



Amazing podiatry always

2025-2026 National Disability Insurance Scheme Annual Pricing Review Submission

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Australian Podiatry Association (APodA) Submission

RE: 2025-2026 National Disability Insurance Scheme Annual Pricing Review
Submission

5 February 2026

Dear National Disability Insurance Agency,

Thank you for the opportunity to provide feedback in relation to the Commonwealth Government's 2025-2026 National Disability Insurance Scheme Annual Pricing Review.

The [Australian Podiatry Association](#) (APodA) is the peak professional body for podiatrists. APodA empowers podiatrists by providing strong advocacy, professional development opportunities, clinical resources, and member support services to assist at every stage of the career journey. Podiatrists are registered through the Australian Health Professional Regulatory Authority (Ahpra), [Podiatry Board of Australia \(PBA\)](#). As stated, *'the Podiatry Board of Australia works to ensure that Australia's podiatrists and podiatric surgeons are suitably trained, qualified and safe to practise'*.

The NDIA states that it has a responsibility to shape market conditions *'where providers can sustainably deliver diverse, high-quality services while participants exercise meaningful choice and control'* [1]. However, the current pricing arrangements do not support this responsibility in relation to podiatry therapy supports. Prices are not keeping pace with the actual cost of delivering sustainable podiatry therapy supports, which threatens service availability as more podiatrists indicate their intention to withdraw from providing NDIS supports.

Podiatry carries unique and significant costs, including strict infection control requirements and the need for specialised equipment and consumables. These rising costs are driving private practices to shift away from participation in funding schemes such as the NDIS and toward private payer models. As a result, participants face reduced access to podiatry therapy supports, undermining their choice and control within the Scheme.

APodA urges the NDIS to strengthen participant choice and control by ensuring ongoing access to podiatry therapy supports. This requires pricing and policy mechanisms that sustain a viable market and enable podiatrists to continue delivering essential services for people with disability.

We welcome the opportunity to provide further details if invited. Please contact, Daniella Florio, at advocacy@podiatry.org.au for further information or questions arising from this submission.

Yours sincerely



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1.0 About podiatrists

Podiatrists are university qualified healthcare professionals focused on the prevention, diagnosis, treatment, and rehabilitation of conditions affecting the foot, ankle, and lower limb. The scope of practice is broad, ranging from prevention in primary care settings through to surgery in private hospitals and can be endorsed to prescribe medicines. They work in the public and private practice settings and manage a wide range of issues, including skin and nail disorders, musculoskeletal problems, diabetic foot complications, and wound care. With over 6,000 podiatrists in Australia, podiatry plays a vital role in maintaining mobility, independence, and overall well-being across all life stages.

Podiatrists have been involved since the inception of the NDIS in 2013. In 2024, out of the over 6,000 podiatrists in Australia, 46% deliver NDIS therapy supports, totalling \$13 million at an average of \$399.44 per participant [2].

In the NDIS, podiatrists support participants to maintain mobility, independence, and community participation that can significantly impact daily living. By enabling participants to move safely and confidently, podiatry aligns closely with the NDIS focus on capacity building and supporting people to live active, connected lives.

Podiatry therapy supports are delivered for a range of people with disabilities such as intellectual disability, autism, physical and/or psychosocial disabilities. These conditions may be accompanied by sensory issues or behavioural challenges.

2.0 Summary of APodA Recommendations

APodA recommends that the National Disability Insurance Agency (NDIA):

1. Introduce specific safeguards to support practice sustainability and prevent provider withdrawal in thin markets.
2. Examine “Stewardship in Thin Markets” in metropolitan areas, not just rural and regional Australia, for professions such as podiatry, who are experiencing workforce shortages.
3. Cease benchmarking against Medicare and private health insurance and sets fair, evidence-based pricing that reflects the true cost of delivering podiatry therapy supports in the NDIS.
4. Review regulatory requirements to ensure they are proportionate and reduce the administrative burden placed on podiatrists.
5. Introduce grants for providers to cover the cost of registration with the NDIS Quality and Safeguards Commission.
6. Commence a dedicated therapy support pricing pilot for small providers as recommended by the Allied Health Professions Australia (AHPA).
7. Conduct a podiatry specific costing study to ensure pricing accurately reflects the high operational costs of delivering podiatry supports.



