Villamanta
DISABILITY RIGHTS LEGAL SERVICE

Discussion Paper

on

National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026

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PO Box 7328
GEELONG WEST VIC 3218

ABN 32 690988 235

☎ Information: 1800 014 111
☎ Admin: 03 5260 1845
💻 Email: legal@villamanta.org.au
💻 Website: www.villamanta.org.au

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Community Consultation

We strongly object to the two week timeframe for consultation on the proposed changes to the NDIS as articulated in the *National Disability Insurance Scheme Amendment (Securing the NDIS for Future generations Bill) 2026 (the **Bill**)*.

The disability community, their families and allies have collectively invested the equivalent of many lifetimes of hours informing the Disability Royal Commission and the NDIS Review on the structural and attitudinal barriers to their full inclusion in the community. The Disability Royal Commission has barely been implemented[1] and the government has not responded to the NDIS Review. Meanwhile there are record numbers of NDIS appeals, the pace of change has been overwhelming, and the community is disheartened and exhausted.

The changes to the NDIS contemplated in this Bill are not consistent with the recommendations of the Disability Royal Commission or the NDIS Review. Responding fully to the breadth of the proposed changes would be a significant commitment of time and we simply do not have the additional resources necessary to do this in two weeks whilst also maintaining our obligations to our clients.

We note that the NDIA itself routinely insists it requires three weeks to respond to even a single page document at the Administrative Review Tribunal, and yet disabled people, their families and allies, and advocates and lawyers have been provided with only two weeks to provide feedback on almost 400 pages of material that will have direct impacts on their quality of life from the most significant changes proposed since the commencement of the scheme.

This discussion paper provides a short explanation of why we consider the Bill creates unavoidable risk to people with disability and should not be passed in its current form.

We would have liked to have provided an analysis of the ways the Bill disproportionately affects certain communities; women, LGBQTI, First Nations, Rural, Regional and Remote, but there simply isn't time. In this respect we endorse the submissions of Women with Disability Australia and the Northern Territory Disability Alliance.

We would have liked to provide statistics but what the causation we seek sits in hospital data, NDIA administrative data, coronial findings, NDIS Quality and Safeguard Commission data, AIHW mortality collections and elsewhere. Until such time as research is conducted into the participant outcomes of the various changes that have taken place and are proposed, it is difficult to connect anecdotal evidence with the available data.

We would have liked to have provided feedback on all of the proposed changes which will affect our community, because the proposed changes are drastic and will have significant impacts. The interactions between the many proposed changes deserve additional attention as they will have a compounding effect, but there simply isn't time.

Finally, we would have liked to have provided recommendations as to how the Bill can be amended to reduce the significant risks to safety of participants, but there simply isn't time.

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[1] The DRC Still Matters | qai

What the Proposed Changes Look Like in Practice

FROM THE PERSPECTIVE OF PARTICIPANTS

Given the limitations of time and resourcing, this discussion paper looks at one proposed change in relation to one specific cohort to illustrate why this Bill requires more consideration.

To be clear, there are structural changes to the NDIS that could be made to improve sustainability without affecting participant safety, and we give examples below, but the Bill looks elsewhere for savings.

The Bill gives the Minister the power to make a determination that reduces the funding of a support type by up to 99.9%. The Explanatory Memorandum confirms the cut to “Social, Civic and Community Participation Supports” (**SCCP**) is expected to be 50 percent for all participants, commencing 1 October 2026.[2]

The cohort we consider in this paper have historically been Villamanta’s main client base. They came out of institutions that were closed due to community outrage at the conditions people were forced to live in. They moved to group homes operated by the Department of Families, Fairness and Housing, and subsequently by a small group of Alliance20 providers. They receive funded NDIS support in the form of Supported Independent Living (**SIL**) and Specialist Disability Accommodation (**SDA**). Many of these people have no family, no friends or relationships outside of the disability settings in which they have lived and spent their days. They have intellectual disabilities or other cognitive impairments like acquired brain injuries.

