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NDIS 2025-2026 Annual Pricing Review

February 2026

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ECIA VIC/TAS acknowledges the traditional custodians of the lands and pays respect to elders past and present. We pay respects to Aboriginal and Torres Strait Islander children, their families, and we commit to creating a future where every child is valued, safe and an empowered member of their community.

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Table of Contents

About us 4
Early Childhood Intervention: the model that delivers outcomes for the future 5
Fund the true cost of quality services....6
Differentiated pricing....9
Workforce 11
Quality now creates savings later....14
The risks and opportunities; now and in the future 16
Appendix: Comparison of funding models 18

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About us

ECIA VIC/TAS welcomes the opportunity to contribute to the NDIS 2025-2026 Annual Pricing Review.

ECIA VIC/TAS exists to champion best practice Early Childhood Intervention (ECI) for children from birth to 9 years old and their families in line with the National Framework Best Practice Early Childhood Intervention.

As a membership-based organization, with over 500 memberships from across Australia, we hear directly from members on the outcomes and challenges children and families are facing. Through consultation with members, they have shared their perspectives on service provision under the current Pricing Arrangements and Pricing Limits (PAPL).

This submission shares many of their comments, case studies and experiences as they work to support the thousands of children and families in their services. The diversity of our membership; large NFP registered providers, small and midsize multidisciplinary and transdisciplinary teams and sole traders brings together examples from all models of service delivery. Many of our members support children and families with the most intersecting vulnerabilities. Sometimes they are the only providers who will take them.

Their stories reflect the day-to-day experiences of families combined with the voices of the wider workforce. It is important to include perspectives from both groups, as one cannot exist without the other. ECIA VIC/TAS are in a unique position to hear and share all sides of the story.

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Early Childhood Intervention: the model that delivers outcomes for the future

ECIA VIC/TAS believes there are two key questions to ask as part of any successful system design.

What does it look like when children are doing well?

When children are doing well, who is responsible for that?

Quality Early Childhood Intervention (ECI) services respond to both questions through their holistic, child and family-centered approaches.

ECIA VIC/TAS believe children are doing well when they are:

- actively involved in their learning and development
- have equitable access to learning and support opportunities
- are growing up in empowered families who are confident to make informed decisions and advocate for their child
- able to have meaningful participation in their communities and everyday life

In responding to the second question ECIA VIC/TAS believe the NDIA/NDIS must take responsibility for supporting children with developmental delays or disability and families to do well by providing:

- access to best practice Early Childhood Intervention programs that are tailored to child and family needs
- supports to build the capability and capacity of child and the family
- timely supports that are delivered when and where they need them as their developmental and functional needs change
- access to skilled and experienced teams spanning NDIS, education, health and Thriving Kids

In 2025, two key reports indicated that Australia's children are struggling. The Front Project- The Cost of Late Intervention (2025) report, articulates clearly the significant financial consequences of failing to intervene when children need in their early years. This is reinforced by 2024 AEDC National Report data showing that only half of Australia's children are on track in more than one developmental domain.

The shift away from best practice ECI under the current PAPL is compromising outcomes for children and families. Funding periods are increasing administrative burden and limit flexibility.
As stewards, the NDIA can and must play their part in fully supporting providers to provide high quality ECI.

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Fund the true cost of quality services

What is needed now:

- Increase hourly rates for line items delivering services to children under the Early Childhood Approach by 20%
- Increase physiotherapy, music and art therapy rates to match those of occupational therapy and speech therapy with increases
- Re-instate travel to the full 100% of time travelled for providers delivering services in natural settings

The case for change:

Three key reports have all indicated the case for change. Each of them recognises the benefits of quality ECI intervention, and recommends a move away from transactional, hour-driven services as they are not outcomes
Driven.
The Independent Pricing Committee (2025) found that*, ' current pricing structures are poorly aligned as they fail to recognise the full scope and value of ECI practice. The report suggests differentiated pricing would better support early intervention, family-centered practice and long-term outcomes for children and families. (pp5-9).*

The NDIS Review (2023) recommended *evidence-based, family-centered intervention with a focus on capacity building, evidence-based, developmentally informed approaches with a move away from transactional models that are hour-driven not outcomes driven.*

The IPC report states *the current pricing rewards a narrow view of face-to-face sessions neglecting the benefits of family coaching, indirect work, collaboration and preventive activity.*

Alignment with best practice approaches as documented in the National Framework Best Practice in Early Childhood Intervention, documents a model that delivers evidence-informed practices that support both child and family in their home and communities.