3.0 Summary of key Issues

Current workforce constraints, rising operating costs, and growing service demand are significantly affecting the viability of podiatry practices. Podiatrists can choose how and where they deliver services and are increasingly prioritising funding models that support business sustainability. A sustainable business model requires reasonable:

- Pricing
- Administrative demands (e.g., reporting requirements, ease of payment)
- Feasibility of service delivery (including management of client complexity)

This submission addresses the 2025-2026 NDIS Annual Pricing Review Terms of Reference by highlighting the following key issues:

- Market sustainability for podiatry therapy supports is under threat with the current NDIS policy settings.
- The true cost of delivering podiatry care, including administrative requirements, infection control, consumables, and regulatory compliance is not reflected in the current NDIS pricing arrangements.
- Benchmarking NDIS against Medicare and private health insurance schedules is not an equal comparison.
- Reduced access to podiatry will lead to higher rates of preventable complications, hospitalisation, and long-term disability.

As one APodA member reflected:

“Working with NDIS participants is the most rewarding part of my job. The complexity and challenges associated with each individual makes it a more inspiring space to work in. The stagnant and now reduced remuneration within NDIS now makes it impossible to continue to provide the same level of multidisciplinary care.”

4.0 Market Stewardship

A key component of the NDIS is to ensure participants have genuine choice and access to high quality services. Podiatry is an in-demand profession with well documented workforce shortages, which directly impacts participants’ ability to access timely, appropriate care. According to the [Jobs and Skills Australia Occupation Shortage List](#), podiatry is in shortage across metropolitan and rural regions in every state and territory in Australia. Podiatry enrolments at universities have also seen a decrease of 17.3% in Australia and New Zealand since 2015 [3].

When funding levels do not reflect the true cost of delivering these podiatry therapy supports, providers are forced to make financial decisions to remain viable. This inevitably leads them to prioritise funding sources that enable sustainability, meaning they may reduce or withdraw services from schemes where funding does not meet service delivery costs. The comments below from an APodA member reflects their capacity and viability in the NDIS scheme:

“Podiatry clinics are busy enough as it is. We could cease seeing NDIS participants and still be booked out weeks in advance. It’s less money and more work that we don’t actually need. I’m confident a lot of clinics feel the same. Unfortunately, that means NDIS participants may struggle to find podiatry care in the future.”



Waiting lists are common across podiatry and are a symptom of workforce shortages. This is particularly problematic in rural and regional areas. For example, APodA have become aware that available appointments in rural Victoria of waiting times of up to four months in Mildura, and six months in Phillip Island.

A reduction in willing providers will further exacerbate existing thin markets for podiatry and reduce participant choice, control and timely access to essential supports. The APodA understands that the NDIA is examining “Stewardship in Thin Markets” [4]. This review is limited to rural and remote areas and excludes the policy and pricing impacting upon the broader service delivery system particularly within podiatry.

The Independent Pricing Commission (IPC) reviewed how current pricing arrangements are working, with a particular focus on their implications for the market’s structure [5]. The [IPC’s Final Pricing Report 2025](#), provides better directions for supporting service viability, workforce needs, and participant outcomes compared to current NDIS pricing arrangements, which retain capped pricing, capped travel, phased out remote loadings, and no cost of living adjustments.

The [Transport Accident Commission \(TAC\)](#) is an example of price setting in a scheme that has led to the development of a thin market. The APodA June 2022 renewal data showed that less than 20 podiatrists in Victoria deliver services for the TAC. Podiatrists have advised that due to the low remuneration fees and administrative demands, they choose not to see TAC clients. Consequently, TAC offer [Above Rate Service Agreements](#) to retain providers in the scheme.

Recommendation 1: APodA recommends that the NDIA introduces specific safeguards to support practice sustainability and prevent provider withdrawal in thin markets.

Recommendation 2: APodA recommends that the NDIA examines “Stewardship in Thin Markets” in metropolitan areas, not just rural and regional Australia, for professions such as podiatry, who are experiencing workforce shortages.

5.0 Benchmarking

In June 2025 the [NDIS Annual Pricing Review 2024-25](#) was released. The analysis provided benchmarking against Medicare and Private Health Insurance and a reduction in the hourly rate for podiatry therapy supports. Following the introduce of this change on 1 July 2025, the APodA surveyed its members to determine the impact of this change. Podiatrists overwhelmingly expressed that whilst they were committed to participant care, the reduction was making them re-evaluate the viability to continue delivering therapy supports in the scheme. They consistently voiced the need to be valued and reasonably remunerated for providing therapy supports.