SIL and SDA for people in group settings attracts a disproportionate amount of NDIS funding[3] According to the NDIA’s data “the proportion of participants with SIL account for 5% of total participants, payments for participants with SIL make up around a third of total payments”.[4] **There are structural reasons for this expense, but they are not contemplated by the Bill.**

Supported Independent Living

It is important to understand how SIL is funded. The provider creates a Roster of Care (**ROC**) which covers the shifts for the residents of the home. This includes varying ratios of staffing, dependent on the time of day and support needs of the residents. If the resident has a nominee or guardian they may see the ROC for the resident, but not the other residents. The resident themselves rarely sees the ROC. The provider claims the funding of each resident based on the ROC.

Over the years we have frequently seen nominees shocked by what is contained in the ROC, stating “but that’s not what actually happens in the house.” While the ROC states the supports apparently needed to properly support the residents, it is not an enforceable agreement of any kind. If the provider does not have sufficient staff to cover the shifts, the residents will simply have less support. The provider still charges according to the ROC, despite not providing all the supports.

Addressing this issue would presumably save the NDIS a significant amount.

Specialist Disability Accommodation

SDA funding was intended to attract investment in the construction of more accessible housing. Group homes, which were mostly owned by DFFH and therefore public housing, are registered as SDA and residents must have SDA funding in their plans to live there. These are not new homes, they already existed, and they are generally not specifically constructed for accessibility. They are just houses.

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[3] According to the Q3 quarterly report for 2025-26, Supplement E, Average funding for participants not in SIL is $65,000. Average funding for participants receiving SIL is $488,600. (Table E.100)

[4] NDIS Annual Financial Sustainability Report 2024-2025, p 64

Further, we have seen community housing register as SDA and then advise current residents they need to apply for SDA funding in their plans. Again, this is existing housing which clearly is not furthering the goal of creating more accessible housing in the community.

Why is the NDIS paying SDA for these properties? Addressing this issue would presumably save the NDIS a significant amount.

CUTTING COMMUNITY PARTICIPATION

The EM recognises that cutting SCCP funding by 50% will impact participants, but states that either going out less, or sharing supports will be sufficient, arguing that shared supports "provide greater opportunities for connection." [5]

The EM also notes that:

- The average SCCP funding for participants who have SIL funding is almost triple the average of other participants; and
- Participants who have SIL funding only use an average of 80% of their SCCP funding[6]

The EM then goes on to suggest that participants could negotiate to pay providers at a lower rate than the price guide maximum. The EM also states that "These changes may increase the rate of participants in SIL requesting an unscheduled plan reassessment or plan variation for their SCCP budgets."

Do these statements accurately reflect the risk to these participants if their SCCP funding is cut by 50%?

Importance of community inclusion

We all saw the effect of COVID lockdowns on the broader community. There was suicidal ideation within a few short months, or even weeks, of being confined to home aside from the essentials. This measure proposes to significantly reduce the amount of time NDIS participants can spend outside their homes indefinitely.

Connection through shared supports

Many people in group homes have to share their supports significantly in the home. SCCP funding, often through a different provider, is the time when they can do their own thing. Go shopping, see the doctor, visit ageing parents, get a mammogram, sell The Big Issue. The activities engaged in are as varied as they would be for any other member of the community heading out for the day.

Having to share a support worker to do this does not create connection, it will create restriction and frustration. When Merryl is going to see her gynaecologist, her housemate is sitting in the waiting room? When Geoff goes to the station to sell The Big Issue, his housemate has to trail along?

High levels of SCCP funding

The group of people we are talking about need support at all times. The alternative to community participation is that they remain at home, but they will still need support there. The main difference is that supports can be shared at home, but as noted above, that is under a ROC over which the person has no control over whether their needs will be met.

If this population has a high level of SCCP funding, it is because it has been deemed reasonable and necessary to ensure they can participate in the community.

