Australian Federation of Disability Organisations

NDIS access changes

Submission to the Department of Health, Disability and Ageing

2 October 2026

Matthew Hall
National Manager – Systemic Advocacy & Policy
matthew.hall@afdo.org.au
+61 414 678 520

Reviewed and approved:

Ross Joyce
Chief Executive Officer

Contents

1 Acronyms and abbreviations 9

2 Executive summary 10

3 Introduction 12

4 Question 1: Do the draft guiding principles provide the right foundation? ... 13

5 Question 2: Should any principles be added, removed or changed? 14

5.1 Proposed changes 14

5.2 Proposed additions 17

6 Question 3: What should be considered in designing a fair, consistent, transparent, disability-informed and evidence-based process? 18

6.1 Be explicit about what is being decided 18

6.2 Assess capacity and performance 18

6.3 Validate tools; do not assume validity 19

6.4 Assessors and assessment conditions 19

6.5 Fair process and safeguards 20

6.6 Structural incentives 20

6.7 Who bears the cost of evidence 20

6.8 Workforce, cost and implementation 20

7 Question 4: Reducing burden, improving understanding, and proportionate assessment 21

7.1 Delays before an application is lodged 21

7.2 Reuse what already exists 22

7.3 Make requirements understandable 22

7.4 A tiered, proportionate pathway 22

7.5 Prove permanence once 23

7.6 Current participants: no blanket reassessment 23
7.7 Fund the burden of evidence 24
7.8 Make referral pathways genuine 24
8 Question 5: What should be considered to ensure the access decision-making process, as well as referral pathways, works well for all disability cohorts? 24
8.1 Communication disability 25
8.2 Cultural and linguistic diversity and First Nations people 25
8.3 Cognitive and intellectual disability 25
8.4 Autistic people 25
8.5 Degenerative conditions 25
8.6 Fluctuating and episodic disability, including psychosocial disability 26
8.7 Complex and multiple needs 26
8.8 Children and young people 26
8.9 Regional and remote communities, and people in closed settings 26
8.10 People without a diagnosis 26
8.11 Urgent pathways for degenerative, life-limiting and catastrophic conditions 26
9 Question 6: Permanence, and whether treatment is likely to improve functional impact 27
9.1 Evidence of permanence 27
9.2 What counts as treatment that would remedy an impairment 28
9.3 Improvement is not cure 28
9.4 No compulsory treatment 28
9.5 Special considerations 29
9.6 How decisions are made 29
10 Next steps 29

Australian Federation of Disability Organisations (AFDO) Ltd is registered as a charity with the Australian Charities and Not for profit Commission. It is also a Public Benevolent Institution, endorsed by the Australian Taxation Office as a Deductible Gift Recipient. A donation of $2.00 or more is tax deductible.

Consent to publication: Australian Federation of Disability Organisations (AFDO) consents to the publication of this submission, including the names and contact details of AFDO staff. The relevant AFDO staff also give that consent.

© 2026, Australian Federation of Disability Organisations (AFDO) Ltd, **ABN: 25 105 510 898**

CC BY-NC-SA (version 4.0): AFDO publishes, distributes, and otherwise makes available its advocacy and policy materials, including this submission, under a Creative Commons licence.

This licence allows any person to distribute, remix, adapt, and build upon the material in any medium or format for non-commercial purposes only, and only if AFDO is credited as the creator of the material. If you remix, adapt, or build upon the material, you must also license your modified material under identical terms.

The **CC BY-NC-SA (version 4.0)** licence includes the following elements:

BY You must give appropriate credit, provide a link to the licence, and indicate if any changes have been made. You may do so in any reasonable manner, but not in any way that suggests AFDO endorses you or your use.

NC You must not use the material for commercial purposes.

SA If you remix, transform, or build upon the material, you must distribute your contributions under this licence.

No additional restrictions: You must not apply legal terms or technological measures that restrict others from doing anything permitted under this licence.

Acknowledgements

Aboriginal and Torres Strait Islander people

Australian Federation of Disability Organisations (**AFDO**) acknowledges Aboriginal and Torres Strait Islander people as the First Peoples and traditional custodians of the land now called Australia. We recognise their deep and continuing connection to Country and community. We pay our respects to the traditional custodians of Country where we work, connect, or meet, which always was, and always will be, Aboriginal land. We also pay our respects to Elders past, present, and emerging.

People with disability

AFDO acknowledges people with disability in all their diversity, particularly those individuals who have experienced or are continuing to experience violence, abuse, neglect, or exploitation. We also acknowledge their families, carers, supporters, and representative organisations and express our thanks for the continuing work done by the many people supporting, protecting, and advancing the rights of people with disability.

Language used in this document

AFDO has chosen to use person-first language (like "people with disability") in this document. Person-first language puts the person before the disability and values the individual by seeing them as a person, not a condition. This aligns with the CRPD and matches the language used by all governments in Australia. Most other Australian disability peaks also use person-first language.

We recognise many people with disability prefer identity-first language. Disability is a part of their identity and shows a connection to their community and pride in disability. Views on language reflect people's identities, experiences of disability, and community attitudes. It is a matter of individual choice and agency. AFDO respects everyone's right to choose how to describe their identity and experiences.

About AFDO

Since 2003, the Australian Federation of Disability Organisations (AFDO) has been the pre-eminent national peak for people with disability, championing their rights through our extensive member organisation network uniquely representing both disability-specific and cross-disability population-based communities with a reach of over 4.5 million Australians.

