports** to NDIS participants. As such, **therapist travel price limits must not be reduced**.

Regarding Therapy Provider Numbers:

- The APR report insists that the supply of therapists support NDIS participants continues to increase (5% over the past 12 months (p52)). This appears to be an illusion.
  - On p61, the APR team comments that "*providers supporting more than 250 participants make up less than 1% of the market*". It is obviously unreasonable for one therapist to work with 250 participants, so based on an average full-time caseload of 25 participants, it is reasonable to estimate that these providers have 10 full-time-equivalent therapists working for them.
  - P61 also states "*65% of all therapy providers support five or fewer participants*," and "*providers supporting 1-5 participants claimed at less than $10,000 each over six months to December 2024*". With 55,370 active therapy providers reported, this means that **nearly 36,000 therapists provide less than 2 hours of therapy supports to NDIS participants each week**.
    - **The above supports my understanding that a clinic like ours counts as 1 provider, even though we currently have 6 therapists in our team. If we worked as sole practitioners, we would count as 6 providers and instead of supporting our current 150 participants per week, we would, according to the APR's report, see a maximum of 30 participants a week.**
- This, as well as our **waiting list continually being 100 or more participants**, is evidence that there are **simply not enough therapists to provide safe, timely supports to NDIS participants**.

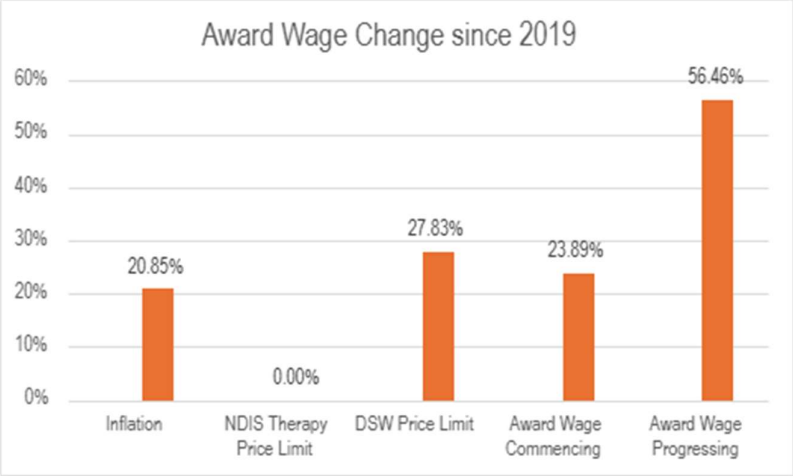
Other APR Report Concerns:

With less than 3 weeks' notice of proposed price limit reductions, it has not been possible to devote enough time to analyse all concerns with this year's APR report whilst meeting obligations to plan for participant continuity of care.

As demonstrated above, with time only a brief review of the APR report, many errors have been detected, notably to do with physiotherapy. Statistically, if the errors were made by chance, they should be evenly distributed throughout the report, i.e. across professions. Therefore, without independent verification of the entire APR report, there is no valid evidence for the reduction of any NDIS price limits.

DSW (Disability Support Worker) Cost Model Comparison:

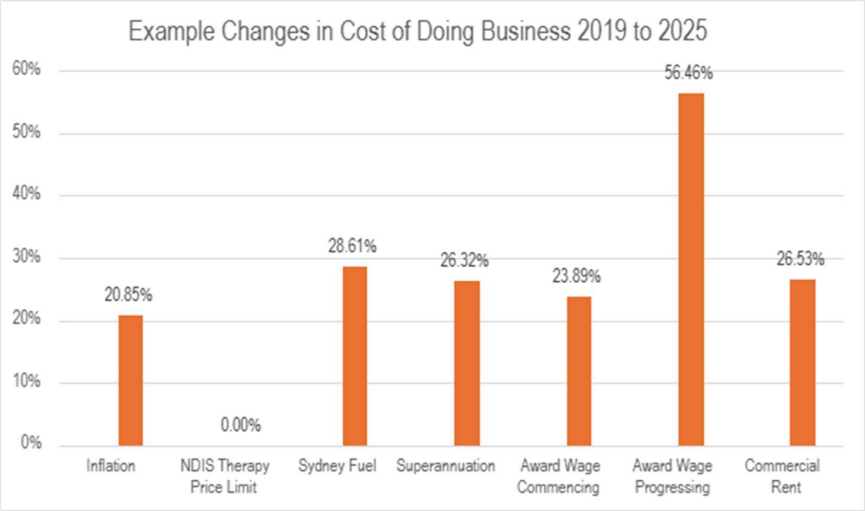
- Appendix A – DSW Cost Model Detailed Breakdown
  - P130 – **Direct on-costs of increased superannuation entitlements applies to therapists** as well as DSWs
  - P130 – "*Any changes in the wage rates directly affects the entire model's cost structures*." **The HPSS Award movements are just as relevant to therapy providers as SCHADS Award movements are to DSWs.**
- This graph shows the change in award wages for allied health professionals, compared to the change in price limit for DSWs and Therapists:



  - DSW Price Limit = Disability Support Workers require no qualifications to work in the NDIS, while therapists require at least a 4-year degree. The NDIA has often cited rises in Award wages and Superannuation for increasing DSW price limits; the same Award wages and Superannuation increases apply to allied health therapists, yet prices have been stagnant for 6 years.
  - Award Wage Commencing = This represents the wage of an allied health therapist starting with an employer in 2019 to that of an equally experienced allied health therapist starting with an employer in 2025. This figure is an underestimate because it is the change in the HPSS Award rate and few (if any) therapists are currently paid at the Award, due to the therapist shortages acknowledged in the APR report.
  - Award Wage Progressing = This represents the progression of an allied health therapist who started with an employer in 2019 and has progressed through pay points in the award through continuous service since. This figure also only represents Award rates; most (if not all) therapists are paid well above award rates. Our clinic's experience is that the most we can retain therapists for is 5 years. After that time, we can't afford to further increase their pay to match offers from large NGO providers or for them to become sole practitioners.

Cost of Doing Business:

- The APR contends that the cost of doing business has settled now that inflation has lowered (p28). However, these are examples of real-world changes:



  - Inflation = Australian inflation data from: https://www.officialdata.org/australia/inflation/2019?amount=193.99
  - NDIS Therapy Price Limit = no orange bar is visible because the price has not changed
  - Sydney Fuel = based on average for regular unleaded petrol of 140.5c/L in July 2019 and 180.7c/L in June 2025
  - Superannuation = The superannuation guarantee rate in July 2019 was 9.5%. In July 2025 it will become 12%. This rate increase of 2.5% represents a cumulative increase of 26.32%
  - Commercial Rent = Calculated on a standard commercial lease contract of 4% rise, year-on-year

Conclusion

The recommendations of this year's APR report are based on poor data selection criteria, unverified data, mathematical errors, statistical misinterpretations and contradictory raising of DSW price limits compared to therapy price limits. The freezing of therapy price limits for the last 6 years is not in line with any other government funding schemes or commercial realities. There is no credible evidence for any price limits to be lowered and the price freeze must be fixed to prevent harm to participants who rely on essential therapy to live an ordinary life. Further, the NDIA should release the cost of this year's APR, as well as all data used, to enable independent verification and determination of value for money of the APR process.

Dr Helen Nicholson

BPhty, MAnSt, PhD

Physiotherapist, provider and family member of 5 NDIS participants

16/06/2025