Women
With
Disabilities
Australia
(WWDA)

Submission

Gendered Risks of the NDIS Amendment Bill 2026

For submission to the Senate Community Affairs Legislation Committee: *National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026*

Women With Disabilities Australia (WWDA)

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Publishing information

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Authorised by:

- **Sophie Cusworth,** Chief Executive Officer

Author:

- **Dr. Diana Piantedosi**, Senior Manager, Policy & Advocacy

Acknowledgement of Country

The authors acknowledge the traditional owners of the land on which this publication was produced. We acknowledge First Nations people's deep spiritual connection to this land. We extend our respects to community members and elders past, present and emerging.

Submission contact

Sophie Cusworth
Chief Executive Officer, Women With Disabilities Australia
E: officeadmin@wwda.org.au

About WWDA

Women with Disabilities Australia (WWDA) is the National Disabled People's Organisation and National Women's Alliance for women, girls and gender diverse people with disability in Australia. WWDA is governed, run, led, staffed by, and constituted of women, girls and gender diverse people with disability. Our work is grounded in a human rights framework across civil, political, economic, social and cultural rights.

Recommendation

The *National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026* would change who the NDIS recognises, who it excludes, what support it funds, and what costs it shifts back to families and other service systems.

WWDA recommends that the Bill not proceed in the absence of a comprehensive, public gender impact analysis and co-design of gender-responsive reforms with women, girls and gender-diverse people with disability.

This is necessary because the NDIS already underserves women. Women make up more than half of people with disability in Australia, but just over a third of NDIS participants. These reforms risk deepening that exclusion before Government has built the alternative supports, safeguards and service systems people are being told to rely on.

WWDA's key concerns

The Bill gives Government broad powers to tighten access, reduce supports, cap funding and shift people to other systems before the rules, assessment tools, safeguards and foundational supports have been designed, tested or made available. This creates three immediate risks:

1. **People may lose access before any alternative exists.**
2. **Costs and care will shift onto families, especially women.**
3. **Future rules, tools and evidence settings may reproduce existing gender bias.**

Government cannot cut first and design the replacement systems later. Right now, for many people with disability, there is nowhere else to go.

1. Tightened eligibility will deepen gendered exclusion.

The Bill risks narrowing access through new functional capacity thresholds, permanence tests, treatment requirements and exclusions based on other service systems. These tests may appear neutral, but they will operate in systems where women, girls and gender-diverse people already face delayed diagnosis, clinical dismissal, under-documentation and barriers to specialist evidence. This is particularly serious for people with fluctuating, episodic, fatigue-related, pain-related, trauma-related, psychosocial and chronic health conditions.

These disability experiences are often harder to document through narrow functional assessments and are more likely to be under-recognised in health and disability systems.

WWDA is concerned that the Bill may:

- treat delayed or unaffordable treatment as evidence that a person has not exhausted “all appropriate treatment”;
- assume health, aged care, compensation or other systems can provide disability support when they often cannot;
- fail to recognise that episodic disability can have permanent functional impact;
- push people with degenerative conditions out of early support, creating higher lifetime costs; and
- weaken protections for people who turn 65 and still require disability support.

Key message for Government: eligibility reform cannot proceed safely until alternative supports are real, available, timely, safe, disability-competent and gender-responsive.

2. Support cuts will shift costs and safety risks onto women.

The Bill risks reducing supports that enable daily living, community participation, safety, autonomy and work. When funded supports are reduced, the need for care and support does not disappear. It shifts to unpaid carers, who are disproportionately women. This will affect mothers, partners, daughters, sisters and friends, including many women with disability who already provide care while managing their own support needs.

WWDA is concerned that support reductions, caps and lower-cost alternatives may:

- push more unpaid care onto women;
- reduce women’s workforce participation and economic security;
- isolate women and gender-diverse people with disability from community safeguards;
- increase risks of violence, abuse, neglect and exploitation;
- replace individualised support with blanket caps or ratios that erase actual need; and
- split whole-person support into artificial impairment categories that do not reflect real life.