We are, firstly, a Disabled People's Organisation (DPO), led, governed, and predominantly staffed by people with disability. We are also a Disability Representative Organisation (DRO) funded by the Australian government.

Our member organisations are national disability-specific or cross-disability peak bodies, other disability-specific advocacy, family an support organisations. This ensures that our work is informed by lived expertise and experience, truly representing our communities.

AFDO is a strong, trusted voice for the disability sector. We advocate on national policy, inquiries, and initiatives with the Federal and state and territory governments. We work to build a community where people with disability:

- have real participation in community life
- can build respectful, valued relationships
- participate socially and economically, and
- contribute as valued citizens.

Our vision

All people with disability can take part equally in all aspects of social, economic, political, and cultural life.

Our mission

Using the strength of our member organisations to harness the collective power of uniting people with disability to change society into a community where everyone is equal.

Our strategic objectives

- To represent the interests and united voice of our members and people with disability at a national and international level in all relevant forums.
- To build the capacity, profile, reputation, and sustainability of AFDO through the strength of our member organisations.
- To enhance the connection and influence in international disability initiatives by policy, advocacy, and engagement, focused on the Asia Pacific region.

Our members

AFDO's member organisations contribute to the national policy agenda and address issues that impact the lives of people with disability in Australia. We understand that disability-specific organisations play a key role in the provision of information and peer support to people with disability and their families. This role keeps them closely connected to their grassroots communities. Each community has its peak organisation that uses its voice to advocate on issues.Information about AFDO's members can be found on **our website.**

Every Australian Counts

AFDO has been involved in Every Australian Counts since the beginning of the grassroots campaign that successfully advocated for the introduction of the NDIS.

AFDO continues to support Every Australian Counts by auspicing the campaign, holding a position on the Steering Committee, and providing administrative, governance, marketing and communications support.

More information about Every Australian Counts, including its current priorities and activities, is available on the **Every Australian Counts website**.

Australian Consumers & Carers Mental Health Forum

The Australian Consumers and Carers Mental Health Forum (**Forum**) is a national initiative that brings together consumer and carer perspectives to develop shared positions on mental health, suicide prevention and psychosocial disability reform. The Forum supports stronger connections between mental health and disability policy and promotes collaboration across a diversity of lived experience communities.

AFDO supports the Forum by providing administrative, coordination and organisational support as well as holding a position on its Steering Committee. More information is available at **The Forum**.

1 Acronyms and abbreviations

This list may assist users of this document to understand what we mean when we use the following terms or abbreviations.

AFDO	Australian Federation of Disability Organisations
Consultation Paper	"NDIS Access Changes Consultation Paper", released by the Department in September 2026[1]
CRPD	United Nations Convention on the Rights of People with Disabilities[2]
Department	Department of Health, Disability and Ageing
DPO	Disabled People's Organisation. A non-government organisation governed, led, and constituted by people with disability, to be distinguished from organisations **for** people with disability,
DRMC	Disability Reform Ministerial Council, which is the Ministerial Council for the purposes of the NDIS Act.
DRO	Disability Representative Organisations funded by the Commonwealth government to represent people with disability. AFDO is one of 11 DROs
Draft Principles	Draft guiding principles for the future NDIS access decision-making process proposed in the Consultation Paper[3]
NDIS or Scheme	National Disability Insurance Scheme
NDIS Act	National Disability Insurance Scheme Act 2013 (Cth)
SWAN	South West Autism Network
TAG	Technical Advisory Group on NDIS Functional Capacity, established in July 2026 by Commonwealth, state and territory governments to provide expert, independent, evidence-based advice to the DRMC to support access reforms

2 Executive summary

1. Adopt the Draft Principles as a starting point, but strengthen them. Add principles on needs-based (not budget-driven) decisions, fair process and review, continuity and no detriment, human decision-making, and privacy. Settle what happens when principles conflict.
2. Require evidence of real-world performance as well as capacity. A single assessment in a standardised environment will misrepresent people with fluctuating, episodic, masked, cognitive and psychosocial disability.
3. Validate every tool for every cohort before it is used, with results published and DPOs involved in testing.
4. Create a proportionate fast-track for clear cases, and ensure that permanence, once established, never has to be proved again. A presumptive pathway could build on a transparent, regularly reviewed list of conditions, including the current List A, co-designed with DPOs and clinicians.
5. Remove the evidence burden from individuals. Fund assessments, reuse existing evidence with consent, preserve the right to apply, and make referral pathways genuine rather than diversionary.
6. Co-design for each cohort from the outset, including communication, cultural, cognitive, degenerative, fluctuating and episodic disability, with disaggregated monitoring.
7. Define permanence and treatment so that no one is forced into treatment to qualify. “Available” must mean realistically accessible to the person, and ongoing management is not a remedy.
8. Separate eligibility decisions from budget pressure, and publish decision data so that drift can be seen and corrected.
9. Require assessors and decision makers to have relevant disability-specific expertise and trauma-responsive practice, including knowledge of the person’s disability type, communication needs, cultural context and life stage.
10. Allow applicants reasonable choice of suitably qualified assessor where an assessment is required
11. Consult again before anything is finalised. Thresholds, tools, evidence requirements and transition arrangements have not yet been put to the community. Any new process should be piloted and independently evaluated before national rollout.
12. Do not reassess current participants. Existing eligibility should stand unless there is a clear, individualised, evidence-based reason for review, with no interruption to supports during any review or appeal.

