Submission to the Joint Standing Committee on the National Disability Insurance Scheme

Inquiry into the Integrity of the National Disability Insurance Scheme

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Executive Summary

This submission argues that the integrity problem in the National Disability Insurance Scheme is not only a fraud problem. It is a **structural integrity problem** and a **moral integrity problem**.

It is structural because the Scheme misaligns money, risk, information, workforce, capacity, health and accountability. It individualises funding in a fragmented and inaccessible world, separates disability from health, assumes capacity where it should be assessed, tolerates low workforce competence, weakens handover, and externalises risk to providers, support staff and families.

It is moral because these harms are no longer unknown. Once a system knows that workers are being injured, participants are being harmed, carers are breaking, hospitals are absorbing social-care collapse, and providers are subsidising systemic incompetence, failure to correct course becomes more than policy error. It becomes systemic negligence.

The NDIS should be a wonderful Scheme. Instead, it is too often:

- punitive to ethical providers,
- disabling to parts of the workforce asked to hold it together,
- frightening and exhausting for participants and carers,
- weak on real-world safeguarding,
- detached from health,
- and shaped by ideology far more than by the realities of providing care.

This submission makes the following central points:

1. Fraud and sharp practice are real, but they have flourished in conditions government helped create.
2. The current integrity response is too focused on policing invoices and too weak on repairing architecture.
3. The NDIS, the NDIA, and the Quality and Safeguards Commission are operating too much in a vacuum.
4. The Scheme lacks the practical competence to reliably define what a good higher-needs plan should look like.
5. Algorithms will not fix that. They will simply standardise the rot.
6. A scheme meant to support people with disability should not be disabling more people in the workforce in the process.
7. The costs of the NDIS are now far greater than the NDIS budget line itself. The Scheme's failures spill over into hospitals, paramedics, police, guardianship systems, mental health triage, families, and the broader economy.
8. Human rights must be upheld, but rights without clinical reality becomes abandonment.
9. Australia urgently needs a supported decision-making and mental-capacity framework, updated guardianship law, a Health Equality Act, worker registration, crisis continuity planning, and a proper interdisciplinary planning standard for higher-risk participants.
10. If integrity is being reviewed honestly, the governing bodies themselves must come under scrutiny.

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1. About this submission

I make this submission as the CEO of Carers and Advocates Australia, and as a person informed by lived experience, provider experience, worker experience, and the experiences of participants and families across a range of high-needs settings.

My intent is to assist the Committee to strengthen integrity, restore public trust, and improve outcomes for participants without further destabilising a market already under severe strain.

My central argument is simple: **the integrity problem in the NDIS is not only about fraud. It is about whether the architecture itself is honest, workable, safe and fit for purpose.**

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2. The integrity problem: structural and moral

In my view, the NDIS currently suffers from both a **structural integrity failure** and a **moral integrity failure**.

It is a structural integrity failure because the Scheme misaligns money, risk, information, capacity, workforce, health and accountability. It individualises funding in a fragmented and inaccessible world, separates disability from health, tolerates low workforce competence, weakens handover, and externalises risk to providers, workers and families.

It is a moral integrity failure because these harms are no longer unknown. Once a system knows that workers are being injured, participants are being harmed, carers are breaking, providers are subsidising incompetence, and hospitals are becoming overflow sites for social-care collapse, failure to correct course is no longer merely unfortunate. It becomes negligence with stationery.

The Scheme has also mistaken **administration** for **understanding**.

It has assumed:

- a plan is a life architecture,
- a functional report is a complete picture,
- choice equals capacity,
- care work is low-skill,
- and risk can be shifted without consequence.

That is why the system feels like a twilight-zone sub-reality. Everyone is pretending the scaffolding is solid while the building sways in the wind.

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3. The nature and extent of non-compliance, including fraud and sharp practices

Fraud and non-compliance in the NDIS do not arise in a vacuum. They arise in a market that has been built with too little regard to competence, continuity, enforceability and real-world accountability.

3.1 Low-barrier entry into high-risk work

It remains far too easy to enter intimate, high-risk disability work with minimal competence, minimal supervision and too little scrutiny. In parts of the Scheme, an ABN and confidence have been allowed to masquerade as expertise.

