

23 September 2026

Via submission portal: [NDIS Access Changes Consultation - Privacy and Collection notice - Australian Government Department of Health, Disability and Ageing - Citizen Space](#)

Catholic Health Australia Submission – NDIS Access Changes Consultation

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views on the design of a future NDIS access process. CHA supports the Commonwealth Government's objective of establishing a fairer and more consistent approach to accessing the NDIS, and to securing the Scheme for people with permanent and significant disability so it is there for future generations, as well as for those who need it today.

Our engagement with NDIS reform is grounded in the dignity of the human person and the responsibility to enable people with disability to fully participate in community life. Moreover, we support reforms that promote responsible stewardship, ensuring that the Scheme's resources are used effectively while preserving the support on which people depend. Our members' experience across disability, health, aged care and community services informs this submission, alongside our earlier contributions to the reform process.

CHA broadly supports moving away from diagnosis-based access lists, which can impose different evidentiary requirements on people with comparable levels of functional impairment. A more consistent approach to functional assessment offers an opportunity to address these inequities. Its success will depend on assessment methods that recognise the interaction between a person's impairment, the supports they use, and the barriers in their environment. It will also need an appropriately trained workforce and accessible evidence requirements.

Our submission sets out the safeguards needed to give effect to this approach. These include proportionate assessment, meaningful participation in decisions, transparent reasons and accessible review. Treatment requirements must also account for what people can reasonably access, so that limited access to health care does not become a further barrier to disability support.

The effectiveness of reform will also depend on the services available beyond the NDIS. Where people are referred to another system, there must be clear responsibility for confirming that suitable support is available and resolving gaps. Changes to access should therefore proceed alongside the development of service capacity and arrangements that protect continuity of care.

CHA welcomes the opportunity to contribute to ongoing discussions and assist in the implementation of reforms that will build a more resilient, sustainable, and equitable disability system for all Australians. If you wish to discuss anything further, please contact Dominic Butler via mobile on 0402 772 571 or email at dominicb@cha.org.au.



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Catholic Health Australia – NDIS Access Changes Consultation

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Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, disability, community, and aged care providers. Our members operate 86 hospitals in each Australian state and the ACT, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, in addition to extensive community and residential aged care. CHA members involved in disability service provision include St John of God Accord and Villa Maria Catholic Homes.

Submission

Section 1 – Guiding Principles

Question 1: Do the draft guiding principles provide the right foundation for a future NDIS access process?

CHA broadly supports the draft principles as currently set out. Their emphasis on rights, participation, equitable assessment and transparency aligns with our commitment to the inviolable dignity of the human person and the common good. These commitments recognise the inherent worth of every human life, irrespective of disability or capacity, and the responsibility to create conditions in which people can flourish and participate in community life.

CHA supports reform to place the NDIS on a sustainable footing. Responsible stewardship requires that resources are used effectively and that the Scheme remains available to future generations. Addressing inequitable access, administrative duplication and gaps in the broader disability support system is necessary to that task. Reform should therefore be assessed against improvements in access, continuity and participation, alongside financial sustainability.

The principles provide a sound foundation achieve this, but their effectiveness will depend on how they shape assessment methods, evidence requirements and individual decisions. A nationally consistent process can still produce inequitable outcomes if people cannot obtain the evidence required or if assessment methods fail to capture the impact of their disability.

CHA therefore believes that these principles should be supported by implementation standards and public reporting on outcomes. This should include assessment delays, disparities between cohorts, decisions changed on review and whether referrals result in appropriate support. Our members' experience across disability, health, aged care and community services reinforces the importance of evaluating these consequences across the broader care economy.

Recommendation 1: Adopt the guiding principles with implementation standards and public reporting that assess access, equity, continuity of support and participation alongside financial sustainability.

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

CHA supports retaining the seven principles, with clearer requirements for participation, equitable access and continuity of support.