Community participation is not optional. For many women and gender-diverse people with disability, it creates visibility, connection, safety and routes to help. Cutting these supports can remove the regular contact that helps people be seen, known and able to report harm.

Key message for Government: support reductions will not remove need. They will shift cost, care and risk onto women and families, leading to crisis-driven responses in other systems.

3. Delegated evidence, budget and automation settings may entrench bias.

The Bill delegates major decisions to future rules, technical advice, evidence standards, budget methods and computer-assisted processes. Those mechanisms may shape access, support needs and funding before Parliament and the disability community can scrutinise their impact.

WWDA is particularly concerned that future rules may:

- prioritise potentially gender bias published research over participant outcomes and practitioner evidence;
- discount supports used by people whose disability experiences are under-researched;
- limit the evidence that assessors can consider;
- use historical data that already reflects gender bias, lower service access and under-utilisation;
- use automated or computer-assisted action without adequate transparency, review rights or bias testing; and
- allow budget methods to shape identified support needs, not just funding levels.

Apparently neutral evidence systems are not automatically fair. Research gaps, diagnostic bias, poor data and under-recognition of women's disability experiences can all become exclusion mechanisms if Government does not build safeguards into the Bill and rules.

Key message for Government: future rules and automated settings must not make women pay for gaps in research, diagnosis and service access.

What WWDA are calling for

The scale of the proposed changes requires more than limited references to gendered impacts in the explanatory memorandum. A comprehensive gender impact analysis must occur before the Bill progresses. It should identify who will be harmed, how costs will shift, which groups face exclusion, and what safeguards must be built into legislation and rules. Retrospective monitoring will come too late for people who lose support, leave work, become isolated, or enter crisis.

Co-design also cannot operate as a safeguard after key policy decisions have already been made. Genuine co-design requires women, girls and gender-diverse people with disability to shape the reform settings before they are settled.

WWDA's recommendation to Government: **WWDA recommends that the Bill not proceed in the absence of a public, comprehensive gender impact analysis, and gender-responsive reforms co-designed with women, girls and gender-diverse people with disability.**

At minimum, Government must demonstrate that:

- foundational supports and other service systems are available before people are redirected away from the NDIS;
- no one loses support before safe and sufficient alternatives exist;
- eligibility tests recognise fluctuating, episodic, chronic, psychosocial, pain-related and trauma-related disability;
- support reductions do not increase unpaid care, isolation, violence risk or economic insecurity;
- budget methods, assessment tools and evidence rules are transparent, reviewable and bias-tested; and
- any delegated power includes parliamentary scrutiny, lived-experience oversight and gender-responsive safeguards.

The bottom line

The primary gender risk does not sit in one provision of this Bill. It arises from the interaction between narrower eligibility, delegated funding powers, support caps, impairment-specific attribution, restricted reassessment, evidence rules and reliance on service systems that are already failing many women, girls and gender-diverse people with disability. The Bill proposes to embed high-risk settings before Government has shown how it will prevent gendered exclusion, care-shifting, violence risk and biased decision-making.

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Supporting Evidence Paper

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Women With Disabilities Australia (WWDA)
May 2026

Purpose of this paper

WWDA’s submission provides a concise statement of our position and recommendations to the Committee. This supporting evidence paper provides the detailed evidence, examples and risk analysis that inform that submission. It is intended to assist the Committee, Ministerial offices and sector stakeholders to understand the gendered implications of the Bill across eligibility, support reductions, delegated powers, evidence rules and implementation risks.

Issue summary: This Bill will shape who the NDIS recognises, who it excludes, what support it funds and what care it shifts back to families and informal supports. In a scheme with documented gender inequities, proceeding without a detailed public gender impact assessment risks entrenching those inequities.