13. Ensure no person is refused NDIS access on the basis that another system is more appropriate unless that service is demonstrably available, affordable, accessible, timely, culturally safe and capable of meeting their disability-related needs in their local area.
14. Provide urgent pathways for degenerative, life-limiting and catastrophic conditions, with decisions in days, acceptance of hospital and specialist evidence, and interim supports where delay risks harm.
15. Measure and report the real end-to-end wait, from a person's first request for help, and prohibit preconditions such as mandatory Community Connections Plans from delaying lodgement.
16. Publish an independently costed implementation plan before commencement, covering assessor workforce by region and disability cohort, assessor competency standards, and protection of therapy and clinical capacity.

In addition, AFDO asks the Department and the TAG to do each of the following:

(a) consult the community again, including DROs and other DPOs, on thresholds, tools, evidence requirements, treatment rules and the transition for current participants, before they are finalised

(b) publish modelling of the projected effect of the reforms on current and prospective participants by cohort

(c) release draft tools and processes for testing, with DRO and other DPO involvement, and publish the results

(d) pilot and independently evaluate any new process before national implementation, and publish an independently costed implementation plan covering assessor workforce, regional access and the protection of therapy and clinical capacity

(e) measure and publicly report the real end-to-end time to an access decision, from a person's first request for help

(f) provide all consultation materials, and later feedback on outcomes, in accessible formats, and

(g) meet with AFDO to discuss this submission.

3 Introduction

AFDO welcomes the opportunity to provide this submission to the Department to "help shape the design and delivery of the proposed reforms to NDIS access and eligibility" and inform the next stages of policy design, alongside expert advice from the TAG"[4]. In this submission, AFDO responds to the seven questions raised in the Consultation Paper.

Discussions with our members and other member feedback have informed this response. Our assessment and recommendations are offered constructively to improve the design and operation of the Draft Principles and the Scheme.

AFDO supports a fairer, more consistent and less burdensome access process. AFDO wants to ensure that access to the NDIS is determined by a process that is fair, clear, consistent, timely, accessible and grounded in human rights. Our recommendations are developed from a systemic advocacy perspective, grounded in the rights of people with disability established by the CRPD and the Australian government's obligations to protect and promote those rights in Australia's domestic laws and policies.[5] We also want to put on the record five concerns, because they shape how we read the Draft Principles. Those concerns are as follows:

1. The fiscal frame

The Consultation Paper gives cost growth and the National Cabinet decision to limit annual growth to between 5 and 6 per cent as reasons for reform. The 2026 Intergenerational Report[6] presents NDIS reform as a leading contributor to the improved long-term budget outlook. An eligibility threshold is therefore never a purely technical matter. The process needs structural protection against cost pressure shaping who accesses the Scheme. Delay and exclusion do not save public money. Costs transfer to hospitals, mental health, housing, child protection and justice systems, and to unpaid family carers.

2. Where people go if they do not qualify

Thriving Kids is the first phase of Foundational Supports providing short-term early intervention services for children aged 8 and under with developmental delay and/or autism who have low to moderate support needs, and for their families, carers and kin[7]. The Consultation Paper refers to future phases of Foundational Supports, but gives no detail[8]. Narrowing access before alternatives exist risks leaving adults and older children with inadequate or no support.

3. Sequencing

The Act received the Royal Assent on 20 August 2026. The Consultation Paper acknowledges that this is an "initial consultation" to inform the foundations of a future access decision-making process, including "principles and design considerations that should guide access reforms"[9]. The Department is not yet consulting on all the details. We are asked to endorse principles before we can see "all the details". **AFDO's responses are therefore provisional.**

4. Transition

Current participants will be reassessed for access to the Scheme over three years from 1 January 2028. For people who have relied on the Scheme for years, this is a source of real anxiety and risk. AFDO's position is set out in our answer to Question 4.

5. Foreseeable harm

Loss or delay of essential supports is not an administrative inconvenience. It can lead to homelessness, carer breakdown, preventable hospitalisation, institutionalisation, neglect, self-harm and premature death. These risks are greatest for people with complex needs, degenerative conditions, psychosocial or cognitive disability, and people without family support, and they should be treated as a core implementation and human rights issue.

4 Question 1: Do the draft guiding principles provide the right foundation?

Broadly yes as a starting point, with significant qualifications.

The Draft Principles are anchored in the NDIS Act and the CRPD (Principle 1), commit to lived experience (Principle 2), are person-centred and strengths-based (Principle 4) name fluctuating, episodic and non-visible disability (Principle 5), commit to transparency, accessibility and reduced burden (Principle 6), and include a commitment to continuous improvement (Principle 7). These are the right themes.

However, the Draft Principles are not yet a sufficient foundation, for five reasons:

- They govern process, not purpose.

  Nothing says who bears the risk of error. A process can be consistent, standardised and transparent and still wrongly exclude people. The principles should say that the system must be designed so that people who meet the criteria are not wrongly refused access.

- They conflict with one another.

  Principle 3 requires a standardised, nationally consistent approach, and the glossary defines functional capacity as ability in a standardised environment that minimises the effect of

personal and environmental circumstances. Principle 4 asks the process to recognise individual circumstances, and Principle 5 requires it to work for fluctuating and episodic disability. The principles do not say which prevails.

- They are not binding.

  The Consultation Paper says they do not represent final government policy. They need to be embedded in the Rules, operational guidelines and assessor training, with accountability for compliance.

- They do not protect against cost-driven design.

  The Draft principles must include structural protection against cost pressure shaping who accesses the Scheme. They must also recognise that delay and exclusion do not save public money, and that costs transfer to hospitals, mental health, housing, child protection and justice systems, and to unpaid family carers.