The lived experience principle should require people with disability to participate in designing, testing and overseeing access processes, with assistance that enables those with complex communication or cognitive needs to contribute. Subsidiarity also recognises the contribution of families, communities and local organisations, and the responsibility of both State and Commonwealth Governments to support their capacity to fulfil their roles. In practice, this means drawing on their knowledge while preserving the person's involvement in decisions and providing the resources needed for effective participation.

Moreover, the person-centred principle should recognise the relationships and assistance that sustain a person's functioning. Achievements made possible through family care, professional support or assistive technology should be understood in that context. The availability of unpaid care should not be assumed to establish that this care can continue indefinitely or that disability-related needs have diminished.

Alongside this, the equity principle should give particular attention to people experiencing poverty, geographic isolation and barriers to care. This reflects CHA's preferential concern for those experiencing disadvantage and requires practical measures to address assessment costs, communication barriers and access to specialist evidence.

Finally, CHA calls for an additional principle that should address continuity of support and shared responsibility across service systems. Where a person is directed to another system, the process should establish whether suitable support is available and who will resolve any gap. For existing participants, responsibility for interim assistance should be agreed before current support ends. This would give practical effect to solidarity and reduce the risk that gaps between Governments and services are left for individuals and families to manage.

Recommendation 2: Strengthen the principles to require supported participation, recognition of informal care and attention to disadvantage. Add an explicit commitment to continuity of support, with agreed responsibilities for resolving service gaps and funding interim assistance.

Section 2 – Access decision-making process design

Question 3: What do we need to consider when designing an access decision-making process that is fair, consistent, transparent, disability-informed, and evidence based?

CHA broadly supports moving away from diagnosis-based access lists which – whilst they helped streamline entry during the transition to the full NDIS – have subsequently contributed to inequitable evidence requirements and access pathways. List A identified conditions considered likely to meet the disability requirements, generally reducing the need for further evidence of functional impact. Whilst List B identified conditions likely to result in permanent impairment, with applicants still required to demonstrate how that impairment affected their functioning.

These arrangements helped the Agency process applications during the Scheme's rollout. However, they established different pathways for people who could have comparable levels of functional impairment, particularly where a condition was unlisted or several conditions contributed to a person's disability. Obtaining the diagnosis needed to use a streamlined pathway could also depend on personal means, location and specialist availability.

A more consistent approach to functional assessment has the potential to address these inequities, provided it accurately captures the real-world impact of a person's disability. Removing access lists should preserve the evidentiary value of diagnoses, including what they establish about prognosis and impairment, and allow for streamlined assessment where eligibility is clear.

The 2023 NDIS Review recommended transparent assessment methods that recognise variation over time and across environments, something CHA supports. Assessment should distinguish functioning achieved through assistance from capacity without that support and account for the interaction between impairment and environmental barriers. Where the statutory definition prevents relevant circumstances from being considered, legislative amendment should be considered.

As CHA has previously argued, assessment tools must be validated for the cohorts in which they will be used, including cultural validation for Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities. First Nations expertise and people with lived experience should be involved in developing and testing these tools before roll-out. While validation findings and limitations should be published, with clear pathways for supplementary evidence where a tool cannot adequately capture the impact of a person's disability.

Implementation also requires sufficient assessors with the qualifications, training and time to apply those tools appropriately. Without this preparation, reform risks replacing existing inequities with differences in assessment quality and availability.

Finally, decision-makers should consider the person's account, relevant clinical evidence and, with consent, observations from carers and providers who know them over time. Written reasons should explain how the evidence relates to each eligibility criterion and why significant contrary evidence was discounted. Applicants must have a practical opportunity to correct factual errors and access review.

Recommendation 3: Replace diagnosis-based access lists with a transparent, validated functional assessment process that accounts for environmental context and variation, preserves relevant diagnostic evidence and provides streamlined pathways where eligibility is clear. Support implementation with a trained workforce, reasoned decisions and accessible review.