Under-utilisation of funding

Unlike SIL, SCCP funding is billed according to use. If a participant has been hospitalised for a period for example, they may have unspent SCCP funding. It seems unlikely the 80% underutilisation is

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evenly distributed, but more likely that some individuals have heavily underutilised and others have used all of their funding. We base this on our experience with clients either using all of their funding, or actively saving some funding for a future event which will require a higher level of funding (for example a holiday or conference). In any case that does not mean their needs will be met with a 50% cut.

Negotiating prices

We have never seen registered providers charge anything but the maximum rate. We have no confidence that either providers will voluntarily reduce their prices, or participants with an intellectual disability living in a group home can negotiate a lower rate with a provider.

Reassessments

The Bill would actively prevent the increased level of reassessments the EM suggests.

Under the Bill, only the participant or their nominee can request a reassessment. Most of these people do not understand how their funding works and have no family to take on the role of nominee. There is nobody to request a reassessment. In any case, the preconditions for being allowed to request a reassessment would not be met – there has not been a significant change in their personal circumstances.

WHAT WILL THE OUTCOME ACTUALLY BE?

The 50% funding reduction is not a reviewable decision.

In many group homes there are no staff during the day because the residents are all elsewhere. Even making adjustments to arrangements, the outcome will be people in group homes being forced to stay home during the day with insufficient supports to be safe, let alone actively living their lives.

The 50% reduction will not take place for all the residents of a house at the same time, so the shared supports will be even more difficult to manage. The reduction will occur when a new plan commences, and while we know of some group homes where all plans have been done at roughly the same time, we also know of many that haven't. What is the first resident whose funding has been cut expected to do when they don't have funding to go out, but there are no staff at home either?

FROM THE PERSPECTIVE OF THE AGENCY'S CAPABILITY

The Bill also proposes limits or reductions of funding to "classes" of participants. There has been a focus on participants with autism and psycho-social disabilities, and it is assumed that these cohorts will have reductions applied.

The EM also states that 5/6 of participants "*would receive the reductions through both plan reassessments and plan renewals occurring over 1 February 2027 to 30 September 2027 once ICT changes allow for bulk renewals (replacing rollovers).*[7]"

It is statistically unlikely that 5/6 of participants have a plan end date between February and September.

The only possible way that this occurs is that the automation power would be used to end date plans, forcing a renewal which would enliven the reduction.

An automated process to create significant changes to a participants funding based on their disability relies on the data held by the NDIA being accurate.

Our experience is that it is not.

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About 18 months ago we had a cluster of clients whose acquired brain injury (**ABI**) was no longer recorded in the NDIA's database.[8] It had been "end-dated." Their ABI had not miraculously healed.

Now we are seeing other impairments removed, with the common feature that autism or psychosocial disabilities are being relied on. The ART has seen this too[9].

It is common for people with intellectual disabilities and ABIs to also have autism and/or psychosocial disabilities. It is entirely foreseeable that individuals in group homes who need 24/7 support will only have autism or psychosocial disabilities recorded and they will be swept up in an automated process which reduces their funding even further.

This cannot be considered a safe or reasonable proposition in any way.

If the Bill was only preparing the groundwork for revoking access to participants before alternative systems such as Thriving Kids exist, we would be arguing that this is putting the cart before the horse. But the Bill proposes such wide ranging reform that it is more like putting the horse in the car.

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[8] We note that participants cannot see what is recorded in the database, despite the fact this could be made available for viewing on the portal or the app. Data transparency would go a long way towards mitigating the risk of poor outcomes. We note also that the impairment notices from the 2024 reforms have not yet been provided to participants.

[9] DTKG and National Disability Insurance Agency (NDIS) [2026] ARTA 736, [4]-[5], HRZI and National Disability Insurance Agency [2023] AATA 481, [171]-[172],

Original Intent

The EM refers to the "original intent" of the NDIS 34 times, taking the position that the changes proposed by the Bill will bring the NDIS closer to what parliament intended in 2013.