The NDIA's insistence on alignment with other models including Medicare (MBS) and private health insurance fails to consider the fundamental differences between the models of care for disability and health. In Appendix 1 we highlight these differences and illustrate deficits in this narrative. Attempting to overlay a

Our bad debts have increased x4. Without visibility (and because the system is too complex for families to navigate), we find out six weeks (several $1000 later) down the track that funding had run out in a plan period (used with another provider).

Families who previously had home visits find it hard to make their funding stretch to the end of plan period meaning periods without service.

The NDIS is not a sustainable financial model. We are allowing natural attrition to reduce our EFT and exposure to NDIS.

I had to sadly tell some of my clients that I can't justify driving more than 20mins away from my clinic location due to the travel charges.

There is significant financial strain on organisations to be viable while covering the costs of funding therapists for their time spent travelling to deliver a service but only getting half the revenue.

Increased admin burden to staff due to funding periods. Families need significant support to help them manage it.

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Medicare model of centre-based care does not align with best practice ECI. Supporting the whole child and family in an investment is the future bringing improved developmental outcomes for the child, and increased family capacity to support the child and a reduction in presentations in justice, mental health, homelessness and health sectors.

ECIA VIC/TAS members report ongoing and sustained financial pressure under the current PAPL. Navigating year on year increases to costs to deliver services, over the past seven years, with no increase to the hourly rates of some disciplines and a reduction in rates to others, fails to consider the essential basic costs to deliver quality services.

Providers are reporting financial losses, depleting capital reserves and the need to seek alternative funding from philanthropy or through cross-subsidisation to continue operations. The current hourly rates insufficient to deliver quality ECI services, with an increasing risk of providers exiting the market once reserves are drained.

Members report increased operating costs around 20% to respond to increasing salaries, essential to retain practitioners. Yet there has been no recognition of this in the pricing for years. Wages have risen year on year, yet the NDIA fail to compensate with stagnant line items.

If the NDIS as an insurance scheme are wanting to see a reduction in service over time, the current transactional model will not deliver this outcome. The future of quality providers delivering NDIS funded services will continue to be at risk.

We have moved from 80% outreach to 20% outreach to reduce the losses associated with travel rate reduction. This is impacting families ability to access supports. This is negatively impacting inclusion and participation outcomes for children. (Provider delivering to 250 children)

Providing an outreach service to vulnerable participants who are unable to drive or use public transport has limited what I can provide as travel cost has been cut.

Our ability to be sustainable as an organization under the current PAPL is impossible and we are being forced to choose between working in a 'clinic-only' model or closing our doors and not providing services at all.

Harder to work with kinder/childcare and school educators with the travel charge changes as I can't justify visiting community settings as much.

Please pay for travel according to the hour. Outreach services are crucial to those that cannot access transport.