If you build the Wild West, you should expect a heap of cowboys to turn up.

3.2 A poor provider and registration framework

The registration framework has too often formalised systems on paper rather than competence in practice. It can add cost without reliably producing safer care. At the same time, broad unregistered provision in intimate, high-risk, home-based settings continues despite years of reviews, inquiries and reform promises.

The result is confusion for participants, weak comparability between providers, and a market where bad actors find it easier to enter than ethical actors find it to survive.

3.3 Information failure as systemic non-compliance

Providers cannot safely staff, supervise or risk-manage care if nobody tells them the basic facts of the person's needs, vulnerabilities, communication profile, transfer requirements, behavioural triggers, crisis history, medication risks or health-related risks.

At present, the system too often works like this: **they did not know what they did not know, nobody knew they did not know, and nobody who did know thought it was terribly important to tell them.**

That is not an integrity framework. It is organised blindness.

3.4 Misuse of "choice and control"

Choice and control is essential, but it has too often been implemented as the absence of guardrails rather than the presence of supported freedom. Where capacity is impaired, fluctuating or absent, preventable harm can be mislabelled as choice.

That is not empowerment. It can amount to systemic neglect.

3.5 Exploitation in labour pipelines

The sector has become vulnerable to exploitative labour pipelines that privilege speed, volume and cheapness over suitability, training and continuity. This is not an attack on migrants. Many come here courageous and capable and are badly served by the current model.

It is an indictment of a policy environment that can funnel people into intimate high-risk work without the professional framework that should protect both them and the people they support.

3.6 A hotbed for exploitation

The low-status attitude toward disability care has made it fertile ground for worker exploitation, sham contracting, wage theft, coercive labour practices and modern-slavery-like conditions. It also raises obvious questions about probity, screening, accountability and national security when intimate personal care is being delivered behind closed doors with minimal oversight.

When a nation treats this work as if it is for labourers only, or mere “bum wiping”, it invites exactly the wrong market response.

4. The impacts of non-compliance on participants and their families

The impacts on participants and families are not merely financial. They are clinical, emotional, social and moral.

Participants are harmed when:

- supports are delivered by under-trained or unsupervised workers,
- providers do not receive the information they need,
- health systems do not understand disability,
- capacity is assumed rather than assessed,
- and safeguarding is treated as a paperwork event rather than a lived reality.

Families are harmed when:

- they become unpaid case managers by default,
- crisis planning is absent,
- continuity collapses,
- and the burden of holding together a fragmented system is simply transferred onto them.

The NDIS was meant to support people to live beyond the burdens of care. Too often it has done the opposite. Participants end up living **within** their care instead of living their lives.

The Scheme has become, in places, like a resort where even the chocolate on the pillow costs money. Everything looks itemised, generous and terribly caring, but every ordinary act requires a line item, a justification, a gatekeeper or a small loan. In the end, many people stay in their room and do nothing.

That is not inclusion. It is expensive loneliness.

5. The costs of the NDIS are more than the NDIS

One of the great failures of the current debate is that it treats the cost of the NDIS as though it sits neatly inside the NDIS line item.

It does not.

The cost of the NDIS is now **more than the NDIS**. It spills into the rest of government, into the labour market, into emergency services, into hospitals, into police callouts, into guardianship systems, into family breakdown, into workforce injury, and into the quiet human misery of living in a system that is expensive but still incapable of producing a good life.

When the scheme fails, the bill does not disappear. It moves.

5.1 The real cost stack of NDIS failure

System area	What happens when the NDIS fails	Who pays
Workforce	Manual handling injuries, psychological injury, violence exposure, turnover, burnout	Workers, providers, insurers, workers compensation systems
Hospitals	Avoidable ED presentations, delayed discharge, poor disability care, crisis admissions	State health systems, patients, hospital staff
Ambulance and paramedics	More transports for preventable crises, longer handovers, more ramping pressure	Ambulance services, paramedics, state budgets
Police	Welfare checks, crisis response, behavioural escalation, service failure callouts	Police, justice systems, families, participants
Mental health triage and crisis lines	Under-trained staff using health triage as a de facto NDIS advice line	Health services, clinicians, participants in true crisis
Guardianship and tribunals	Capacity disputes, overuse of guardianship, reactive legal intervention	State systems, guardians, families, providers
Families and carers	Unpaid coordination, lost work, burnout, crisis management	Families, carers, the broader economy
Ethical providers	Unfunded supervision, unfunded continuity, absorbed risk, unpaid crisis management	Providers, workers, participants when providers collapse

This table is not actuarial. It is reality.