We fail to see how this is so. Rather, the change to the Objects and removal of Principles relating to participants plans are not tweaks, they are indicative of the fact that this Bill radically changes the NDIS and what supports and safeguards it provides to people with disability. The following significant shifts are demonstrably not what the original intent of the Scheme was:

- Removal of "reasonable and necessary" as a guiding principle
- Removal of individual planning and choice and control for participants
- Removal of the whole of person approach

COST SAVING OR COST SHIFTING

The support needs to people with disability do not simply disappear because NDIS funding is reduced. The "saving" to the Federal government becomes a cost to someone else, including:

- The health system. As funding cuts have occurred we have seen an increase in the reliance on hospitals to ensure the safety of the participant. This is not a good outcome for anybody, with the participant's life placed on hold and the general public having their access to healthcare delayed. Further, extending the time for an access request decision will place further burdens on hospitals as discussed below.

- Families. When a participant lives with their family and requires assistance to access the community, family members will assist, with the default generally being mothers. While this may make sense for children or young people, for how long do we expect mothers to be available to support their children? What about when their child is 40? 50?

- The welfare system. The NDIS has allowed many carers to return to paid employment, reducing the welfare cost and increasing payment of income taxes. Reducing supports will likely reverse these shifts. A heightened focus on what families should provide for children, without clarity about the balancing of significantly additional care needs and preservation of the capacity to provide informal supports suggests that mothers are going to feel additional pressure should the Bill pass in it's current form.

- Other systems such as aged care (which hospitals use as a way of clearing beds when the person no longer needs treatment) and justice (when behavioural responses are not well supported and situations escalate) are likely to experience additional pressure.

This was absolutely not the original intent of the Scheme.

THE SYSTEM DEFICIENCIES

The Bill also provides for significant broad Ministerial powers to intervene in the funding for participants and price settings for supports, as well as the operation of the Act itself

The extraordinary Ministerial powers to cut funding have the sole safeguard of the Minister having regard to the safety of participants.

There is absolutely no way the Minister can possibly have access to information about how a funding determination will affect the safety of participants, given they have no access to participant details, or any relationship with participants. The Minister can only have regard to participant safety on the basis of aggregated data from the NDIA.

As noted, the NDIA does not even hold reliable data about the disability of a participant. We note the comment in the NDIS Annual Sustainability Report 2024-2025 that states "[t]here have continued to be significantly more participants missing a primary disability in the system compared to previous years."[10]

An increase in absence of data means a loss of data.

If the NDIA have lost data about participants disabilities, how can the Minister possibly have sufficient information to have regard to the safety of participants, when making decisions that will reduce their access to supports that have been deemed reasonable and necessary by a planner considering their individual needs?

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Fairness

COMPLEXITY OF SYSTEMS AND TRANSPARENCY OF INFORMATION

We refer to the Submission of Chris Coombes in relation to the complexity of the decision making process under the Bill. A process of separating out impairments and identifying their source and permanence in isolation and then identifying the specific support required for that impairment alone is virtually impossible in many cases because that's simply not how bodies work. Placing the onus on the participant to prove that the NDIS is the right system to provide that support for that impairment from that cause is an incredibly complex and difficult ask.

It would be more useful for the various different schemes to work out how to negotiate these difficult boundaries and allocate responsibility accordingly.

The Bill proposes to have a plan created and in use, and then when it renews it enlivens all the relevant determinations, price caps and other savings measures, but this is not documented in the plan itself. The proposal that an NDIS participant will have a plan which states a funding amount which is not actually the amount available to them is staggering.

RIGHTS AND OBLIGATIONS OF PARTICIPANTS

Throughout the Bill there are significantly increased requirements on participants and nominees, without corresponding increases for the NDIA itself.