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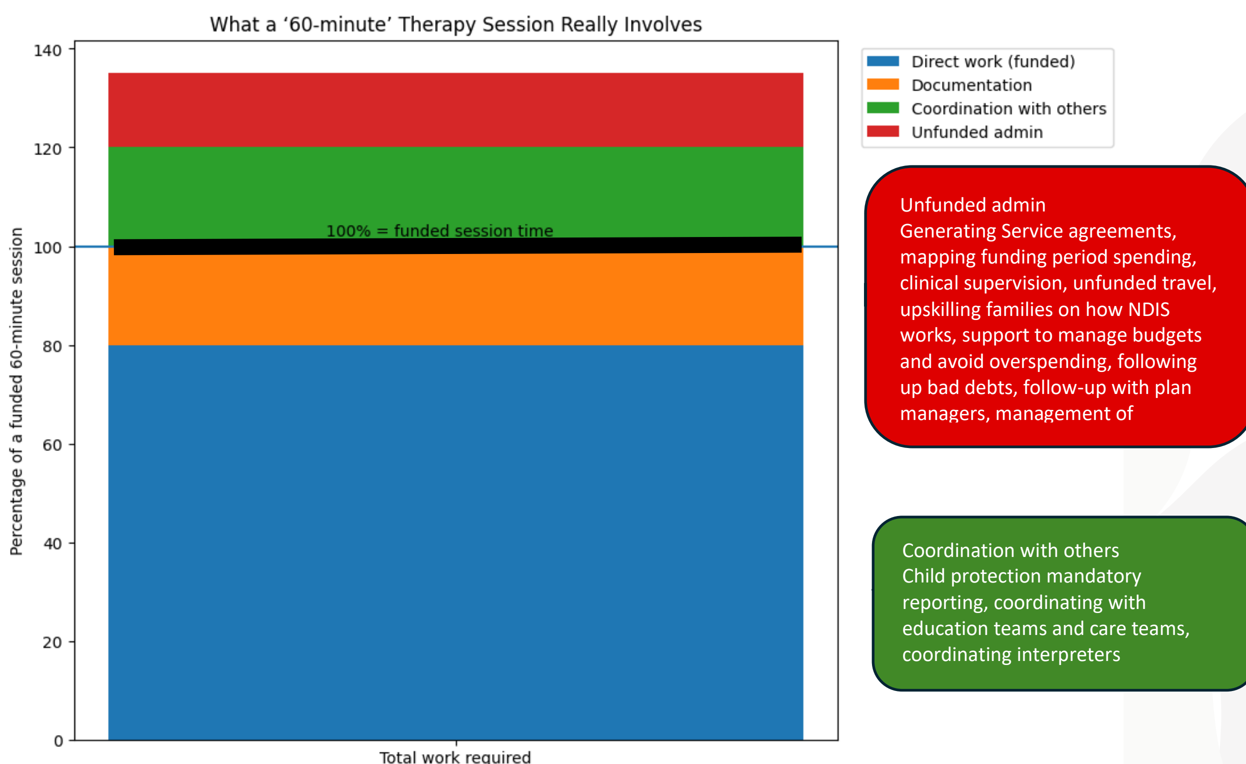
The NDIA consultation asks the typical duration of an NDIS therapy session seeking to understand the regular tasks associated with delivering the session.

> A typical ECI home or community-based setting is 60-90 minutes long. It may be longer if there are a very many intersecting complexities, such as involvement with child protection, collaboration with education, community and health professionals, mandatory reporting responsibilities and coordination of interpreters. Follow-up from each session can include writing case notes, sending follow-up emails or making phone calls to other practitioners working with the family, and communicating with education settings. Attempting to overlay a Medicare-style, centre-based health care model with no follow-up or collaboration fails to recognise the social and fiscal impact of a holistic service.

The IPC report talks of the masking of essential activities in the current pricing model. The diagram below illustrates the work completed during the hourly session that is funded along with the unfunded tasks that are essential to quality service.



IPC (2025): "Hourly pricing masks essential but unpriced activities, systematically disadvantaging higher-value services." (pp. 5–6)

NDIS Review (2023): "Early intervention should be family-centred, developmentally informed and focused on long-term outcomes, not transactional service delivery." (Rec 6)

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Differentiated pricing

What is needed now:

- Additional loadings for registered providers to cover the costs associated with registration, governance and auditing
- Additional loading for Key Worker services delivered in natural settings
- Additional loadings for Key Worker services delivering in line with best practice, focussed on team around the child and collaboration approaches

The case for change:

The NDIA has the power to keep quality service providers in the sector now and into the future. ECIA VIC/TAS members often work with families with the highest levels of complexity and vulnerability, often those that other providers will turn away. Without this cohort of providers in the sector, this cohort of children and families will lose ongoing services.

The current financial strain on quality providers particularly registered providers is not sustainable and many are already moving away from delivering NDIS funded supports.

Research indicates working in natural settings creates life-long positive outcomes and represents value for money. The relational nature of ECI is integral to building the capacity of the family and other adults in the team working with the child. This work is largely invisible in the current pricing structure with the expectation that it is absorbed into the current hourly rate.