5.2 Human cost

The human cost is harder to count and easier to ignore.

It includes:

- carers whose lives narrow into permanent crisis coordination,
- workers injured in body and mind,
- participants left living inside care rather than beyond it,
- children supported by inadequately screened or under-trained adults,
- families terrified that the next provider collapse, roster failure or hospital misstep will be the thing that tips everything over.

Every provider collapse is not a market correction. It is an invoice redirected to emergency departments, ambulance services, police, mental health teams, and exhausted family members.

5.3 Workforce injury cost

The disability and care workforce carries a serious physical and psychological burden. Manual handling, violence exposure, trauma exposure, moral injury and poor risk planning all contribute to injury and churn.

In my view, based on sector conditions and internal analysis, the lower-bound burden of workers compensation and workforce injury associated with the care environment already runs into the **hundreds of millions of dollars**, quite apart from recruitment cost, training loss, replacement labour, management time and collapsed continuity.

A scheme meant to support people with disability should not be disabling more people in the workforce in the process.

5.4 Hospital cost and ramping

The hospital system is increasingly being forced to absorb social-care failure. When disability supports break down, families burn out, or care is poorly planned, the person does not evaporate. They appear in emergency departments, inpatient wards, ambulance bays and transitional holding arrangements.

Hospitals cannot substitute for a functioning social-care system.

The result is:

- more avoidable presentations,
- more delayed discharge,
- more unsafe admissions,
- and more ramping.

The NDIS debate cannot be honest if it ignores the degree to which disability system failure is loading cost into the health system.

5.5 Burden on paramedics, police and triage systems

The pressure does not stop at hospitals.

Paramedics are called because there is no crisis continuity. Police are called because there is no safe social-care response left in the moment. Triage lines are used because under-trained support staff have nowhere else to get immediate guidance.

In South Australia and elsewhere, frontline reports increasingly suggest that health triage functions are being used as de facto disability support lines by workers who have been placed in roles they are not trained to manage. That is not what triage systems are for. It is simply where people go when a fragmented system has left them holding risk they do not understand.

5.6 Costs imposed on the rest of government

The NDIS is not just drawing on its own budget. It is imposing hidden costs on:

- state health systems,
- ambulance services,
- police,
- guardianship and tribunal systems,
- housing and homelessness services,
- carer support systems,
- and the productivity of the wider economy.

The true cost of the NDIS is therefore not only what the NDIA spends. It is also the cost of the damage the current model exports into the rest of public life.

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6. The effectiveness and adequacy of successive government policies

Successive governments have not lacked reviews. They have lacked the courage to accept what the reviews mean.

We have spent extraordinary time and public money reviewing disability, safeguarding, workforce, capacity, violence, abuse, neglect, sustainability, hospital pressure and provider failure. The problem is no longer that no one knows. The problem is that ideology, political caution and institutional self-protection have repeatedly trumped practical reality.

The great computer keeps being asked the wrong question, and everyone still looks mildly impressed when it answers “42”.

6.1 Counter to human rights in practical effect

The current system too often confuses:

- choice with capacity,
- rights language with delivery architecture,
- and participation with the loudest ten per cent of the disability conversation.

People with disability have the right to live as themselves — truthfully, safely and with dignity. They have the right to be disabled without being punished for it, and without the system pretending that disability disappears if the policy language is enthusiastic enough.

6.2 A top-down reform with no proper architecture around it

The NDIS was a top-down reform. It changed who held the money, but did not sufficiently build the surrounding architecture:

- a professional workforce,
- reliable health integration,
- lawful information continuity,
- supported decision-making structures,
- accessible mainstream environments,
- or realistic market settings.

We cannot implement a half-baked new idea and then act surprised when the market does not nobly adapt. Markets do not become ethical because government is hopeful. All the market will do, if the incentives are wrong, is ask for more money, cut corners, or exit.