- They do not address accountability or redress.

  There is no principle on reasons for decisions, review rights or what happens while a decision is contested.

The Draft Principles also need practical force. They must set enforceable limits on assessment burden, delay, and the risk of interrupted supports. They must also make it clear that the evidence demanded is proportionate to what needs to be decided. A person diagnosed with a progressive, life-limiting condition such as Motor Neurone Disease should not face the same evidentiary pathway as a person whose functional impact needs further exploration. Requiring both to complete the same assessment would be neither consistent nor fair, and for many, dangerous.

5 Question 2: Should any principles be added, removed or changed?

AFDO does not recommend that any of the Draft Principles is removed.

We propose amendments to each of the Draft Principles. We also propose ten additions.

5.1 Proposed changes

Our proposed changes are set out in the table below.

Draft principle	Proposed change	Reason
1. Aligned to the NDIS Act and human rights	Identify the CRPD articles that bear directly on access: Article 5 (equality and non-discrimination), Article 9 (accessibility), Article 12 (equal recognition before the law), Article 17 (integrity of the person), Article 19 (living independently and being included in the community) and Article 25 (health, including free and informed consent).	Makes the principle testable, and anchors the treatment and permanence questions (Q6) in consent and integrity.
2. Informed by lived experience	Include express reference to DROs, other DPOs, and First Nations organisations, as co-design partners. Require co-design to be funded and ongoing, and require people with lived experience in assessor workforces and governance.	"Informed by" can be met by consultation alone. This is inadequate.
3. Evidence-based and consistent	Clarify that "standardised" means consistent criteria and methodology, and not a snapshot at a single point in time, nor a single tool. Require evidence of both capacity and real-world performance. Require each tool to be validated for each cohort before use. State that where principles conflict, rights and fairness to the individual outweigh administrative consistency.	The glossary defines functional capacity[10] as ability in a standardised environment that minimises personal and environmental circumstances. That sits uneasily with Principles 4 and 5.

Draft principle	Proposed change	Reason
4. Person-centred and strengths-based	Add that a strengths-based approach must never be used to understate support needs, and that assessors must be trained accordingly. Convert “minimise burden” into operational commitments (see response to Question 4).	Strengths-based framing can be misread as evidence of lower need, especially for people who mask or have learned to cope.
5. Equitable, inclusive and safe	Add intersectionality, people in closed or institutional settings, people without a formal diagnosis, and rural and remote communities. Require cultural safety to be defined with First Nations and culturally and linguistically diverse communities.	Those most likely to lack formal evidence are often those facing the greatest barriers to getting it.
6. Transparent, proportionate and accessible	Add: the right to lodge an application is never restricted; existing evidence is reused with consent; statutory timeframes apply; every decision comes with plain-language reasons mapped to the criteria.	Turns aspirations into enforceable features and prevents informal gatekeeping through referral pathways.
7. Continuous quality improvement	Require regular publication of de-identified data by cohort (approval rates, time to decision, review and overturn rates), independent evaluation that includes DROs and other DPOs, and a duty to correct identified bias.	Without published data, bias against particular cohorts cannot be seen or fixed.

5.2 Proposed additions

(a) Decisions turn on disability and its impact, not on budget targets. Eligibility is determined by whether a person meets the criteria, not by cost containment. Decision-makers should not be set approval targets, and thresholds should not be adjusted to meet financial objectives.

(b) Fair process, accountability and review. Every person receives plain-language reasons linked to each criterion, has a right to internal and independent external review with advocacy support, and has defined timeframes at each stage.

(c) Continuity and no detriment. Changes must not cause a loss of supports during review, appeal or transition. People already determined to have a permanent disability should not be required to prove it again.

(d) Human decision-making and safe use of technology. Access decisions are made by accountable people with appropriate expertise. Any algorithm, scoring tool or automated process is disclosed, validated, contestable, and never the sole basis for refusing access. The Robodebt Royal Commission showed the harm caused when rule-driven systems displace human judgment and shift the burden of proof onto individuals.

(e) Privacy, consent and data governance. Information collected at access is used only for stated purposes, shared only with informed consent, and held securely. People are told what is collected and why.

(f) Proportionality, presumptive eligibility and no unnecessary reassessment. The evidence required must match what actually needs to be decided. Where a diagnosis or existing clinical evidence clearly establishes permanent and significant disability, access should be streamlined, and people should not be asked to repeat evidence or eligibility testing that has already been established.

(g) No cost barrier. No one should be denied, delayed or discouraged from access because they cannot afford evidence, assessments, travel, interpreters, communication supports or advocacy. Any assessment required by government should be provided free of charge.

(h) Timeliness and urgent access. Access decisions must be made quickly enough to prevent avoidable harm, with urgent, low-burden pathways for people at risk of hospitalisation, homelessness, violence, neglect, self-harm, institutionalisation or death.

(i) Real availability of alternatives. A person should not be redirected to another system unless the alternative support is demonstrably available, accessible, affordable,

appropriate, timely and sufficient in their local area. A theoretical service is not an available support.

(j) Disability-specific expertise. Anyone assessing functional impact must be appropriately qualified, with expertise in the person's disability type, communication needs, cultural context and life stage.

(k) Finally, the principles should state an order of precedence. Where they conflict, the rights, dignity and fair treatment of the individual should outweigh administrative consistency and efficiency.

6 Question 3: What should be considered in designing a fair, consistent, transparent, disability-informed and evidence-based process?

Consistency does not mean treating every person identically. Fairness requires flexible pathways for different circumstances, with common safeguards and clear decision-making.