The IPC report illustrates this by saying,

- providers who do *not* undertake this additional work are over-compensated
- providers who *do* undertake it (such as ECI services) are systematically under-compensated (pp6-7)

As a provider, we are finding the additional administrative burden unsustainable: added 1/2 hour of unbillable time to onboarding (explaining and negotiating plan periods); multiple back and forth with families during and at the end of each plan period to understand residual funding; disruption to caseload/work planning for staff (staff have to pause a family for a few sessions at the end of a plan period due to possible overspend - and usually overspend is the result of a family engaging multiple providers and each provider has no visibility of plan usage).

I had more flexibility before to see children in their natural environments (childcare, mums house, dads house) but now have to be stricter for majority of the visits being in our clinic setting. I am doing more telehealth for my clients who live a further distance than 20mins from our clinic.

Less children and families are able to access therapy services. The most vulnerable families are the most negatively impacted.

We are less able to have consistent community or home based sessions less able to provide training to stakeholders in naturalist environments center based sessions are less reinforcing due to limited play/toy/educational resources.

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ECIA VIC/TAS view this work is essential being the 'glue' the facilitates collaborative teams focussed on consistent goals and strategies across all settings. Many of the tasks a Key Worker undertakes to support the whole family can be referred to as, 'the glue.' They are tasks that lead to increased family functioning and a reduction in parental stress.

Case study

An ECIA VIC/TAS member shared her experiences of delivery services to twenty-eight children in a very remote rural area. Taking a team of practitioners, (Speech pathologist, occupational therapist and physiotherapist) they travelled and based themselves in the local town for a week with a plan to meet with all the children and families over the course of the week. The organisation covered the cost of travel to and from the town, (8 hours driving each way) and accommodation for the team each night. Virtual services are offered but with minimal internet access and devices they are not a secure option for service delivery on a regular basis.
Despite verbal commitments from the families to come into town to meet with the team, not all attended, in fact only half attended. Under the current PAPL, the organisation was only able to charge the time of the scheduled meeting.
The manager reported that the operating losses for the week spent were around $10,000, encompassing travel to the remote town, accommodation, payment of staff wages and general operating expenses. The ability to continue to support these children and families is time limited by the reserves the organisation has with a significant risk that they will need to discontinue services.

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Workforce

What is needed now:

- Additional lump sum payments for organisations recruiting and training new graduates and early career professionals
- Additional lump sum payments for organisations taking on student placement
- Fund the true cost of supervision and professional development outside the hourly rate through payments to providers
- Additional loadings for workers delivering services in rural and remote areas to cover cancellations and no-shows
- Fully fund travel for allied health assistants
- Invest in training and registration for Allied Health Assistants to support rural and remote communities

The case for change:

The health and wellbeing of children with developmental delay/disability and their families relies on a skilled and responsive workforce providing evidence informed supports, when and where they need them.

Focussing on recruitment and retention is critical to create a sector that is viewed as one that provides career development and pathways for the future.

In our consultations with our members, they highlighted their commitment to children and families and the ECI way of working as a preferred model. However they also comment on the:

- Significant admin burden supporting families to manage NDIS plans
- Loss of enjoyment being unable to just focus on delivering quality supports as per their training
- Frustration at the pricing model eroding their ability to support workforce development
- Burnout and mental health challenges

I feel like I'm working harder than ever before and delivering the gold standard of Key Worker services. The impacts on my mental and physical health have been huge.

Cost of supervision of next generation of practitioners is not covered in the hourly rate. Therapists are telling us that they are unwilling to take on the clinical supervision of students because the time spent supervision/mentoring/reflecting with them will impact them being able to meet organisational utilisation targets. (Manager of a large NFP)

Due to investment of time in training and education for early careers//students/grads this means being unable to meet billables, despite time investing in training and educating such a cohort increases future likelihood of them working within our organisation and being able to contribute to financial stability

The NDIS is not a sustainable financial model. We are allowing natural attrition to reduce our EFT and exposure to NDIS. We have not been able to take new graduates since 2023. (We used to take 2-3 per year).
With less staff, we have reduced the number of students we are taking.

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- High turnover of staff as they begin a career in ECI and then quickly move on to other areas such as community health, hospital or programs such as School Readiness Funding in the Education sector
- Limited career progression opportunities

We asked members, '**Does the current PAPL support you to take on new graduates or students**?