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Executive Summary

The Bill proposes substantial changes to NDIS access, planning and supports. The Bill would establish broad powers before the rules, assessment tools, safeguards and adult foundational supports needed to prevent harm have been designed, tested or made available. The Government has repeatedly cited the 2023 NDIS Review as justification for reform[1], yet the Review itself cautioned against selective or piecemeal implementation, stating that its 26 recommendations and 139 supporting actions are "interdependent" and "must be implemented as a package to achieve a more inclusive and fairer Australia for all people with disability[2]." Peer-reviewed analysis has also found that the 2023 NDIS Review did not adequately examine gender inequities in the Scheme[3]. The Bill therefore proceeds from an evidence base that does not fully account for gendered disability experience, in the context of persistent gendered inequities identified in the Joint Standing Committee's latest annual report[4].

The Explanatory Memorandum acknowledges some gendered impacts, particularly the gendered nature of unpaid care[5]. However, it does not provide a detailed gender impact analysis of how the reforms will affect participants. It gives limited attention to women, girls and gender-diverse people with disability, despite evidence that they already face barriers across the NDIS, health, mental health, family violence, housing and care systems.

WWDA is deeply concerned that the proposal will compound these known inequities. Given the scale of the proposed reforms, government should transparently assess gendered impacts before the Bill proceeds. Retrospective monitoring or consultation after key policy decisions have been made cannot substitute for a prospective gender impact assessment. Genuine co-design requires affected communities to shape policy design before settings are settled, particularly where reforms may reduce access to supports, shift costs to unpaid carers, or increase unmet need.

Key Message #1: The NDIS already underserves women. This Bill will make that worse.

Women make up over half the disability population[6] but just over a third of NDIS recipients[7].

Women's participation rates in the scheme have remained stagnant at 37-38% since scheme inception[8]. Women also find it harder to access the scheme as they get older[9]. There are similar rates of access approval for male and female children aged 0–14. However, from ages 15+ male access requests are approved at far higher rates than females and applicants gendered 'other'[10]. This gendered gap widens for each age band through to 64.

Research[11] indicates three reasons why women are underserviced by the NDIS:

- Women are under diagnosed with conditions commonly accepted by the NDIA (e.g. autism) while being far more likely to be diagnosed with chronic health or autoimmune conditions that are less likely to be accepted by the NDIA;
- Women are socialised to deemphasise their own needs, which may mean women are "less effective self-advocates than men"[12]; and
- The gendered nature of caring responsibilities alongside the complications women face in having these responsibilities supported, particularly in relation to parenting.

WWDA has long advocated for the establishment of a gender strategy to address persistent gender inequality in the NDIS[13]. The Joint Standing Committee's latest annual report recently affirmed this call for action[14]. It recommended restarting the currently 'shelved' NDIS Gender Equity Strategy, improving gender data collection and reporting, and strengthening responses to violence[15]. **The design of the current reforms is contrary to this guidance and risks significantly worsening known inequities.**

Table 1: Key Concerns

1. Tightened eligibility will deepen gendered exclusion.	2. Support cuts will shift costs and safety risks onto women.	3. Delegated evidence and budget settings may entrench bias.
Functional capacity thresholds, peer comparison, permanence tests and alternative-service exclusions may miss fluctuating, episodic, fatigue, pain, trauma-related and co-occurring impairments. These settings will operate in a Scheme that already underserves women.	Cuts to social, civic and community participation, caps, ratios, lower-cost alternatives and tighter reassessment may isolate women and gender diverse people, reduce natural safeguards and push unpaid care onto mothers, partners, daughters and sisters.	TAG design, standardised tools, peer-reviewed "generalisable" research, limits on practitioner evidence, automated recommendations and budget methods may reproduce gender bias already present in diagnosis, health systems, evidence, service use and plan utilisation data.