Participants and nominees have the following additional requirements under the Bill:

- A requirement to access all "appropriate treatment" in order to be able to access the Scheme, without any protections for bodily autonomy or privacy.
- A requirement to provide information within 90 days or face suspension, without any obligations on the Agency to comply with disability related communication adjustments or that reasonable attempts are made to contact other parties who may be able to provide relevant information.
- Longer wait times for both access requests and reassessments. The risks of these extended times are heightened for specific cohorts.
    - For access this includes people in hospital after a medical event which has caused them to seek access to the scheme (for example spinal cord injury or acquired brain injury). Once rehabilitation has completed, which is when permanence can be established, the wait time for a decision about access changes from 21 to 90 days. That's three months to find out if access is granted, not to have a planning meeting, have funding allocated, engage service providers and start planning discharge. This will cause significant pressure on the applicant and their family, and decrease available hospital beds for others.
    - For reassessments this includes people who have had a rapid deterioration in their condition or significant change in the informal supports available to them. Examples include the death of a parent that was providing significant informal support, leaving the participant alone for extended periods, or a loss of mobility requiring equipment to get in and out of bed, sitting upright being important to reduce the risk of pneumonia. Three months is a very long time for someone to wait for the request to even be considered in such circumstances. People have died waiting.[11]
- An expectation that they can know that a Ministerial determination has been made which reduces the amount of funding available to them when their plan renews. This also requires them to be monitoring their plan reassessment date. This also requires them to be able to calculate the difference between what is written in the renewed plan (the actual funding) and the funding available to them as a result of the determination/s. Currently NDIS plans average about 34

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[11] Victorian coroner's finding COR 2025 003184, COR 2025 000483, COR 2023 007101

pages. They have become longer and more complex, not simpler. We would estimate that the vast majority of NDIS participants will not know enough about all of these matters to understand that their funding will suddenly reduce. Debts to service providers seem inevitable in this context. Participants will likely have no capacity to pay such debts, but that will not prevent conflict and legal action occurring.

- Requirement to make claims within 90 days and to keep evidence of claims for 3 or 5 years, including the potential for a debt to be raised if a document related to a claim is not available when requested, without the exception of it being reasonable in the circumstances. There are infinite scenarios where this could apply, a person keeping paper copies could have a fire, a flood, enter aged care and have family members dispose of old documents. A single invoice could have been misplaced, amidst a reliable pattern of other invoices suggesting the frequency and cost of the support are consistent with the missing invoice. An invoice could be missing and the service provider has subsequently gone out of business and cannot be asked for a replacement.
- The potential for rapid and unexpected changes to occur to their funding due to automation based on incorrect data, without the transparency and safeguard of access to see the impairments recorded by the Agency in their system.[12]
- The potential for automated rejection of payment claims, with the finance area of the NDIA already having been experienced by participants as uncontactable. If providers are not paid they will cease service and we have seen an increase in providers being prepared to take debt recovery action against participants.

We consider this shift to create a very real increase in risk of mortality to participants on the basis that:

- people using disability support services already experience substantially elevated mortality and avoidable death relative to the general population[13]
- the available evidence indicates that avoidable harm often occurs where deterioration is not recognised early, responses are delayed, care is fragmented, or preventive health needs are not met[14]
- the Bill alters settings that affect how quickly supports can be accessed, adjusted, renewed or defended, including access criteria, reassessment settings, renewal processes, and administrative requirements
- if those settings create additional delay, evidentiary burden, inflexibility or service-gap risk, high-risk participants will likely face increased exposure to the same conditions in which avoidable harm is already known to occur.

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[12] It has long been apparent that Agency managed is the default funding management type. When a change is made to a plan and the funding management defaults back to Agency managed this can have a very negative impact on a participant. This is the type of issue we would expect to be high risk in any automated process. If thousands of participants were to lose access to their supports overnight due to a change in plan management, this is a scenario that the NDIS contact centre would not be equipped to resolve.

[13] Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018* (2020).

[14] Death of people with disability | NDIS Quality and Safeguards Commission, Health risks, service use and outcomes of people with disability | NDIS Quality and Safeguards Commission, Julian Trollor, Preeyaporn Srasuebkul, Han Xu and Sophie Howlett, 'Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data', *BMJ Open* 7(2) (2017) e013489.

For that reason, mortality and avoidable harm should be treated as live implementation risks of the reform package, and all additional obligations on participants contemplated in the light of the significant additional risk to participants.

RIGHTS AND OBLIGATIONS OF AGENCY

On the other hand the Bill reduces the expectations on the Agency.