The majority responded that they used to but are now needing to scale down or cease this work. Digging deeper into the reasons why, members commented on the significant leadership and supervision time required to support new graduate development and student placements- work that is not accounted for in the current hourly rates. In a sector where there are limited vertical career options it is essential to provide role diversification to retain practitioners. Training and supervision are highly valued for skill development and career progression, yet we are seeing practitioners leave the ECI sector as these opportunities diminish.

Part-time and blended work patterns are increasing as practitioners seek desirable remuneration and flexibility amid rising cost-of-living pressures. Members increasingly report needing to supplement their employment with work in other sectors such as hospital work to make ends meet.

ECIA VIC/TAS C-suite members comment on the pressure of rising wages in accordance with industrial instruments, with no corresponding increase to NDIS hourly rates. This erodes their ability to reinvest in their organisation and maintain financial sustainability. Many report capital reserves being depleted or the need to cross subsidise NDIS funded work. Leaders have quantified significant losses due to changes in travel arrangements, in the order of 11% of revenue per year and $200,000 per year lost from revenue generation in the case of a nation-wide provider.

The risk is clear: providers may choose not to deliver NDIS funded supports resulting in thousands of children without supports.

Case study – conversation with final year Occupational Therapy students as they begin their search for work.

Question: Would you consider working with children and families in the NDIS sector?

OT student 1 – No, it is too hard. I have heard that you need to see too many children a day and don't get paid to travel to see them.

OT student 2 – No the KPIs are too high, and I am worried I won't get the support I need at the beginning.

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The cut to travel funding by 50% has had a direct impact upon the use of Allied Health Assistants in rural areas. The case study below recounts a conversation with a registered regional Victorian provider.

Case Study – Feedback from a manager delivering services in rural Victoria following the cut to travel funding.

The manager reported the need to completely re-design their allied health assistant model. Prior to the cut, allied health assistants were working with children and families in the outlying areas, travelling to see them and implementing programs designed by their allied health team. Both AHA and families reported on the benefits and positive outcomes being achieved. As a result of the cut to travel funding, the AHA were no longer able to travel at all. Their hourly rate being halved when they are covering significant distances in regional areas made the service no longer financially viable and they have had to cease this offering. The only alternative for these children and families is to visit their clinic, removing children from education programs for a day at a time with travel up to two hours each way. Their educational outcomes are now being impacted.

Reinstating the ability to charge for all travel time, particularly for rural and remote areas for allied health assistants is one strategy to address the therapy desserts that exist in regional areas. Regional providers use practical approaches including clustering families in geographical locations to make the best use of travel time and cost, and combinations of virtual and in person supports. Under the current PAPL they are no longer possible, the financial burden is too great.

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Quality now creates savings later

What is needed now:

- Increased alignment to the National Framework Best Practice Early Childhood Intervention by funding travel to deliver services in communities
- Additional funding for quality services engaged in collaboration and teamwork in line with best practice
- Access to additional funding to complete current unfunded work such as engagement and coordination with interpreters and mandatory child protection notifications
- Registration of all providers that is visible to families

The case for change:

As an insurance scheme the NDIS is designed to invest early to minimise spending later. An early investment in high quality services ECI leads to life-long outcomes for children and families and reduced spending in later life.

One of the current narratives around the NDIS is more is better. The current market driven approach has supported this narrative despite misalignment with best practice.

The Independent Pricing Committee cautions pricing that does not represent the true cost to serve, and the impact will be seen through:

- high-quality providers moving out of the market
- favour lower-overhead, less comprehensive models
- reduce real access despite nominal funding availability (pp5-6, 34-35)

In our consultations with members they expressed a strong commitment to providing quality with many registered under the National Practice Standards. For those who are not registered, members highlighted the barriers, including the costs of registration, audit fees, and the time required to complete all unfunded compliance tasks.

We are needing to consider another restructure and further reduce indirect time of senior staff, which will likely reduce their capacity for clinical oversight and therefore potentially impact the quality of services delivery to our clients.

Clinicians need to be able to focus on therapy not all the juggling.