1. Tightened eligibility will deepen gendered exclusion

The NDIS already has documented gender inequities in access. Women have lower participation rates than men[16], the access gap widens from adolescence[17], and the Joint Standing Committee on the NDIS has recommended that the NDIA recommence work on the shelved Gender Equity Strategy[18]. These issues should shape how Parliament assesses any Bill that tightens who can enter the Scheme, remain in the Scheme, or seek reassessment when support needs change.

The eligibility reforms create a particular risk because they narrow what decision-makers can recognise as disability-related need. Functional capacity, permanence, treatment history and access to other service systems may appear neutral on paper, but each relies on evidence produced by systems where women, girls and gender-diverse people already experience delayed diagnosis, clinical dismissal, under-documentation and unsafe or unavailable services. Without safeguards, the Bill may treat these existing inequities as evidence of lower need or ineligibility.

The current reform focus has centred on developing a support system for Thriving Kids. However, the NDIS Review also recommended a parallel expansion of home and community care supports for adults under 65 with lower-intensity and episodic needs, including people with chronic health conditions[19]. **This adult support system has not yet been built.** Many people are currently directed to health, aged care, compensation, insurance or other service systems that either do not provide the required disability supports, provide them only for a limited period, or provide payments that do not meet lifetime disability-related costs. Access decisions must therefore turn on whether another system actually provides timely, safe, accessible, disability-competent and sufficient support in practice, rather than whether another system could theoretically be responsible for providing it.

The Bill may make episodic disability harder to recognise by requiring people to exhaust “all appropriate treatment” before their impairment is considered permanent. This will disadvantage people with disability related to chronic health conditions, particularly where timely treatment, rehabilitation and allied health support are unaffordable, unavailable or inaccessible. WWDA’s 2025 Economic Security Survey found that 75% of respondents experienced health insecurity in the past six months, including delaying or missing GP or specialist appointments, or being unable to access prescription medication because of money shortages[20]. It also found that 75% lived with one or more chronic health conditions, and 60% said physical health created a barrier to seeking or keeping work[21].

Chronic condition management plans provide only five subsidised allied health sessions per year[22]. For many people, this is not enough to manage episodic disability, maintain function, prevent deterioration or stay engaged in work. This creates a user-pays access barrier. People with money, transport and local services may be better able to show they have exhausted treatment. People without those resources may be excluded because they could not access the treatment the Bill expects them to have tried. This would increase inequity, delay support, worsen preventable deterioration and push more people out of work. It would also increase downstream costs where delayed support leads to avoidable hospitalisations and more intensive support needs.

Public reporting has already linked loss or denial of NDIS support to people choosing voluntary assisted dying[23]. This underscores the seriousness of tightening disability access before safe, adequate and timely alternatives exist. In an already gender-unequal Scheme, these risks require prospective gender and human rights assessment before the Bill proceeds. Table 2 identifies the minimum safeguards needed to prevent that outcome. Eligibility and reassessment decisions must recognise functional impact over time and in context. They must also account for inaccessible treatment, failed service systems, fluctuating disability and urgent safety changes before people are pushed further into crisis.

Key Message #2: Compensation is not lifetime disability support.

A WWDA member shared that she sustained a brain injury and requires lifelong disability support. Under Victoria's Transport Accident Commission (TAC) scheme, she may receive about $80,000 once, minus legal fees, while her disability support costs exceed $40,000 each year. The TAC does not fund some disability supports, including support coordination, and most domestic supports stop after five years. She also could not access treatment at the time of injury because she had no money, lived five hours from specialist rehabilitation, and left hospital without being told what treatments existed. WWDA also understands that, after a workplace injury, WorkSafe supports are reassessed and often stop after two years[24]. The Bill risks treating compensation schemes as an alternative to the NDIS even when they do not provide adequate, ongoing disability support.

Key Message #3: Early support prevents higher lifetime costs.

