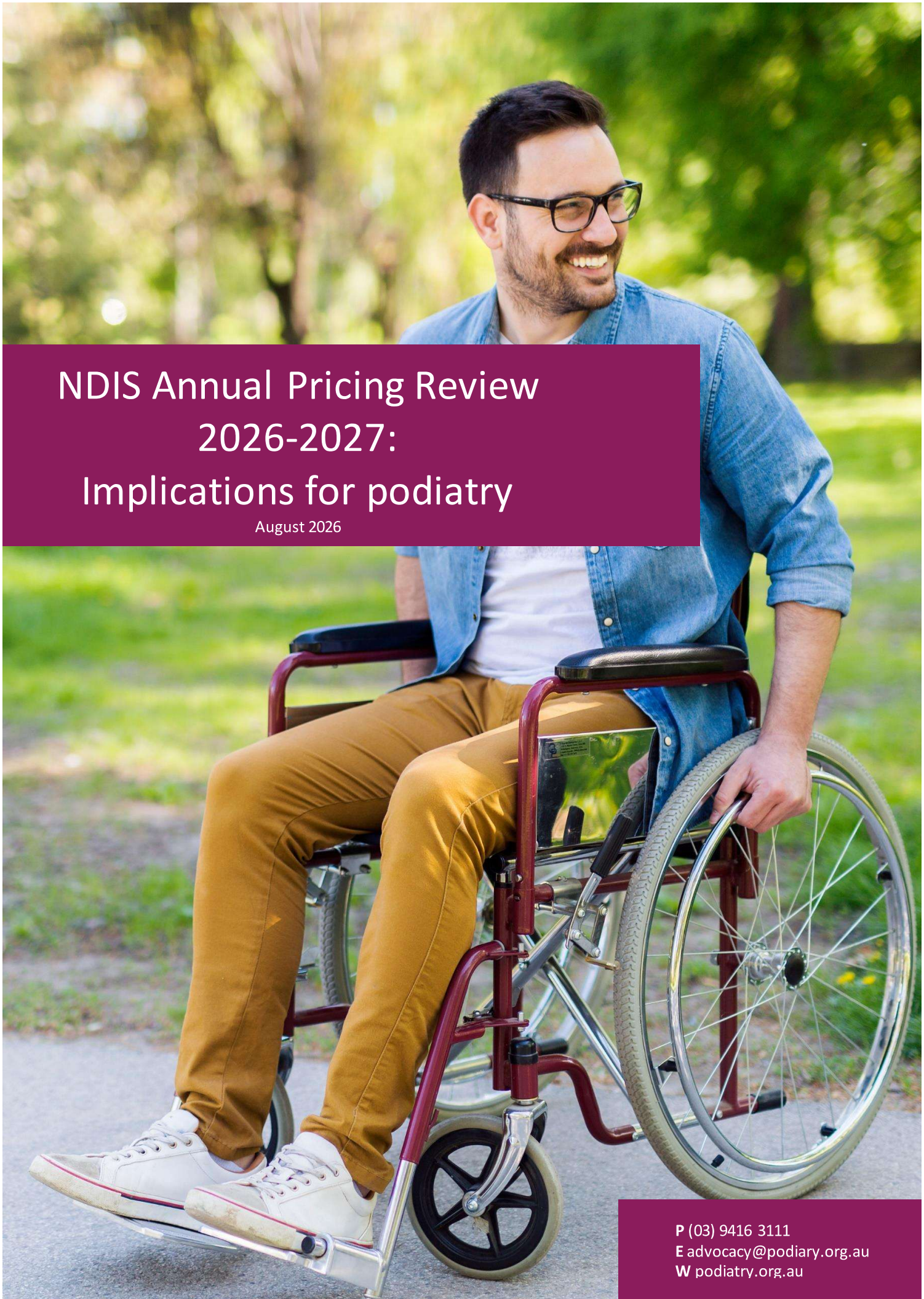

NDIS Annual Pricing Review 2026-2027: Implications for podiatry

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Executive Summary

The NDIS Annual Pricing Review (APR) for 2026-27 concluded that current podiatry pricing remains appropriate and recommended no change to the National Disability Insurance Scheme (NDIS) hourly therapy rate. This conclusion was based largely on benchmarking against Medicare Benefits Schedule (MBS) data and data from two undisclosed private health insurers (PHIs), with the National Disability Insurance Agency (NDIA) finding that NDIS podiatry prices remain above comparable market rates.