We work so hard to do what we can to align with best practice but the 2025 PAPLs have further eroded working in NATURAL SETTINGS, responding to FAMILY NEED, supporting INCLUSION in community, EMPOWERING the family to navigate systems.

The current PAPL has impacted frequency of face-to-face which subsequently reduced implementation fidelity and progress towards goals

We work with large numbers of families who are experiencing family violence, have child protection involvement, are going through traumatic separations, are financially disadvantages, are non-English speaking. The erosion to funding impacts these families most significantly. We must do better at a system level to support these families.

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To retain quality providers in the market, the NDIA must mandate registration for all through a registration process that is cost effective and does not burden providers with unnecessary administration. Leveraging off current registration systems and reforms occurring in other sectors such as child safety, is an opportunity to re-design the current registration approaches.
Co-design with providers and peaks would provide opportunities to test and see real time feedback on universal registration system design.

One of the key questions practitioners ask when applying for a new role is, "How will I be supported and what is your supervision model?". This resonates with our members who recongise the importance of life-long learning and the commitment to consistently delivering evidence-based practice. The tension that exists between leaders and practitioners often emerges in this conversation as leaders balance the need to maintain financial viability with providing the critical supports required for practitioners to deliver high-quality services.

NDIS rates no longer reflect the time leaders dedicate to supervision and mentoring of all staff, to ensure compliance with each discipline's registration body. This creates a risk of reduced quality in clinical practice and contributes to staff turnover, as clinicians move between roles seeking better support and professional development opportunities.

One client had to pause services for 2 months due to overspending in their funding period. This meant no support with the transition to school. They had different providers, so it was harder to keep track for the family. The family have expressed confusion, and burn out from trying to navigate the system – let alone changes.

Therapists reported the additional mental load of remembering when funding periods for individual clients change and organising updates of service agreements, chasing families etc.
Takes time away from actually delivering services to the client or working efficiently when delays relating to these occur.

We continue to strive to deliver in line with the National Best Practice Framework for ECI, however this is putting considerable strain on our service's financial viability and continued operation. Other revenue streams need to be considered if we are to continue operating, which may then reduce the services we can deliver funded under the NDIS.

We still try and operate in the guidelines and delivery high-quality services but this has placed us under financial stress and concern for our viability and impacts (reduces) job satisfaction.

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The risks and opportunities; now and in the future

What is needed now:

- Differentiated pricing for quality providers
- Realignment of Music/Art/physiotherapy rates to those of Speech Pathology and Occupational therapy
- Funding rates that cover the true cost to provide quality services
- Fully funded travel to allow practitioners to deliver services in natural settings
- Work force planning that values the expertise and experience of ECI practitioners
- Full alignment with best practice in ECI
- Registration to ensure quality and compliance oversight
- Additional loadings for supervision/mentoring/training of students and early career professionals

The case for change:

In the NDIA's consultation with providers, a key question was asked:

What is the single biggest risk of differentiated pricing the NDIA must address?

ECIA VIC/TAS members respond to this question stating simply that if differentiated pricing is not implemented their organisations may need to do one of the following:

- cease to provide NDIS funded services
- close operations all together

The impact of these actions will be thousands of children and families across Australia without services or stuck on waitlists with no access to support.

The 50% reduction in travel is having a significant impact on business. This will become more of an issue long term particularly in region/rural areas like ours.

Children are not able to have therapies front loaded so they can have a more intense approach in the beginning, this has also been hard to implement things as a key worker as you can't take a long-term approach and implement different things at different times.

Providing an outreach service to vulnerable participants who are unable to drive or use public transport has limited what I can provide as travel cost has been cut.

Funding periods have added excessive burden to families: the complexity is extreme for educated families and is out of reach for those with lower levels of education; keeping on top of invoice payment is now far harder to manage (eg: understanding how much funding is left in a plan period requires staying on top of forecasted services, current unpaid invoices, multiple providers).

As a provider, we are funding the additional administrative burden unsustainable: added 1/2 hour of unbillable time to onboarding (explaining and negotiating plan periods); multiple back and forth with families during and at the end of each plan period to understand residual funding; disruption to caseload/work planning for staff (staff have to pause a family for a few sessions at the end of a plan period due to possible overspend - and usually overspend is the result

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The risks associated with late intervention are:

- poorer developmental outcomes for children with failure to maximise neuroplasticity at critical points
- increased family stress
- lost opportunities for meaningful participation in family and community life
- poorer transitions through life stages
- increased costs to governments with presentations in justice, mental health and health later in life
- lost benefits to taxpayers as the insurance principles deliver long term outcomes
- increased risks of youth suicide, homelessness, crime, unemployment and obesity.