6.3 Quality and Safeguards is systemically misaligned

The current safeguarding environment is badly misaligned with the realities of choice, control, capacity, training and care delivery.

In my view, systemic negligence within the regulatory architecture now endangers more people than it protects, because it too often regulates paper instead of competence, penalties instead of preconditions, and providers instead of the care architecture itself.

If providers are denied the information, training, supervision and legal clarity required to deliver safe care, but are then exposed to punitive consequences when predictable failures occur, that is not real-world regulation. It is an impossible environment.

If the practical mandate were to destroy ethical disability care, the current settings would be uncomfortably close to achieving it.

6.4 The scheme lacks planning competence

A further difficulty is that the Scheme still lacks the practical competence to define, with sufficient reliability, what a good plan should look like for many higher-needs participants.

That is a profound integrity problem.

A system cannot claim integrity if it does not understand the thing it is regulating. Too many plans are built on partial functional snapshots, weak risk understanding, incomplete handover, unrealistic assumptions about capacity, and a poor grasp of what safe care actually requires.

If the underlying model of care-planning is wrong, automating it will not improve it. It will merely standardise error, codify blind spots and produce poor plans more quickly.

There is no substitute for competence.

7. Over-reliance on narrow assessment logic

Too much reliance has been placed on narrow functional assessment logic as a proxy for whole-of-life care understanding.

Occupational therapists are valuable professionals, but a functional assessment is not the same thing as a comprehensive care architecture. It does not, by itself, provide a complete picture of:

- complex clinical needs,
- serious behavioural risk,
- psychosocial deterioration,
- trauma,
- safeguarding vulnerability,
- or the workforce, supervision and crisis-continuity structures required to keep someone safe.

This is not a criticism of occupational therapists. It is a criticism of a Scheme that has leaned too heavily on fragments and then acted as though the whole human picture has been captured.

It has not.

Nor should capacity in complex intellectual, cognitive or acquired-brain-injury matters be casually determined by whichever professional happens to be nearest. In higher-risk neurocognitive cases, specialist neuropsychological expertise should be available and treated as the minimum benchmark.

The same is true for serious mental illness. Support workers are not substitute mental health clinicians, nor should they become quasi-correctional babysitters because the broader system has nowhere else convenient to dump complexity.

That is unfair to participants, dangerous for workers, and profoundly dishonest as public policy.

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8. Capacity, guardianship and the need for legal reform

Australia urgently needs to modernise its legal architecture around capacity, decision-making and care.

Full guardianship is too blunt for many disability contexts. It does not adequately reflect:

- the spectrum of capacity,
- the fluctuation of capacity,
- or the reality that a person may be able to make some decisions, some of the time, with support.

We need an Australian **Supported Decision-Making Act** or **Mental Capacity Act** that:

- treats capacity as decision-specific and support-sensitive,
- reduces overuse of guardianship,
- enables supported decision-making with legal force,
- allows for funded case management and life management alongside the person,
- minimises coercion and unmanaged risk,
- and recognises that losing total control of one’s life is not the only alternative to chaos.

Ireland’s capacity framework is a useful model because it creates structured forms of decision support rather than forcing everyone into the binary of “fully autonomous” or “under guardianship”.

This is useful not only for disability, but also for aged care.

8.1 Life-care directives, not just palliative directives

Australia also needs a clearer legal instrument for disability and aged-care planning across the life course.

An advance care directive is often designed around palliative or end-of-life contexts. That is not always appropriate for disability.

Many people with disability need something closer to a **life-care directive** or equivalent legal care-planning instrument that sits alongside supported decision-making and case management. It should support life, not only decline. It should clarify how care is to be understood, delivered and escalated across an ongoing life, not merely at the point of death.

8.2 Who can determine capacity

There also needs to be greater clarity around who is properly qualified to determine capacity in complex cases. Capacity assessment should not default to whichever professional is available. In higher-risk cognitive, acquired brain injury, intellectual disability or complex neuropsychological matters, specialist assessment should be the rule, not the exception.

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9. Health equality and the medical–human rights divide

The current false battle between the medical model and human rights must end. A functioning system needs both.

Human rights without clinical reality becomes abandonment. Medicine without dignity becomes cruelty.