The Australian Podiatry Association's (APodA) position, however, is that this benchmarking approach does not adequately reflect the realities of providing podiatry services for NDIS participants. In particular, the review fails to sufficiently account for the complexity of participant needs, the time required to deliver safe and effective care, and the significant administrative and compliance obligations associated with NDIS service delivery.

Podiatry also differs from many other allied health professions in its cost structure. The delivery of podiatry services requires specialised clinical equipment, ongoing investment in consumables, and rigorous infection prevention and control measures. These factors create substantially higher operating costs than those associated with many consultation-based or talking therapies, despite reimbursement rates often being comparable or, in some cases, lower.

At the same time, demand for podiatry services within the NDIS continues to increase, while the number of podiatry providers has declined. This trend raises concerns about the long-term sustainability of service delivery, particularly in thin markets, and risks reducing participant access, choice and continuity of care.

1.0. NDIS Annual Pricing Review 2026-2027 findings relevant to podiatry

The NDIS APR 2026–27 identified podiatry as a small but important component of the NDIS therapy market [1].

Table 1: NDIS data for the six months to December 2025 [1]:

Indicator	2025–26
Total payments	$14 million
Participants accessing podiatry	34,165
Podiatry providers	2,671
Current NDIS hourly rate	$188.99

The NDIA concluded [1]:

- Current podiatry pricing remains within an acceptable range.
- No price increase is required.
- Existing pricing sufficiently reflects market conditions.
- Benchmarking against PHI and MBS supports current pricing arrangements.
- National pricing with remote and very remote loadings should continue.

The APR also relied heavily on assumed rather than actual consultation times, adopting a median podiatry session length of 30 minutes based on MBS and private health insurance (PHI) utilisation

data. This assumption is a key input to the pricing methodology, as NDIS therapy prices are set on an hourly basis, while many comparator systems use session-based pricing. To enable comparisons, the NDIA converts session fees into "implied hourly rates" using estimated consultation durations. MBS does not provide data on session lengths, and therefore it is unknown how this assumption was determined.

2.0. Podiatry therapy supports engagement and trends over time

NDIS have been reporting on the engagement of NDIS participants, the cost to the NDIS and participation of the podiatry provider participation over time. Below is a comparison of the change in these areas and trends that appear to be emerging.

It is important to note that the NDIA changed the way they reported annual pricing and there was no report for 2025-26; this data is incorporated into the NDIS APR 2026-2027.

Table 2: NDIS participants accessing podiatry therapy supports [1-3]

APR Year	NDIS Participants
2023–24	28,251
2024–25	32,545
2026–27*	34,165

*NDIS comparative data for 2025-26

Between 2023–24 and 2026–27:

- Participant numbers increased by 5,914.
- Total growth was approximately 21%.
- Demand continues to increase despite pricing settings.

Table 3: Podiatry therapy support expenditure in the NDIS [1-3]

APR Year	Expenditure
2023–24	$10.7 million
2024–25	$13 million
2026–27*	$14 million

*NDIS comparative data for 2025-26

Over the three-year period:

- Total payments increased by approximately 28%.
- Growth appears driven primarily by increased participant numbers rather than increased pricing, particularly as the podiatry rate decreased from $193.99 to $188.99 on 1 July 2025.

Table 4: NDIS expenditure per participant on podiatry therapy supports [1-3]

APR Year	Average Expenditure per Participant
2023–24	$378.74
2024–25	$399.44
2026–27	$409.77

The average expenditure per participant has increased slightly over the last 3 years for podiatry therapy supports. When compared to the average annualised plan budget for active NDIS participants as of September 30, 2025, of $84,500 for Supported Independent Living (SIL) and $63,900 for NDIS participants not in SIL [4], expenditure on podiatry therapy supports is insignificant.

The small expenditure in podiatry therapy supports delivers significant value for the scheme in supporting NDIS participants to achieve their goals.

Table 5: Podiatry provider participation in the NDIS [1-3]

APR Year	Podiatry Providers
2023–24	2,738
2024–25	2,833
2026–27*	2,671

*NDIS comparative data for 2025-26

Key observations:

- Provider numbers increased between 2023–24 and 2024–25.
- Provider numbers subsequently fell to 2,671 in 2025-26.
- Compared with the previous year, there was a decline of approximately 5.7%.

In 2023-24, 32,545 participants accessed podiatry therapy supports from 2,833 providers, representing an average caseload of 11.5 participants per podiatry provider [3]. By comparison, in 2024-25, 34,165 participants accessed podiatry therapy supports from 2,671 providers, equating to an average caseload of 12.8 participants per podiatry provider [2].