The price changes, combined with current policy settings such as the Podiatry and foot care supports policy under the guidelines of [Disability-related health supports](#) Policy, are contributing to podiatrists either intending to leave the Scheme or limiting their services to participants with lower levels of complexity [6].

Key actions podiatrists reported they were likely to take as a result of the price changes include [6]:

- **62%** beginning to decline referrals for clients with complex disabilities
- **57%** ceasing travel to provide home visits
- **47%** considering leaving the NDIS altogether



If 47% of podiatrists leave the NDIS, this would result in approximately 1,331 podiatrists ceasing to provide services, potentially impacting access for thousands of participants.

The cost of delivering therapy supports in the NDIS is different to delivering services in Medicare and Private health insurance (PHI) schemes.

Private health insurance podiatry visits offer flexibility and are guided entirely by individual needs. Patients pay the full fee on the day and may claim rebates if eligible. These visits can range from addressing simple, one-off issues to providing regular general treatment and preventative care. There are no formal administrative requirements unless clinically necessary. For home visits, pricing includes a travel component, and an out-of-pocket fee applies.

The differences between delivering services in Medicare and NDIS are highlighted in the table below.

Category	Medicare Benefits Scheme (MBS): Chronic Disease Management (CDM)	NDIS (Therapy & Capacity-Building Supports)
Purpose of scheme	Short term, limited allied health support for chronic disease management.	Disability related functional needs, mobility, independence, and prevention of secondary complications.
Eligibility	GP managed chronic disease plan; not disability specific.	Participants with functional impairments related to their disability.
Number of visits	Up to five allied health visits per calendar year, shared across <i>all</i> allied health professions (e.g. podiatry, physiotherapy, dietetics).	Determined by participant goals, functional needs, podiatry assessment, and funding within plan. No arbitrary visit caps.
Appointment length	Typically, 20-30 minutes.	Length determined by clinical need. Longer sessions common for complex disability presentations. 71% of podiatrists deliver hourly sessions [2].
Complexity of care supported	Limited—model designed for stable chronic conditions. Not suited for complex disability.	High complexity supported. Includes neurological conditions, intellectual disability, behavioural issues, high risk foot, mobility impairment.
Out of pocket costs	Often gap fees (difficult for Disability Support Pensioners)	No out-of-pocket costs if properly funded through plan.
Scope of podiatry supported	Narrow scope: routine care, simple assessments. May exclude complex interventions.	Full scope: functional assessments, mobility support, gait retraining, orthotic/assistive technology prescription, wound prevention, education, multidisciplinary care.
Who determines frequency of visits	GP sets CDM plan; podiatrist has limited influence.	Determined by podiatrist's clinical assessment + participant goals + plan funding.
Decision-maker for care	GP and MBS rules; decisions often funding driven.	Participant + podiatrist + support coordinator. Decisions clinically driven.

Suitability for disability	Low – scheme does not account for complexity, behaviour, mobility needs or high-risk foot.	High – specifically designed to address disability related functional needs.
Examples of service limitations	Does not cover frequent ongoing care needed for high-risk foot; neurological conditions, amputees; short appointments restrict meaningful intervention.	Supports ongoing, preventative, and capacity building interventions; higher frequency; multidisciplinary collaboration.
Home Visits	Limited. Often gap fees (difficult for Disability Support Pensioners).	Travel included

MBS and PHI also increase annually with the Consumer Price Index (CPI) compared to NDIS which has seen a reduction in fees. The NDIS fee structure is not keeping up with inflation and at risk of losing a significant proportion of providers.

Appendix 1 includes a real-world lived experience from Jane who is a NDIS participant. This demonstrates how access to podiatry therapy supports through the NDIS reduced the impact of her disability, allowing Jane to wear shoes again and re-engage in a community program. The model of service delivery available through the Medicare Benefit Scheme (MBS) does not support her needs.

Recommendation 3: APodA recommends that the NDIA cease benchmarking against Medicare and private health insurance and sets fair, evidence-based pricing that reflects the true cost of delivering podiatry therapy supports in the NDIS.

6.0 Differential Pricing

The podiatry profession is already subject to regulation and high standards of professional conduct, ongoing training, and clinical governance through the [Ahpri Podiatry Board of Australia](#). Podiatrists have a long history of delivering high quality services, often as sole practitioners or within small businesses, which form a significant proportion of the NDIS workforce.