The current system is too often punitive toward the realities of disability for which the participant receives care in the first place. We should be supporting people to be the best they can be, not pretending there is no disability and setting them up to fail.

I recommend a national **Health Equality Act**, or equivalent legislative reform, to make clear that people with disability are entitled to equal access to medical treatment and life-preserving care, and that such care must not depend on a clinician's private view of a person's "quality of life".

There also needs to be much better legal clarity around clinical pathways, care pathways and directive instruments. The seven-step clinical pathway is not a legal document. A healthcare team's internal process is not the same thing as a properly executed advance directive, supported decision arrangement or life-care directive.

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10. Workforce, exploitation, safety and safeguarding

The NDIS workforce is being used up.

If the prevailing policy attitude is that the sector merely needs more "bum wipers", then safeguarding will continue to fail. That attitude guarantees the importation and turnover of under-prepared, transient and poorly supported labour in roles that require judgement, dignity, reliability and ethics.

Support work is not a better-paying Uber. It is a vocation, a safeguarding role and, in many settings, a specialised practice.

Workers carry:

- manual handling risk,
- psychological injury,
- trauma exposure,
- violence risk,
- medication risk,
- and moral injury.

Yet plans rarely contain proper occupational health and safety logic.

Worker safety is participant safety.

Plans for higher-risk participants should include practical work health and safety settings, care ratios, transfer requirements, equipment requirements, escalation rules and crisis continuity arrangements.

Better trained staff can safely do more. That is good for participants, good for workers, and good for cost control.

10.1 National training and registration

Support staff should be nationally trained, credentialled and registered according to risk and scope of practice.

A national framework should include:

- minimum training standards,
- tiered scopes of practice,
- supervision requirements,
- portable credentials,
- and ongoing professional development.

10.2 Child safety and checks

The current child-safety position is not good enough.

Requirements around worker screening and Working With Children Checks remain inconsistent enough across jurisdictions and arrangements that child-facing disability support can still occur under a patchwork of safeguards. That is not a sensible way to protect disabled children.

There should be no ambiguity: any worker providing disability support to a child, especially in private homes or one-to-one settings, should have both appropriate NDIS screening and any required child-related clearance. Disabled children should not be supported by unscreened or poorly screened adults simply because the regulatory map is confusing.

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11. Provider viability and infrastructure instability

The current business model does not work.

Ethical providers are already subsidising the incompetence of the system:

- absorbing unfunded supervision,
- carrying unpaid continuity,
- managing crises without structure,

- and shouldering insurance and legal risk in an environment that refuses to tell them enough to do the job properly.

This is not sustainable.

When providers collapse, the system does not save money. It moves cost into:

- hospitals,
- police,
- families,
- crisis accommodation,
- ambulance systems,
- and emergency care.

If providers continue to collapse en masse because they are doing the right thing in an impossible environment, the health system will be overwhelmed.

The NDIS cannot keep pretending provider failure is merely a market event. It is a public-system failure.

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12. Human rights, mutual obligation and the purpose of government

Human rights matter. They must be upheld. But rights are not the sole responsibility of government, and government should not become the arbiter of what a good life outcome is.

Government's role is to facilitate the conditions in which people can live, participate, contribute and pursue lives of their own. It is there to equalise opportunity, not to dictate the human spirit through a plan.

That is why **life, liberty and the pursuit of happiness** remains the correct frame.

Government should facilitate. It should not attempt to define the whole of a meaningful life.

The current system has instead created dependency for all life outcomes and too few avenues for people to create their own lives.

We are not helping enough people live beyond their care. We are asking them to live inside it.

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13. Peak bodies, activism and who gets heard

Disability peak bodies and governments alike must move away from performing primarily for the most articulate, connected and policy-fluent parts of the disability community.

The NDIS debate has too often become **nothing about us without some of us** rather than **nothing about us without all of us**.

People with intellectual disability, cognitive disability, fluctuating capacity, very high support needs, children, carers and frontline workers must count too.

The voices we hear most are not always the voices carrying the most risk.

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14. Practical reforms required

I recommend the Committee support the following reforms.

14.1 Supported Decision-Making / Mental Capacity Act

Create a nationally consistent legal framework for supported decision-making and capacity, reducing overuse of guardianship and enabling more nuanced, lawful support.