Overall, despite growing NDIS participant demand for podiatry therapy supports, the podiatry provider market has contracted and the average caseloads per podiatry provider has increased. For the small size of the expenditure per NDIS participant, this trend raises concerns about access to podiatry therapy supports, especially in locations where thin markets exist such as regional, rural and remote areas.

Reduced access to podiatry therapy supports has the potential to reduce mobility and independence. Additionally, it is anticipated that inability to access these therapy supports will also result in adverse outcomes such as increased disability, additional visits to General Practitioners and avoidable hospitalisations that result in amputations.

3.0 Podiatry workforce and market pressures

As demand for podiatry therapy supports in the NDIS is increasing, the proportion of the podiatry workforce willing to participate in the scheme is contracting. The Ahpra registered and practising podiatry workforce is experiencing small but steady annual growth [5] yet the proportion of participation across this workforce in the NDIS is declining – refer to table 6.

The APR notes there are approximately 6,700 registered podiatrists nationally, which is higher than the Ahpra Podiatry Board of Australia's figures of 6,131 registered practising podiatrists [6]. It is unknown why the official data from the Australian Health Practitioner Regulatory Authority (Ahpra), was not used. The figure used in the NDIS APR 2026-2027 report overestimates the availability of registered podiatrists [1].

Table 6: Podiatry provider participation in the NDIS as a proportion of the registered practising podiatrists [1-3, 6-8]

APR Year	Providers	Ahpra Registered	Proportion
2023–24	2,738	5,982	45.8%
2024–25	2,833	6,083	46.6%
2026–27*	2,671	6,131	43.6%

*NDIS comparative data for 2025-26

4.0 Comparison of APR Findings with APodA Policy Position

The APR concludes that current NDIS pricing arrangements for podiatry are appropriate, noting that podiatry price limits exceed the 75th percentile of comparable market rates and that MBS and PHI fees remain suitable benchmarks. Consequently, the APR does not recommend any changes to existing pricing settings [1].

APodA does not support this conclusion and considers reliance on MBS and PHI benchmarks to be inappropriate for assessing the adequacy of NDIS pricing.

Comparison with MBS fee settings suggests that current NDIS pricing may undervalue rather than overvalue podiatry services. From 1 July 2026, the MBS benefit for a standard podiatry consultation is $63.40 per 20-minute service, equivalent to $190.20 per hour. As the MBS benefit represents 85 per cent of the scheduled fee, this equates to a scheduled MBS fee of approximately $223.76 per hour [9]. In comparison, the current NDIS price limit for podiatry services is $188.99 per hour [1].

This means that NDIS-funded podiatry services are priced below the equivalent Medicare scheduled fee, despite typically involving:

- Greater clinical complexity and higher support needs
- Increased care coordination and multidisciplinary collaboration.
- More extensive reporting, documentation and administrative obligations.

Accordingly, APodA considers that MBS and PHI fee schedules do not provide an appropriate benchmark for NDIS-funded podiatry supports and are likely to underestimate the true cost of delivering these services to participants.

APodA further notes that podiatry has unique operating costs not faced by many other allied health professions, including:

- Clinical instruments.
- Sterilisation equipment.
- Infection prevention and control requirements.

The APR does not appear to have specifically examined these podiatry-related cost drivers.

5.0 Assistive Technology

Although the APR guideline acknowledges orthoses and medical grade footwear as assistive technology supports access to podiatry-related assistive technology within the NDIS is frequently hindered by lengthy assessment and approval processes, inconsistent decision-making, and a lack of clarity regarding eligibility requirements. Similar requests can receive different outcomes depending on the planner, delegate or region, creating uncertainty for both participants and providers. Delays in accessing clinically necessary supports can lead to deterioration in foot health, increased pain, reduced mobility, greater falls risk, and potentially avoidable hospitalisations.

For many participants, orthoses, footwear modifications and other lower limb devices are not supplementary interventions but central components of disability support. They are often critical to:

- Maintaining mobility.
- Improving functional capacity.
- Preventing falls.
- Reducing pain.
- Managing deformity.
- Preventing skin breakdown and wounds.
- Delaying or avoiding more intensive supports

A further challenge is the insufficient recognition of podiatry-prescribed assistive technology. These supports are sometimes incorrectly classified as everyday living expenses or health system responsibilities rather than disability-related supports, creating barriers to timely access. Funding decisions may also fail to recognise the preventative value of these interventions, despite their ability to maintain function, support independence and reduce the need for more costly health and support services over time.

6.0 Key Risks and Considerations for Future Planning

The 2026–27 APR data presents a mixed picture for podiatry within the NDIS. While participant numbers and overall expenditure continue to grow, several emerging trends indicate potential risks to the long-term sustainability of the podiatry market and participant access to services.