6.1. Registration, Provider Capability and Quality

Registration and assurance requirements in the NDIS must recognise the compliance, cost and quality investments already required of Ahpra registered providers. A large proportion of podiatrists choose not to register with the NDIS because of the administration burden involved. The process is viewed as duplication of safeguards already in place for the profession and podiatrists can still deliver services for self-managed and plan managed participants in the scheme. [Commonwealth Government data](#) indicates that approximately one third of private podiatrists operate as sole practitioners.

There is significant administration requirements under the NDIS compared to other funding schemes. This includes registration and compliance issues as a business and service agreements and report writing for participants. As an APodA member pointed out:

“It’s time consuming and not worth the amount of mucking around - especially with demands in podiatry already we don’t need them, there are so many clients needing podiatry”



APodA has also received direct correspondence from members confirming withdrawal of services months after the introduction of the price change with one podiatrist stating:

“I have moved away from the NDIS space due to the amount of paperwork involved and red tape”

For providers who choose to register with the NDIS, additional audit requirements create significant financial and administrative burden. As outlined in the AHPA submission, these audit costs are a key barrier to registration, particularly for providers in regional and rural Australia. An APodA member reflected this stating:

“Simplify the NDIS system. Acknowledge our registration board and therefore reduce the red tape for qualified and board certified professionals”

Podiatrists must also meet infection control standards set by the National Health and Medical Research Council (NHMRC).

Comparison of regulatory requirements across schemes:

Scheme	Baseline Requirements	Additional Requirements
NDIS (non-registered)	Ahpra registration	Nil
NDIS (registered)	Ahpra registration	NDIS Worker Screening Police Check Working with Children Check Policies and procedures; audit cycle every 18 months–3 years depending on registration type
Medicare	Ahpra registration; provider number for each location	Nil
Private Health	Ahpra registration; provider number for each location	Nil
Support at Home	Ahpra registration; police check; professional indemnity insurance	Nil

A risk proportionate registration model would reduce unnecessary duplication and ensure that podiatrists are not subject to additional regulatory burden that exceeds that of comparable schemes.

Podiatrists delivering therapy supports in the NDIS must invest in professional development, training, supervision and outcome measurement to meet professional requirements including:

- Completion of a minimum of 20 hours of CPD annually under Ahpra.
- Maintenance of structured training schedules if a registered NDIS provider.
- Collection of outcome measures to support evidence-based care.

In addition to ensure that needs of complex NDIS participants are met, providers must allocate additional resources for staff training and ongoing support for supervision and professional development. Through the APodA survey one member summed up by stating:

“Participants in the NDIS are typically more complex than those in other schemes. This requires the upkeep of different skills & training from varying diagnosis & conditions, mental

health & behaviours, not to mention keeping informed on regulatory compliance in order to maintain best practice in care provision and within the NDIS framework.”

Recommendation 4: APodA recommends that the NDIA review regulatory requirements to ensure they are proportionate and reduce the administrative burden placed on podiatrists.

Recommendation 5: APodA recommends that the NDIA introduce grants for providers to cover the cost of registration with the NDIS Quality and Safeguards Commission.

6.2. Size of Provider

The NDIA’s therapy pricing work under the Therapy Quality Supports Pilot Program appears to include only large providers, which limits the representativeness of the findings. This approach excludes a substantial portion of the podiatry workforce and risks generating pricing settings that do not reflect the true mix of providers delivering NDIS services.

A number of issues arise from this limitation:

- Under-representation of sole practitioners and small businesses: The Commonwealth Government’s [Health Workforce Data Website](#) shows that 31.5% of podiatrists are sole practitioners and 48% are in group practices, which demonstrates the significance of smaller providers to the sector.

One member highlighted the challenge this creates: *“Need a lot of admin support. Very hard for small/solo practices.”*

- Large providers may not include podiatry: Many large multidisciplinary organisations do not offer podiatry at all, meaning their data cannot accurately represent podiatry specific workflows, operating costs or workforce structures.
- Existing regulation must be recognised: Any future registration or pricing changes must adopt a risk proportionate approach that acknowledges that podiatrists are already regulated under Ahpra, with clear clinical, professional and safety standards.

The APodA is concerned about the potential for unintended consequences if the Pilot findings are applied broadly without meaningful podiatry involvement. Podiatry workforce distribution, service models and business operations differ substantially from many other allied health professions, particularly those concentrated within large providers. As such, policy decisions based on incomplete data risk disadvantaging the podiatry sector and reducing service access for NDIS participants.