14.2 Update guardianship law

Update guardianship legislation to reflect fluctuating and spectrum-based capacity, and reduce unnecessary full guardianship.

14.3 Health Equality Act

Establish a legal framework to ensure equal access to medical treatment and clarify the status of healthcare decision instruments.

14.4 Independent baseline assessment for higher-risk participants

Introduce an independent, clinically informed baseline assessment for higher-risk participants so providers are not operating blind and care can be planned properly from the start.

14.5 National worker registration and training

Introduce national worker credentialling, tiered scopes of practice, minimum training standards, supervision expectations and portable recognition.

14.6 Interdisciplinary planning standard

Require a minimum interdisciplinary planning standard for higher-risk participants. A narrow functional report is not enough.

14.7 Mandatory lawful handover

Mandate a minimum handover dataset between providers and from hospitals or other systems into disability supports.

14.8 Crisis continuity addendum in higher-risk plans

Every higher-risk plan should include a crisis continuity addendum so carer breakdown, provider exit or emergency does not immediately endanger the person.

14.9 Restrict self-management in high-risk supports

High-risk supports should not operate as an exemption from safeguards.

14.10 Strengthen provider definition and gateway regulation

Include labour hire, matching platforms, plan managers, intermediaries and other high-influence actors in a risk-proportionate provider framework.

14.11 Australian-resident accountability

Require an Australian-resident accountable person for higher-risk provider entities, with beneficial ownership transparency and real onshore accountability.

14.12 Mainstream accessibility reform

If the real world remains inaccessible, the NDIS will keep funding expensive workarounds for ordinary life.

14.13 NDIA and Commission accountability

Integrity cannot be one-sided. The NDIA and the Commission must be accountable where their own failures materially contribute to harm, provider collapse or service breakdown.

14.14 Occupational health and safety inside plans

Higher-risk plans should include occupational health and safety logic, practical staffing assumptions, equipment requirements and risk settings.

14.15 Child safety consistency

Create a nationally coherent child-facing screening rule for disability work so that disabled children are not protected by postcode roulette.

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15. Practical checklist

The Committee should recommend immediate action on the following:

1. Create a Supported Decision-Making / Mental Capacity Act
2. Update guardianship law
3. Develop a Health Equality Act or equivalent framework
4. Introduce independent baseline assessment for higher-risk participants
5. Require a minimum interdisciplinary planning standard
6. Implement national worker registration and nationally consistent training
7. Add occupational health and safety logic into higher-risk plans
8. Require crisis continuity addenda in higher-risk plans
9. Mandate lawful handover and a minimum information dataset
10. Restrict self-management for high-risk supports
11. Tighten provider-definition and ownership rules
12. Improve mainstream accessibility
13. Establish stronger NDIA and Commission accountability
14. Reform consultation so that it reflects all people with disability, not merely the loudest subset
15. Stop treating support staff as disposable labour and start treating them as intrinsic to outcomes
16. Create a nationally coherent child-facing screening requirement for disability supports
17. Require that higher-risk provider entities have real Australian-resident accountability and enforceable governance presence

16. Closing

This inquiry is about integrity. It must therefore ask a larger question than whether the invoice matches the line item.

It must ask whether the architecture itself is honest, competent, safe and humane.

The NDIS should be one of the best things Australia ever built. Instead, it is too often fragmented in an inaccessible world and a health system far beyond the NDIS vision, and that fragmentation endangers the lives of people with disability.

Fraud matters. Non-compliance matters. Sharp practice matters. But so do structural dishonesty, workforce exploitation, pseudo-professional influence, punitive regulation without system repair, and the pretence that rights can be delivered by ideology without competence.

Government's role is not to dictate the total shape of a meaningful life, nor to define acceptable life outcomes for disabled people. Its role is to build the conditions in which people can live, participate, contribute and pursue lives of their own.

If we continue on the present path, the likely outcome is not restored trust. It is more provider collapse, more workforce injury, more hospital overflow, more arbitrary plan cutting, and more preventable harm.

If the Committee wishes to review integrity honestly, it is time not only to look at the cowboys. It is time to look at the town that invited them, wrote them a permit, and then acted shocked when the saloon burned down.