6.1. Decline in providers

The most significant concern is the decline in provider numbers despite increasing demand. Between 2024–25 and 2026–27, the number of podiatry providers decreased from 2,833 to 2,671, while participant numbers increased from 32,545 to 34,165 [1, 2]. This suggests that the existing workforce

is supporting an increasing number of participants with fewer providers available to deliver services. If this trend continues, participants may experience longer waiting times, reduced choice of providers, and increasing difficulty accessing services, particularly in regional and rural areas where workforce shortages exist.

6.2. Podiatry workforce

Underlying this issue is the relatively small size of the podiatry workforce. The APR notes that there are approximately 6,700 podiatrists nationally, significantly fewer than many other allied health professions [1]. In an environment where demand for podiatry services is increasing across the health, aged care and disability sectors, the profession has limited capacity to absorb additional NDIS demand without targeted strategies to improve workforce attraction, retention and participation.

6.3. Pricing methodology

A further concern relates to the assumptions underpinning the APR's pricing methodology. Because NDIS therapy prices are set as hourly rates while many comparator systems charge on a per-session basis, the NDIA converts session-based fees into "implied hourly rates". This is done by applying estimated consultation lengths for each profession, based on the 25th percentile, median and 75th percentile of session durations drawn from MBS and PHI data and informed by consultation with allied health peak bodies.

The APodA notes the outcomes of our consultation with the NDIA in early 2025:

- a graduate working with NDIS emailed on 17 January 2025 and requested a meeting with 2 business days' notice. The emailed asked the APodA to come to a meeting with answers to questions related to session lengths and non-face-to-face activities.
- The APodA requested more time to consult quickly with some podiatrists that work in the NDIS. This was challenging with so many people on holidays and a sample of one could not be considered as representative data.
- The APodA met with the graduate and other NDIS officials on 29 January 2025. During this consultation, the APodA outlined the complexity of different models of service delivery including home visits, in-clinic visits and those to community housing. Additionally, the uniqueness of podiatry therapy supports and costs associated with meeting infection control standards, consumables required and minor surgery to be delivered was outlined.
- As a follow on the APodA received from the NDIS an email on 20 February 2025 posing a completely different set of questions. The intention was for the NDIS to better understand therapy session structures, pricing models and ancillary costs. There was no deadline for provision of this information and an acknowledgement that the APodA would require time to undertake this activity.
- The APodA advised in March that to deliver a well informed and representative perspective a profession-wide consultation would need to be undertaken. The APodA suggested multiple workshops capturing insights from members across different work settings and ensuring a balanced representation using the Modified Monash Model. As a small peak professional body a request was made for resources to support this research.
- The NDIS advised that they didn't have the resources to support the APodA to undertake this research.

In summary, the consultation with the APodA **did not** result in the provision of information to the NDIS on sessions lengths. In July 2025, the hourly rate for podiatry therapy supports was cut by $5 per hour [2].

The review relies heavily on a median consultation length of 30 minutes derived from MBS and PHI data. Since the MBS doesn't collect data on length of service for podiatry services and the consultation with the APodA resulted in no data on this question, it is unknown how the use of 30 minutes has been derived. Essentially, the methodology used to derive the 30 minutes lacks transparency. Table 59 presents MBS and PHI session fees alongside the reference consultation times used to convert these fees into hourly rates; however, the source of the underlying calculations is listed simply as "NDIA calculations from MBS and PHI data" [1]. This makes it difficult for stakeholders to understand how the reference times were determined, assess their validity, or evaluate whether the resulting benchmark hourly rates accurately reflect contemporary clinical practice.

Additionally, many concerns have been raised about the appropriateness of comparing NDIS with MBS and PHI-funded services. In the NDIS, participants present with greater complexity and require more intensive, individualised support than is typically seen in MBS or PHI-funded services. As a result, consultation lengths observed in these systems may not accurately reflect the time required to provide safe and effective care to NDIS participants.

Podiatrists working with people with disability frequently provide longer consultations involving behavioural support strategies, complex clinical decision-making, engagement with family members and carers, multidisciplinary care coordination, report writing and home-based service delivery.

These additional requirements increase both the time and cost associated with service provision and raise questions about whether current pricing adequately reflects the realities of NDIS practice.