Question 4: How could the access decision-making process, including referral pathways, be designed to reduce administrative burden and make it easier and more equitable for people with disability, their families and carers to understand what information is needed and how decisions are made? How could this support a proportionate approach to minimise the assessment burden on persons who are clearly eligible with very significant functional impairment?

CHA supports assessment requirements proportionate to what remains uncertain about eligibility. Where existing evidence clearly establishes that the access requirements are met, the Agency should reach a decision without requiring another comprehensive assessment. People with very significant functional impairment may need detailed planning to determine their supports, but this should not unnecessarily delay an otherwise straightforward access decision.

A 'collect once, use many times' approach would help reduce this burden. Existing clinical reports, assessments and service records should be reused across access, planning and review where they remain accurate, relevant and suitable for the decision. Further evidence should be requested only to resolve an identified gap, with the Agency explaining why existing information is insufficient. Applicants must be able to review, correct and supplement their records, so that established evidence about permanent impairment can be retained while information about changing needs is updated.

CHA also supports publicly funded access assessments and additional evidence required by the Agency. Applicants should also have a named contact, accessible guidance and a choice of telephone, face-to-face and digital assistance, with independent advocacy available where needed. Guidance should explain the evidence requirements, how information will be considered and the reasons for decisions. These arrangements would reduce reliance on personal means and families' capacity to navigate administrative processes.

Appropriately governed AI could assist with organising records, identify existing evidence, and coordinate appointments and referrals. Analysis of waiting times and service capacity could also help direct assessment and navigation resources towards areas of unmet demand. Any proposed use should demonstrate a reduction in burden and delays after accounting for verification and correction requirements, and undergo privacy, security and equity assessment. Outputs used by staff must be checked against evidence, while evaluative judgements about eligibility, permanence and support needs are accountable to human decision-makers.

Consent arrangements require particular care. Applicants should receive accessible information about how AI would be used, what information it would process and whether external providers would have access. Where consent is relied upon, it must be informed, voluntary and specific, with supported decision-making and clear arrangements for withdrawal. Providing evidence for an access application should not be treated as blanket consent to unrelated AI processing or model training. Declining an optional AI-enabled service should not disadvantage an applicant or restrict access to human assistance and review.

Referral pathways should similarly minimise repeated assessments and the need to retell personal histories. Relevant information should accompany referrals through appropriate information-sharing arrangements, with the receiving service confirming whether it can meet the person's needs and when support can begin. A named agency should remain responsible for following up unsuccessful referrals and escalating gaps, with agreed interim assistance where necessary, including where delays prevent hospital discharge.

Recommendation 4: Adopt proportionate assessment requirements and a safeguarded 'collect once, use many times' approach, with expedited decisions where eligibility is clear, publicly funded additional evidence and coordinated referrals. Any AI use should demonstrate practical benefit and be subject to appropriate consent, privacy and oversight arrangements, with evaluative decisions remaining the responsibility of accountable human decision-makers.

Question 5: What should be considered to ensure the access decision-making process, as well as referral pathways, works well for all disability cohorts including people with communication, cultural, cognitive, degenerative, fluctuating, episodic or complex support needs?

A nationally consistent access process must accommodate differences in how people communicate, experience disability and participate in assessment. Adjustments should enable people to establish their eligibility without imposing additional evidence requirements simply because their needs are complex.

CHA has previously raised concerns that the proposed plan reassessment thresholds could disadvantage people with episodic, fluctuating or progressively deteriorating conditions. For these cohorts, support needs can change substantially without presenting as a single, sustained decline. Although those concerns related to planning, the underlying distinction is also relevant to access, as an impairment may be permanent even where its severity fluctuates, and a period of relative stability does not by itself establish that disability-related support is no longer required.

Access decisions should therefore draw on evidence of functioning over time, including the frequency, duration and severity of episodes, their cumulative effects and the assistance required between episodes. Assessment of degenerative conditions should consider the expected course of impairment, while multiple impairments should be considered together. Existing clinical and service records may provide a more reliable account than another isolated assessment and should be used wherever suitable. Applicants should not have to wait for deterioration or experience a crisis to demonstrate an impairment already established by the available evidence.