The opportunities resulting in providing quality early childhood intervention services early are:

- improvements to the lives of children and young people
- strong communities with a strong sense of belonging and participation
- reduced pressure on government spending with future savings
- a workforce that is skilled and stable and contributes to the national economy

ECIA VIC/TAS view early intervention delayed as early intervention denied.

As the market steward the NDIA must act now to enable quality early childhood intervention providers to deliver quality services to children and families and ensure a stable workforce for the future.

ECIA VIC/TAS are keen to engage with the NDIA and support their reforms through consultation and policy development.

Being Child and Family centred can be difficult to align when NDIS funding is for the child and therefore parent directed supports are ignored / unable to be provided as they otherwise could be.

When the whole scheme is setup to be impairment focused providing practice in a strengths based manner undersells the child's support needs and ultimately results in plans insufficiently funded.

We resist anything that reduces the quality of our service, but each time the changes roll out there comes a time when our bottom line is impacted too heavily and we have to make a practice shift.

Please reinstate Key Woker model as best practice, bill it all under one price and stop families from having to travel to up to 5 different appointments per week because their support coordinator thinks that they know better.

Ecologically based service provision is limited by school's willingness to incorporate NDIS providers as well as the lost productivity in travel funding

Funding periods create another barrier to operational simplicity and require more administrative support to monitor these periods. Also limits the ability to provide block based or intensive supports during key transition periods or to support client choice / preferences.

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Appendix: Comparison of funding models

The table below compares episodic health treatment models with comprehensive disability services. A 15 minute Medicare funded treatment to address a single health concern cannot be compared to disability services that create life-long child, family and community changes. Key differences include, GAP fees leading to lack of access, inclusion in family and community and value for money based on hourly rates.

	Medicare (MBS) In clinic setting	Private Health Insurance. In clinic setting	NDIS In community setting
Eligibility	Anyone with a Medicare card limited by ability to pay a GAP fee	Only people who can afford to pay for extras cover, and pay the gap per service.	Any child with developmental concerns, delay or disability.
Payment of GAP fee required?	Yes	Yes	No
Travel included	No	No	Yes
Access to a skilled team.	Uncoordinated and limited by funding per year.	Uncoordinated and limited by funding per year.	Yes with a team around the child approach.
Funded assessments	Yes with GAP fees	Yes with GAP fees	Yes for program planning, not for diagnosis for access to NDIS
ECI sessions	Limited number in clinic- health related	Limited number in clinic - health and some disability related	Disability specific, capacity building, equipment prescription and fitting, support with transition to education settings, emergency and disaster management, collaboration with community services.
1 hour of therapy delivered by speech pathologist or Key worker	Rebate: $58 paid by Medicare GAP fee of $100-$150 paid by parent Typical Total cost $208 per hour.	Rebate: Around $80 paid by health insurer. Gap feel around $40–$120 Typical total cost $200	NDIS rate for Speech pathology $193.99/hr for an in clinic setting.
Session limits	Strict annual limits 5 CDMP, 10 Better Access sessions per year.	Annual limits, typically $500-$800, buying 3-5 sessions per year based on market rate of $200/hr/session.	Flexible depending on the child's plan.
Funding basis and rebate amounts	CDM $58–$137 per session (partial coverage; gap fee applies).	Annual caps of $500- $800 depending on the policy you buy.	Individualized funding under the NDIS (average package size $26,000).
Session times	15-20 mins	15,30 or 60 mins	45 -90 mins depending on needs and family choice.
Reporting	Unfunded at the end of the CDMP sessions.	Unfunded following funding exhausted or final session.	Completed as part of the NDIS funding package.

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References:

The Cost of Late Intervention
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Working together to deliver the NDIS | NDIS Review
National Best Practice Framework for Early Childhood Intervention | Australian Government Department of Health, Disability and Ageing