6.1 Be explicit about what is being decided

The threshold for "substantially reduced functional capacity" is the heart of the reform. Fairness cannot be judged until the community can see the threshold options and who each would include or exclude. AFDO asks for modelling of the projected effect on current and prospective participants, by disability type, age, gender, cultural background and location, to be published before decisions are made.

6.2 Assess capacity and performance

The Consultation Paper defines functional capacity as what a person can do in a standardised environment. That concept is useful for consistency but cannot stand alone. Many people perform a task once, in a quiet clinic, and cannot sustain it in daily life. Autistic people, people with psychosocial disability, chronic pain or fatigue, and people who have learned to mask or compensate are especially at risk of being under-assessed. The process should require evidence of how impairment affects real-world functioning over time and across settings, and decision-makers should be required to weigh both.

Functional capacity is also not the same as support need. A narrowly standardised assessment in an artificial setting does not capture the practical support a person needs at home, at school, at work, and in the community, during periods of fluctuation, or when informal supports are unavailable. Assessors should be required to consider variability, fatigue, pain, sensory overload, executive functioning, safety, informal support arrangements, the environment, and whether a person can undertake an activity reliably, repeatedly and independently, not only once.

Many people also cannot accurately describe their functional impact because of communication, cognitive, psychosocial or trauma-related barriers that are part of their disability. Assessors must be skilled at rephrasing and probing questions, and the process must not depend on a person explaining their own disability fluently. A single universal functional capacity assessment is not an appropriate gateway for every applicant. Where functional evidence is genuinely required, it should use disability-specific, proportionate, and independently validated approaches.

6.3 Validate tools; do not assume validity

No tool should be adopted unless it has been shown to be reliable and valid for the specific cohort being assessed, including children, people with intellectual or cognitive disability, communication disability, psychosocial disability and First Nations and culturally and linguistically diverse people with disability.

Testing should be staged, include DROs and other DPOs, and have its results published, including where a tool performs poorly for a group.

Tools designed for other purposes should not be repurposed without that testing. The experience of the 2021 independent assessments proposal, which was dropped after strong community concern, is a reminder of what happens when this is rushed.

Pilot and independently evaluate any proposed process before national implementation, with public reporting of outcomes by disability cohort, location, age, gender, First Nations status, cultural and language background, socioeconomic status, assessment cost, wait time, decision and review outcome. The process should not proceed nationally unless it is shown to improve equity and reduce burden without excluding people who are clearly eligible.

6.4 Assessors and assessment conditions

Assessors need disability-specific training, including in trauma-informed practice, communication access, and recognising masking and fluctuation.

People should be able to choose their assessor type where possible, the mode and setting, the time allowed, who attends, and whether to use their own trusted treating professional.

People should be able to review and correct a draft assessment before it is finalised.

Supports must be provided as of right: interpreters, Auslan, augmentative and alternative communication, supported decision-making and advocacy.

Assessors need expertise in the relevant disability type, not only generic assessment skills. A generic process that assigns, for example, a physiotherapist to assess an autistic person, or a

speech pathologist to assess a person with a spinal cord injury, will not accurately capture functional impact. Specialist assessor pathways should be created for particular cohorts.

People should be able to choose their assessor from a range of suitably qualified options, wherever they live. A trauma survivor, for example, may need to choose an assessor of a particular gender.

6.5 Fair process and safeguards

Plain-language reasons, review rights, statutory timeframes and a clear complaints pathway are essential. If technology is used to triage, score or flag applications, it must be disclosed, regularly audited for bias, and subject to human review. People must be able to find out whether and how it was used in their case.

Supports should continue while a review is being decided wherever interruption would create a risk of harm.

6.6 Structural incentives

How assessments are funded and how decision-makers are measured will shape outcomes. If staff or assessors are rewarded for lower approval rates, or if cost targets are communicated downward, the process will drift regardless of the principles. AFDO recommends separating eligibility decisions from budget management, prohibiting approval-rate targets, and monitoring approval and overturn rates by cohort as an early warning system.

6.7 Who bears the cost of evidence

The Consultation Paper notes that outcomes are influenced by access to supporting evidence. Specialist reports are expensive and waiting lists are long, particularly outside capital cities. A fairer process must fund the evidence it requires.

The Consultation Paper does not say who will pay for functional capacity assessments. If applicants or participants must pay, the NDIS becomes harder to reach for people already living in poverty. In regional and remote areas, even a funded assessment may not be available within a reasonable distance or time. Any assessment required by government should be free, and the costs of travel, interpreters, communication supports, and advocacy must also be met.

6.8 Workforce, cost and implementation

The Consultation Paper proposes that new applicants complete a functional capacity assessment from 1 January 2028, while current participants are reassessed over three years

(noting also our response to Question 4). Together, this would create very great demand for qualified assessors when regional and remote communities already face severe allied health shortages. Clinicians drawn into assessment and report writing are not delivering therapy, rehabilitation, diagnosis and clinical care. This would lengthen waitlists and shift costs to other systems. Before implementation, government should publish an independently costed national implementation plan that includes:

- workforce demand and supply modelling by region and disability cohort, and the number, qualifications and disability-specific competencies of assessors required
- a plan to prevent assessment work from reducing access to therapy, rehabilitation and clinical care
- a plan for regional, rural, remote and very remote communities
- a full cost estimate to government, participants and families, and
- independent validation evidence for each tool and cohort before it is used for access decisions.