Communication and participation requirements should be identified before assessment begins. This includes interpreters, Auslan, alternative communication, accessible information and a trusted supporter chosen by the person. Additional time, familiar surroundings or several shorter interactions may be appropriate, but should not become routine requirements for every person within a particular cohort. Throughout the process, the person's will and preferences must remain central.

Assessment methods must also be culturally validated for Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities. First Nations expertise and people with lived experience should inform their development and testing, with supplementary evidence available where a tool has limitations. Implementation requires assessors with the relevant cultural capability and practical arrangements to address regional workforce shortages and travel barriers.

Referral pathways must be capable of responding when needs fluctuate or escalate. A receiving service should confirm that it has both the expertise and capacity to meet the person's needs, including during periods of increased support, with clear arrangements for urgent escalation and interim assistance. Consistent with our earlier submission, administrative timeframes must account for the consequences of delay, particularly where a person's circumstances are deteriorating.

Recommendation 5: Require access and referral processes to recognise that permanent impairment may fluctuate and that needs may change without sustained deterioration. Use suitable longitudinal evidence, culturally validated methods and individual participation adjustments without unnecessary reassessment, supported by timely escalation and continuity arrangements when needs increase.

Section 3 – Evidence requirements

Question 6: What factors and evidence should be considered when determining whether an impairment is permanent or likely permanent, including whether appropriate treatment is likely to improve the functional impact of an impairment?

CHA supports consideration of appropriate treatment when determining whether an impairment is permanent or likely to be permanent. Decisions should draw on clinical history, treatment already undertaken, the expected course of impairment and the reasoned opinion of appropriately qualified treating practitioners. Longitudinal evidence from allied health professionals and support services should also be considered, particularly where functional impact fluctuates or several impairments interact.

The assessment must distinguish treatment likely to remedy or alleviate an impairment from ongoing care that manages symptoms, maintains function or prevents deterioration. Continuing treatment, periods of stability or the prospect of some improvement should not, by themselves, displace evidence of permanence. A person may benefit from treatment and develop greater independence while continuing to require disability support.

Where further treatment is considered necessary, decision-makers should identify the treatment, its expected effect on functional impact and the timeframe in which that benefit could reasonably occur. This should account for previous treatment responses, contraindications, clinical risks and the views of treating practitioners. Requirements must respect bodily integrity and informed decision-making, and should not leave applicants repeatedly pursuing treatments with uncertain or negligible prospects of benefit.

As CHA has previously noted, treatment requirements must also reflect what a person can reasonably access. Public funding alone does not establish that treatment is available within a reasonable timeframe or accessible given waiting lists, out-of-pocket costs, travel requirements and cultural appropriateness. This includes circumstances where people face long waits for psychiatric care, unaffordable specialist fees or limited services in regional and remote communities. An applicant should not fail the permanence requirement on the basis of treatment that is not reasonably available to them.

Responsibility for addressing these barriers rests with Governments and the relevant mainstream services. If eligibility depends on obtaining treatment that is unavailable or unaffordable, a person may be unable to access either the health care they need or disability support. Gaps in the health system would then become grounds for exclusion from the NDIS, with the consequences falling most heavily on people already experiencing disadvantage.

Implementation should therefore provide a clear pathway for resolving treatment barriers and arranging interim support where required. Any decision that further treatment is necessary should explain its evidentiary basis and allow the applicant to provide supplementary evidence or seek review. Legislative amendment should be pursued where necessary to give effect to reasonable accessibility.

Recommendation 6: Base permanence decisions on individual clinical and longitudinal evidence, distinguishing ongoing management from treatment likely to improve functional impact. Require further treatment to be clinically appropriate and reasonably accessible, including in cost, location, timeframe and cultural appropriateness, with clear Government responsibility for addressing barriers and arranging interim support.