- While individuals are required to provide evidence they have accessed all "appropriate treatment" in order to gain or retain access to the Scheme, there is no obligation on the Agency to:
    - Take a trauma informed approach to a demographic who have historically been subjected to medical interventions without consent including forced sterilisations electroconvulsive treatment, and for whom bodily autonomy is a human right that must be observed; and
    - Provide information about what they consider to be "appropriate treatment" for any condition and the medical advice that informs this view; and
    - Provide evidence of the medical training of NDIA staff who will be considering whether a particular treatment is appropriate in the circumstances, including their training in acting in a trauma informed way when making such enquiries; and
    - Provide evidence of how they will respect the privacy of individuals whose doctors state that a particular "appropriate treatment" is inappropriate in the circumstance and not require those individuals to disclose highly personal and sensitive information about their body, their history or their circumstances that are irrelevant to the making of an access decision.
- There is no requirement to comply with disability related communication methods when attempting to contact participants, or use a variety of means to reach out. For example if a participant is in hospital, on remand, or homeless, they may be uncontactable using the details the Agency has. However, their nominee, support co-ordinator or other service providers should be able to provide further context. While in theory the Hospital Liaison Officer or Justice Liaison Officer should have provided this type of information, in our experience there are very incomplete processes and contact can be very hit and miss. A participant could easily be discharged from hospital only to find that their regular supports do not attend because their plan has been suspended, and the very supports they need to contact the NDIA to deal with this are unavailable to them.
- There is no requirement to respond in a reasonable timeframe. The Bill reduces the time for participants to comply with certain requirements but extends the time available to the Agency. As noted above, this poses a significant risk to some cohorts of individuals.
- There is no requirement to respond at all. The Bill both increases the time in which the Agency should consider a request for a reassessment and strips the deemed decision when they don't. The Bill would also allow the Agency to simply ignore all requests for reassessment without any review or appeal rights applicable to participants. At some point this will result in an automated renewal which cuts funding even further.
- There is no requirement for the Agency to effectively communicate a Ministerial determination so that participants can understand what funding they have available in a timely manner.
- There is no requirement to ensure that a decision about cost effectiveness actually achieves the same outcome. A standard wheelchair may be cheaper than a bariatric wheelchair, but is useless to the individual who can't fit in it.
- There is no requirement to ensure that unutilised funding in a plan is not removed at renewal inappropriately. If funding has been made available for a capital item such as home modifications, specialised equipment, or for specialised therapeutic interventions such as behaviour support, this funding should not be made unavailable by automatic renewal. There are many reasons why this funding may not have yet been claimed, but should be available going forward.

- There is no requirement to maintain accurate records. As noted above, the evidence suggests that the Agency has actually lost participant information, and our experience is that they have lost not only data but documents and reports.[15] It cannot be acceptable that a Commonwealth agency has a lower evidentiary burden than people with disability and their families.
- There is no requirement to make available the basis of automated decisions, especially those made by "impairment", "disability" or "health condition", which is information held in the NDIA's database, and which could easily be made available to participants and their nominees via the portal or app. Currently, their only way to access this information is an FOI request which can take many months.
- There is no requirement to ensure that participants experiencing claim rejections can quickly and easily speak to an actual human being who can explain what the problem is and assist the individual to resolve it.
- There is no requirement to provide Compensation for Detriment caused by Defective Administration | Department of Social Services.
- There is no requirement to ensure that documents that can now be incorporated into the legislation are consistent with the legislation, current, and accurate. There have been many incidents of various NDIA materials being inconsistent with each other. The extraordinary power to incorporate other materials into the legislation must come with some safeguards that these will not subvert or override the intention of Parliament.

In short the Bill does not reform the NDIS in ways that improve it, the Bill creates an even greater administrative workload on participants and nominees without corresponding obligations on the NDIA to act fairly and with due regard for participant outcomes.

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[15] See our previous evidence about this here: Microsoft Word - Performance of the NDIS - additional material 23.10.25