7 Question 4: Reducing burden, improving understanding, and proportionate assessment

The most effective way to reduce burden is to avoid unnecessary assessments, remove duplication and accept the reliable evidence people already have. A functional capacity assessment added on top of existing requirements creates another barrier for people already managing disability, poverty, caring responsibilities and complex service systems, rather than simplifying access. A person should not have to become expert in presenting their own disability to a bureaucracy to receive support. For many people, difficulty understanding, recalling or articulating how disability affects daily life is part of the disability.

7.1 Delays before an application is lodged

In its submission in response to the Consultation Paper, AFDO member SWAN reports that people it supports have waited three to six months for an initial meeting with an NDIS partner, that Access Requests have been held for months before being actioned, and that some people have been required to complete a Community Connections Plan before their request progresses. It reports that the time between a person first seeking access and the NDIA approving the request can be 12 months or longer. Because the NDIA measures wait time only from the point an NDIS partner submits the request, reported processing times understate what people experience.

AFDO recommends:

- starting the official timeframe on the date a person first asks the NDIA or an NDIS partner for help, and reporting end-to-end times publicly
- requiring NDIS partners to accept, register and progress Access Requests promptly, and prohibiting Community Connections Plans or similar processes from being a precondition to lodging and deciding a request
- direct NDIA lodgement being available at all times, rather than redirecting people to partners
- a named contact or navigator for people with complex needs and degenerative conditions
- fully funded independent advocacy, with advocates, supporters and carers able to assist throughout. SWAN reports that most disability advocacy providers have closed their waitlists for NDIS advocacy because funding has not kept pace with demand, and
- clear, rapid escalation pathways for people in crisis, including hospital discharge delays, homelessness, violence, carer breakdown or risk of harm.

7.2 Reuse what already exists

With the person's consent, draw on existing evidence and determinations, for example from health records, the Disability Support Pension, education records and state and territory systems, so people tell their story once.

Accept existing reports from treating professionals without requiring a new report where one already answers the question.

For lifelong conditions, do not require recent reports merely to repeat what is already established.

Accept hospital discharge summaries, school evidence, support worker evidence and lived-experience evidence where appropriate.

7.3 Make requirements understandable

Publish, for each cohort and in plain language, Easy Read, Auslan and community languages, what evidence is needed and how it will be assessed. Provide a way to track progress, set statutory timeframes, and give decision letters that map reasons to each criterion and explain review options.

7.4 A tiered, proportionate pathway

The Consultation Paper asks how to minimise burden for people who are clearly eligible. We propose three pathways, with the person always able to move to a fuller assessment if the fast-track does not capture their needs:

- **Fast-track**. For people with lifelong conditions that reliably result in very significant functional impairment (for example profound intellectual disability, Deafblindness, high-level spinal cord injury, or progressive neurological conditions such as motor neurone disease), eligibility is confirmed on the word of a treating professional and a brief functional summary. This does not reinstate diagnosis lists as a gate. Anyone without such a diagnosis proceeds through the standard pathway and is not disadvantaged. The specific criteria should be developed with clinicians and DPOs. This could build on a transparent, regularly reviewed list of conditions suitable for presumptive eligibility, drawing on the current List A and co-designed with DPOs, clinicians and people with lived experience. Further examples raised by SWAN include major amputation, congenital absence of two limbs, permanent bilateral blindness and Down syndrome, which SWAN recommends be added to List A.
- **Standard pathway**. A standardised functional assessment supported by existing evidence.
- **Supported pathway**. For people with complex, fluctuating or multiple needs, or who face barriers to evidence, with more time, a multidisciplinary approach and funded advocacy.

7.5 Prove permanence once

People whose permanent disability has been established should not be repeatedly required to prove it. Reassessment of eligibility should occur only when there is a genuine reason, such as a significant change in circumstances, not as routine. The transition for current participants should reflect this, with those who have stable, lifelong, significant disability exempt from full reassessment.

7.6 Current participants: no blanket reassessment

AFDO opposes a blanket reassessment of current participants. They have already established that they meet the disability requirements. A mass reassessment assumes that the problem lies with participants rather than with decision quality, inconsistent administration and service gaps, and it would divert scarce allied health and NDIA resources from delivering supports. SWAN notes that the NDIA already conducts around 1,200 to 1,250 eligibility reassessments each week of participants it believes may no longer meet the requirements.

Many long-standing participants no longer hold diagnostic reports from decades ago. SWAN reports that the NDIA has required new and expensive genetic testing to prove that older adults with Down syndrome still have Down syndrome, without accepting evidence from a general practitioner. Requirements like this show how reassessment can penalise people for gaps in historical paperwork. If transition arrangements are considered, they should include, at a minimum:

- existing eligibility remaining in place unless there is a clear, individualised and evidence-

based reason for review

- no loss of eligibility based solely on a new tool, a missing report, inability to afford an assessment, failure to attend an inaccessible appointment or difficulty communicating with the NDIA
- no interruption to supports while any reassessment, internal review or external review is underway
- free assessments, advocacy, communication supports, interpreters and travel assistance;
- decisions made by appropriately qualified staff with disability-specific expertise, and accessible written reasons
- full review and appeal rights, including timely independent merits review, and
- public reporting on reassessment outcomes by cohort, location and demographic group, including reasons for removal, review outcomes, interruptions to supports and serious incidents.

7.7 Fund the burden of evidence

Fund assessments and specialist reports for people who cannot afford them. Provide navigators, including peer and community-led support, and telehealth and outreach for people in regional and remote areas.