Degenerative conditions often require early and ongoing support to maintain function, delay deterioration and prevent higher future costs. Multiple sclerosis is one example and it affects three times more women than men in Australia[25]. Australian research[26] found that NDIS packages for people with multiple sclerosis rose sharply with disability severity, from AU$34,224 for 'mild' disability to AU$114,585 for 'severe' disability. The study also found "a striking variability in packages approved" and that "restricted mobility seems to be the driving factor".

Once people were no longer employed, plan values were significantly higher: AU$88,439 for unemployed participants compared with AU$33,881 for employed participants. **The Bill risks denying early, preventative disability support until functional decline becomes severe, even though timely support can help people maintain function, participate in work and reduce higher future Scheme costs.**

Key Message #4: Episodic disability has permanent functional impact.

A WWDA member with multiple sclerosis described episodic disability as "not knowing what body you will wake up in". During exacerbations, she experiences leg spasticity, loss of movement on one side of the body, brain fog, severe fatigue, visual disturbances, nerve pain known as the "MS hug", and reduced fine motor function that makes brushing hair, vacuuming and cleaning almost impossible. The severity of symptoms fluctuates, but the functional impact is permanent. She described the vigilance required to monitor her body, track warning signs, pace activity and constantly adjust daily routines to prevent exacerbations that can stop functioning for days. NDIS-funded cleaning and allied health supports helped her maintain routines, use adaptive equipment, live independently, and remain in full-time work. **Functional measures must also capture what a person forgoes to perform a task.** A person may get through a workday only by giving up cooking, cleaning, social connection, exercise or recovery time afterwards. **A functional threshold that only captures visible impairment at one point in time will miss the constant self-management work and trade-offs required to live with episodic disability.**

Key Message #5: Health costs and availability should not decide NDIS access.

A WWDA member with multiple sclerosis entered the NDIS Early Intervention stream. As the 'Key message 4' shows, her disability is episodic, but managing it requires constant vigilance. Her NDIS plan funded the allied health support she needed to understand her body, recognise warning signs, manage fatigue, use adaptive equipment, reduce exacerbations and stay in full-time work. It also funded weekly cleaning, which helped her maintain her home, preserve dignity and allow her to live independently. Five subsidised allied health sessions a year would not have come close to meeting that need, and the health system does not provide practical disability supports such as cleaning. **If the Bill requires people to exhaust "all appropriate treatment" before their impairment is recognised as permanent, access will depend on who can pay to prove they have tried enough.** People with money, transport and local services will be better placed to build the treatment history the Bill demands.

People without those resources may be excluded because they could not access the very treatment the law expects them to have completed.

Key Message #6: Turning 65 should not mean losing disability support.

Current NDIS settings allow a person who enters the Scheme before 65 to remain in the Scheme after they turn 65. This safeguard matters because aged care is not resourced to meet disability support needs. For example, the ABC has reported Graham Crossan is 80 and has advanced motor neurone disease. He cannot walk, eat, talk or breathe without support, yet he was denied increased home care after an aged care assessment algorithm found he was not eligible[27]. His wife Gaynor provides 24-hour care, has injured herself trying to move him, and says "both our safety" is at risk[28]. **The Bill risks weakening the protection current participants rely on if future rules treat aged care as an alternative to the NDIS, despite evidence that it cannot safely meet high disability support needs.**

Table 2: Eligibility safeguards

Bill lever	Gendered risk	Minimum safeguards
Functional capacity thresholds	May underestimate disability when functional impacts are fluctuating, episodic, fatigue-related, pain-related, psychosocial, neurodivergent or trauma-related. This risk is greater for women and gender-diverse people who have adapted by withdrawing from work, study, parenting, caring or community life.	Functional capacity assessment must capture ordinary and worst days, reliability, safety, duration, recovery time, fluctuation, masking, co-occurring impairments, and violence-related barriers to participation.
Reliance on peer comparison	Peer comparison can compound this risk where the assumed comparator reflects male-pattern participation, and fails to account for the supports, safety conditions and resources required for women and gender-diverse people to participate in work,	Remove peer comparison from functional capacity assessment. Assessment should focus on the person's actual functional impact, support needs and barriers to participation, including how disability interacts with gender, violence, caring roles,