6.4. Participants with complex needs

There are also growing concerns about access for participants with the most complex needs. APodA survey findings suggest that some providers are reducing home visits, limiting their acceptance of high-complexity participants, or considering withdrawing from the NDIS market altogether [10]. These decisions are often driven by concerns regarding financial viability and the increasing administrative burden associated with NDIS service delivery. The consequences are likely to be most significant for participants with severe physical disabilities, neurological conditions, complex foot deformities, chronic wounds, high falls risk and other conditions requiring regular specialist podiatry intervention. Reduced access for these cohorts may ultimately lead to poorer health outcomes and increased costs elsewhere in the health and disability systems through preventable complications, hospitalisations and loss of functional independence.

7.0 Strategic Considerations for APodA

7.1. Cost of podiatry therapy supports

The findings of the APR reinforce the need to build evidence to inform decision making to ensure NDIS pricing and policy settings accurately reflect the value and costs of podiatry therapy supports. A key priority should be establishing a stronger evidence base on the true cost of delivering podiatry therapy supports within the NDIS. This includes quantifying the costs associated with sterilisation, equipment, consumables, clinical infrastructure and the significant administrative requirements unique to the disability sector. A dedicated podiatry costing study using an evidence-based health economics design would inform future pricing reviews and challenge assumptions based on unrelated healthcare funding systems.

The APodA notes that the NDIS has commenced a three-year pricing workplan [11]. This workplan includes a Quality Supports Therapy Pilot to identify features of quality service provision and the costs associated with delivery of services. Out of the 27 large, registered providers selected only one of them provides podiatry therapy supports [12]. The Commonwealth Government's Health Workforce Data Website shows that 31.5% of podiatrists are sole practitioners and 48% are in group practice [13], which demonstrates the significance of smaller providers to the sector. The NDIS sample of one large business is not representative of podiatry therapy supports being delivered, and the APodA should continue to raise concerns about the potential for the findings to be applied across all podiatry therapy supports delivered in the NDIS.

7.2. Provider participant and market sustainability

In parallel, APodA will continue to monitor trends in provider participation and market sustainability. The recent reduction in provider numbers represents early warning sign of market withdrawal, particularly among small providers and those servicing regional, rural and remote communities. Tracking provider participation over time, alongside regional service availability and workforce trends, will be critical in identifying emerging access issues.

7.3. Preventative health

There is also an opportunity to strengthen the economic argument for podiatry by demonstrating its role as a preventative health intervention. Table 12 in the 2026-27 APR [1] provides an expenditure comparisons across different therapy support. Compared to many other therapy supports, podiatry represents a relatively low-cost investment that can help prevent high-cost downstream consequences, including falls, wounds, infections, pressure injuries, hospital admissions and amputations [14-16]. Better quantification of these avoided costs would help position podiatry as both a clinically essential and economically valuable component of participant supports.

7.4. Benchmarking

Future advocacy should also continue to challenge the APR's reliance on MBS and PHI benchmarking. These funding systems are designed primarily for episodic healthcare and do not adequately reflect the complexity, duration, administrative burden and support coordination requirements associated with disability-related service delivery. APodA should advocate for pricing methodologies that are specific to the NDIS environment and grounded in the actual costs of supporting people with disability.

7.5. Participant access

Protecting participant access should remain a central advocacy objective. Ongoing monitoring of waiting times, service availability and participant experiences will help identify areas where access is deteriorating. Collecting participant and provider case studies, alongside data on unmet need and functional outcomes, will provide important evidence of the real-world consequences of current pricing settings and support future advocacy for sustainable reform.

7.6. Strengthen Recognition of Assistive Technology

While the APR recognises orthoses and medical-grade footwear as assistive technology supports, participants continue to face significant barriers to accessing these clinically necessary interventions. Lengthy approval processes, inconsistent decision-making and unclear eligibility requirements can delay access to essential supports that maintain mobility, reduce pain, prevent falls and avoid more costly complications. The APodA will continue to advocate for stronger recognition of podiatry-related assistive technology within the NDIS, including orthoses, footwear modifications and other lower-limb devices, as these supports are fundamental to independence, participation and the prevention of higher-cost health and support needs.

8.0 Conclusion

The 2026–27 APR portrays the podiatry market as stable and appropriately priced. However, the underlying data reveals a different story. While participant demand has increased by more than 20% over three years and expenditure continues to grow, provider numbers have begun to decline. Combined with an already limited workforce and increasing participant complexity, these trends suggest emerging access and sustainability risks.

The APR's continued reliance on MBS and PHI benchmarking does not capture the realities of NDIS podiatry practice. MBS and PHI are designed primarily for episodic healthcare and do not adequately reflect the complexity, duration, administrative burden and support coordination requirements associated with disability-related service delivery.

The APodA's call for a podiatry-specific costing study remains strongly supported by the available evidence and should be a central component of future advocacy efforts.

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