7.8 Make referral pathways genuine

Where someone is found not to meet the criteria, a referral to mainstream or Foundational Supports means something only if an appropriate service exists, is accessible, and the person is actively connected to it. A referral to nothing is a refusal. Referral should not delay a decision or substitute for one.

8 Question 5: What should be considered to ensure the access decision-making process, as well as referral pathways, works well for all disability cohorts?

We set out the principal design considerations here. Across all cohorts, we recommend co-design with DROs, other DPOs, and cohort-specific organisations. We also recommend validation before implementation, disaggregated monitoring after it, and a workforce that includes people with lived experience of disability.

8.1 Communication disability

Standardised tests that rely on speech or self-report are biased against people who communicate differently. Allow augmentative and alternative communication, communication partners, Auslan and interpreters, more time, and observation and third-party evidence. Communication difficulty must never be treated as evidence of lower credibility or lower need.

8.2 Cultural and linguistic diversity and First Nations people

Concepts of disability differ across communities, and stigma may deter disclosure. Provide accredited interpreters, culturally safe assessors, First Nations-led and community-controlled assessment options, and tools validated with these communities. Avoid deficit framings and consider assessment on Country or in community. Fund First Nations and culturally and linguistically diverse liaison workers and free interpreting.

8.3 Cognitive and intellectual disability

Provide supported decision-making, Easy Read, and trusted supporters. Draw on people who know the person well, and allow multiple sessions. A person's functional capacity for the purposes of access must never be treated as a judgment about their legal capacity. Some people will need multiple appointments, observation in real-world environments, and information from people who know them well.

8.4 Autistic people

Functional impact can be hidden, masked or misunderstood. An autistic person may appear capable in a short, structured appointment but be unable to sustain functioning at home, school, work or in the community. Sensory overload, social communication demands, executive functioning difficulties, burnout, co-occurring mental health conditions and the effort of masking are unlikely to be visible to a generalist assessor using a standardised tool in a short time. Trauma triggers can also lead to shutdown and loss of the ability to communicate.

8.5 Degenerative conditions

Assess on prognosis and trajectory rather than waiting for function to be lost. Build in automatic recognition of progression so people are not forced through repeated assessments as their condition worsens. Delay is especially harmful. Needs can increase rapidly while a person waits for an assessment slot, an access decision, a support needs assessment and then a budget, turning a manageable situation into an emergency.

8.6 Fluctuating and episodic disability, including psychosocial disability

A point-in-time assessment will often capture a good day. Evidence should cover a defined period, the frequency and severity of episodes, and the supports needed during them. The current Rules recognise that an impairment can be permanent even where its impact varies, and that principle must be retained. Recovery-oriented care should not be read as evidence that the impairment has been remedied. Apparent stability may depend on substantial informal support, treatment or secure housing that is not guaranteed, and the assessment must take that into account.

8.7 Complex and multiple needs

Avoid siloed single-domain assessment. Allow multi-source and multidisciplinary evidence and coordinated assessment so people do not repeat their story to different assessors.

8.8 Children and young people

Clear, tested pathways are needed between Thriving Kids and the NDIS so that children at the boundary are not shuffled between systems or made to wait. The TAG is not advising on Thriving Kids thresholds, so the interface needs separate attention.

8.9 Regional and remote communities, and people in closed settings

Provide telehealth, outreach, and funded travel, and ensure access for people in prisons, forensic and mental health settings, out-of-home care and experiencing homelessness. Assessment availability cannot be assumed: long waiting lists, limited disability-specific allied health and high travel costs mean that a process that is national on paper but relies on metropolitan services is inequitable in practice. Telehealth should be offered where suitable, but not assumed to suit everyone.

8.10 People without a diagnosis

Barriers to diagnosis, including cost, waiting times, discrimination and the way conditions present across genders and cultures, mean that many people with significant impairment have no formal diagnosis. Accept functional evidence from allied health professionals, educators, support workers, family and peers.

8.11 Urgent pathways for degenerative, life-limiting and catastrophic conditions

For some conditions, every delay causes harm. A person with Motor Neurone Disease, a progressive and life-limiting condition, cannot safely wait months for a functional capacity assessment, an access decision, a support needs assessment and a funding allocation. The

same applies to people following catastrophic injury, major amputation, permanent bilateral blindness, or sudden-onset quadriplegia or paraplegia. SWAN is concerned that adding an assessment step would produce waits comparable to other heavily burdened systems, noting that Disability Support Pension applications typically take about eight months to assess and periodically 12 to 18 months. Delay does not save money. People remain in hospital longer, rely on exhausted family members, go without equipment and personal care, and reach crisis before help arrives. Urgent access pathways should include:

- a decision within days, not months, when diagnosis and immediate functional impact are clear
- acceptance of hospital, specialist or treating practitioner evidence without an additional functional capacity assessment
- immediate interim supports where delay would create a foreseeable risk of harm, and
- single point of contact and active coordination with hospitals, primary care, disability organisations and family supports.

9 Question 6: Permanence, and whether treatment is likely to improve functional impact

Consistent with the NDIS Act, the Consultation Paper defines a permanent impairment as one that is likely to be lifelong and unlikely to be substantially remedied by available and appropriate treatment. Each part of that definition needs careful consideration and clear interpretation.