Recommendation 6: APodA recommends that the NDIA commence a dedicated therapy support pricing pilot for small providers as recommended by the Allied Health Professions Australia (AHPA)

6.3. Participant Complexity and Intensity

Due to their disability, NDIS participants generally present with higher clinical podiatric risk. NDIS participants are inherently complex. Managing behavioural issues or cognitive impairments commonly experienced by people with intellectual disability or psychosocial disability requires significant time, skill, and rapport-building. A participant’s complexity should therefore be accommodated by increased resourcing and services within their NDIS plan and funding allocation rather than imposed on providers through differential pricing.



Introducing price differentiation based on complexity would add unnecessary administrative burden, increase inequity, and overlook the existing regulatory oversight already governing podiatry practice. Instead, the system should ensure participant-specific complexity is appropriately funded through their individual plan.

6.4. Podiatry Operational Costs

Unlike other allied health professions, podiatry carries higher operational expenses. These costs stem from the use of specialised equipment, consumables, and personal protective equipment (PPE), as well as the requirement to use sterilised instruments to comply with Australian Standards for Infection Control. This makes it significantly more expensive to provide than talking based therapies, even though talking based therapies are typically reimbursed at higher rates.

Recommendation 7: APodA recommends that the NDIA conduct a podiatry specific costing study to ensure pricing accurately reflects the high operational costs of delivering podiatry supports.

7.0 Conclusion

Current workforce constraints, rising operating costs, and growing service demand are placing significant pressure on the viability and sustainability of podiatry practices. As independent health professionals, podiatrists can choose how and where they deliver services. Increasingly, they are prioritising funding and operating environments that support business sustainability and enable them to provide safe, high-quality care. A sustainable service model requires reasonable pricing, manageable administrative demands and feasible service delivery conditions that reflect the complexity and risks associated with podiatry care.

Current NDIS policy settings do not support market sustainability for podiatry services, and existing pricing does not accurately reflect the true cost of care. These costs include not only direct clinical time but also essential administrative work, infection control requirements, consumables, regulatory compliance, and the overheads associated with maintaining safe, accredited practice environments.

Benchmarking NDIS pricing against Medicare or private health insurance schedules does not provide a reasonable basis for comparison.

Workforce shortages across both metropolitan and rural regions are intensifying market vulnerability. Increasing numbers of podiatrists are withdrawing from NDIS service provision due to unsustainable pricing and administrative burden. Without intervention, reduced access to podiatry will drive higher rates of preventable complications, avoidable hospitalisation, and long-term disability.

A pricing structure that supports the true cost of podiatry therapy supports will support market stability, strengthen participant outcomes, and uphold the integrity and intent of the Scheme.

8.0 Appendix 1

Case Study

Jane is a 50-year-old woman with an intellectual disability and autism. She is non-verbal, has sensory issues and communicates via hand gestures or actions. These hand actions, for example, may include holding a staff member's hand or pushing them away. When she becomes anxious, she can become aggressive towards others or will use her hands to slap and punch herself.

Jane resides in a supported accommodation house with 4 other residents with 24-hour staffing. She responds well to routine, consistency and regular staff interactions. Jane attends a day centre where she engages in sensory activities, however, her sensory challenges mean she doesn't want anyone to touch her feet.

Jane was attending a local podiatry service under the Medicare Benefit Scheme for nail care. She found attending any medical clinic stressful and would become anxious as it was not part of her routine and an unfamiliar environment. The noise and smells of the clinic and waiting for her appointment increased her anxiety. When she did see the podiatrist, Jane would refuse to sit in the podiatry chair, and on the occasions she did, would refuse the podiatrist touching her feet.

Jane's nails became extremely long, ingrown and had thickened due to a fungal infection. Jane was unable to communicate to staff if she was in any pain, however she began to refuse wearing shoes, likely due to the pressure of the nails in her shoes.

It was deemed unsafe for her to attend because she wouldn't wear shoes and her day placement was ceased.

Podiatry was then offered through NDIS. The podiatrist was able to provide home visits where Jane was more relaxed and comfortable. Flexible short visits were able to be organised to suit Jane's sensory needs and introduce her podiatric therapy supports.

As a result, Jane was able to start wearing shoes and has returned to day placement.

Without access to podiatry services through the NDIS, Jane's ability to participate in everyday activities was significantly limited. Thanks to flexible and regular home visits provided by NDIS-funded podiatry services, her individual needs were met—leading to a more inclusive, independent, and fulfilling life.

9.0 References

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