9.1 Evidence of permanence

- Diagnosis, prognosis and the natural history of the condition, from treating clinicians.
- The duration of the impairment, treatments tried and the person's response to them.
- Longitudinal functional evidence from allied health professionals, support workers, carers and the person themselves.
- Where the nature of a condition is lifelong (for example Down syndrome or cerebral palsy), permanence should be presumed without further proof, as it should for degenerative conditions.
- For conditions known to be permanent, degenerative or life-limiting, rely on diagnosis and appropriate clinical confirmation rather than repeated functional capacity assessment. Examples raised by SWAN include Motor Neurone Disease, spinal cord injury resulting in quadriplegia, paraplegia or tetraplegia, major amputation or congenital absence of two limbs, permanent bilateral blindness and Down syndrome.

9.2 What counts as treatment that would remedy an impairment

- **Available**. Means realistically accessible to this person, in a reasonable time, at a cost they can bear, within a reasonable distance and in a culturally appropriate form. A treatment with a two-year public waiting list, or one available only in a distant city, is not available.
- **Appropriate**. Clinically indicated, evidence-based, safe, and consistent with the person's informed choices, other conditions and circumstances. This is a matter for the person and their treating clinicians, not for an assessor to second-guess.
- **Likely**. A real probability, not a theoretical possibility. The standard of proof should be published and clear.
- **Substantially remedied**. Means a substantial reduction in functional impact, not just a reduction in symptoms. Ongoing medication or therapy that manages or stabilises a condition does not remedy it. If treatment must continue indefinitely to maintain function, the impairment remains.

9.3 Improvement is not cure

Treatment may improve symptoms, comfort, skills or functioning in some contexts without removing a person's disability-related support needs. SWAN gives two examples. A non-speaking autistic person may gain the ability to communicate verbally after years of weekly speech pathology, yet weekly speech pathology is not available outside the NDIS. A person with Ehlers-Danlos syndrome may be able to maintain their function only with multiple physiotherapy sessions a week, while Medicare supports a maximum of five physiotherapy sessions a year.

People must not be required to exhaust every possible treatment, intervention or rehabilitation option before they can access the NDIS. SWAN reports that applicants with Postural Orthostatic Tachycardia Syndrome (POTS) are currently required to provide evidence of weekly hospital-based intravenous hydration, which is not available in Western Australia. It is unreasonable to require people to travel interstate, or from regional and remote communities to a metropolitan centre, to try a treatment before access is granted.

9.4 No compulsory treatment

People must not be required to undergo medical, surgical, pharmacological or psychiatric treatment in order to qualify. This would be inconsistent with free and informed consent and respect for the integrity of the person under the CRPD (Articles 17 and 25). A person's informed decision to decline or discontinue a treatment, because of side effects, risk, cultural or personal values, should not by itself defeat a finding of permanence. The Department's published information on the reforms indicates that rules on treatment will be developed

through later consultation; AFDO asks that they be put to the community before they are made.

9.5 Special considerations

- **Psychosocial disability**. Recovery is not a binary state and episodic impact is common. Assess persistence of functional impact over time, and do not treat engagement in recovery-oriented supports as evidence of remedy.
- **Children**. Early intervention may improve outcomes, but access to the NDIS must not be delayed on the speculative basis that it will. Developmental trajectory should be assessed by clinicians with paediatric expertise.
- **Fluctuation**. Permanence does not require constant severity.

9.6 How decisions are made

- Publish guidance on permanence and treatment, informed by the NDIA's Evidence Advisory Committee and clinicians, with disability community review.
- Decision-makers should have access to independent clinical advice with disability expertise and should give weight to the treating clinician's view.
- Where evidence about permanence is genuinely uncertain, provide provisional access with a defined review, rather than refuse. Provisional access must not become a route to repeated reassessment, and the person should not lose supports during review.
- Do not require recent reports for lifelong conditions.

10 Next steps

AFDO asks the Department and the TAG to do each of the following:

(a) consult the community again, including DROs and other DPOs, on thresholds, tools, evidence requirements, treatment rules and the transition for current participants, before they are finalised

(b) publish modelling of the projected effect of the reforms on current and prospective participants by cohort

(c) release draft tools and processes for testing, with DRO and other DPO involvement, and publish the results

(d) pilot and independently evaluate any new process before national implementation, and publish an independently costed implementation plan covering assessor workforce, regional access and the protection of therapy and clinical capacity

(e) measure and publicly report the real end-to-end time to an access decision, from a person's first request for help

(f) provide all consultation materials, and later feedback on outcomes, in accessible formats, and

(g) meet with AFDO and its members to discuss this submission.

Endnotes

1 Department of Health, Disability and Ageing, NDIS Access Changes – Consultation Paper, Commonwealth of Australia, 31 August 2026, retrieved from https://consultations.health.gov.au/disability-and-carers-group/ndis-access-changes-consultation/, accessed 4 September 2026.

2 United Nations Convention on the Rights of Persons with Disabilities, 2515 UNTS 3 (entered into force 3 May 2008), retrieved from https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd, accessed 7 January 2026.

3 Note 1, pp. 5-6.

4 Note 1, p. 2.

5 Australian Human Rights Commission, Disability Rights Guide, Commonwealth of Australia, 5 May 2025, retrieved from https://humanrights.gov.au/resource-hub/by-resource-type/pages-missing-assets/chapter-1-legal-and-human-rights-obligations, accessed 5 August 2026.

6 The Treasury, Intergenerational Report "Australia's future to 2066", Commonwealth of Australia, September 2026, retrieved from https://treasury.gov.au/publication/2026-intergenerational-report accessed 25 September 2026.

7 https://www.health.gov.au/our-work/foundational-supports-for-people-with-disability?language=en, accessed 30 September 2026.

8 Note 1, p. 3.

9 Note 1, p. 7.

10 Note 1, p. 9.