Bill lever	Gendered risk	Minimum safeguards
	study, parenting, caring or community life.	service access and economic inequality.
Permanence tied to "all appropriate treatment"	Risks turning health-system failure into NDIS exclusion where diagnosis or treatment is delayed, unaffordable, unsafe, culturally inappropriate, traumatising, regionally unavailable or clinically contested. This will disproportionately affect people whose conditions are degenerative and/or poorly recognised in health systems, including women with chronic health-related, psychosocial, pain-related or trauma-related disability.	Permanence must not be denied because treatment was inaccessible, unsafe, unaffordable, inappropriate or delayed by gender bias. The Explanatory Memorandum and Bill contemplate circumstances where it may be inappropriate to determine there are treatment options available[29]. This must include considerations of safety, trauma, cost, culture, regional access and availability.
Alternative supports through other systems	May redirect people to health, mental health, aged care, compensation, housing or family violence systems that are unavailable, delayed, unsafe, not disability-competent, or unable to meet disability support needs. This risks shifting unmet need onto women, families and informal supports, and crisis systems.	No exclusion based on another service system unless that service is actually available, timely, accessible, disability-competent, safe, culturally appropriate and able to meet the person's support need.
Sequencing with foundational supports	Tightened access may push people into service gaps before foundational supports exist, particularly adults with chronic, episodic, psychosocial or fluctuating disability. This will disproportionately affect women and gender-diverse people who already face	Do not commence tighter access or alternative-service exclusions until foundational supports are funded, available, accessible, disability-competent and gender-responsive. For example, **the 2023 NDIS Review recommended joint investment in expanded**

Bill lever	Gendered risk	Minimum safeguards
	under-recognition across health and disability systems, and a higher prevalence of chronic health conditions.	**home and community care programs for adults under 65 with lower-intensity and episodic needs**, including a national benchmark of around 235,000 places[30].
"Significant and ongoing" and "unanticipated" reassessment thresholds	May miss urgent, time-critical changes in support need, including gender-based violence, homelessness, carer breakdown, pregnancy, parenting, relapse, hospital discharge, episodic deterioration or sudden loss of informal support. A person should not need to prove a crisis is "ongoing", or defend why an unsafe change was "unanticipated", before support becomes available.	Create urgent and fast-tracked reassessment or variation triggers for gender-based violence, unsafe housing, carer loss, episodic deterioration, parenting, pregnancy, hospital discharge and other safety risks. Clarify that "unanticipated" means unanticipated when the plan was approved. Do not require crisis or instability to become ongoing before support can be adjusted.

2. Support cuts will shift costs and safety risks onto women

This section addresses how the Bill may reduce supports that contribute to safety, autonomy and participation. *Changing the landscape* identifies violence against women and girls with disability as a human rights issue shaped by gender inequality and ableism[31]. The Disability Royal Commission also found that reducing isolation, strengthening safeguards and supporting community inclusion are central to preventing violence, abuse, neglect and exploitation[32].

The Bill sits within a care system that already relies heavily on unpaid labour. Current NDIS settings assume support from families, carers, informal networks and the community. **In 2020, replacing unpaid care with paid support was estimated to cost $77.9 billion[33], more than twice the cost of the NDIS over the same period[34].** Reducing funded supports therefore shifts costs rather than removing them.

That costs shift is gendered. Women are the majority of primary carers:

- 12.3% of Australian women identify as carers, representing 71% of all primary carers[35]
- Nearly 90% of primary carers for children are women[36]

- Women often carry dual care responsibilities for elderly parents as well as their children often referred to as “the sandwich generation”[37]

Many carers have disability themselves. Reduced supports will increase unpaid care, coordination, transport, supervision and advocacy. This creates a direct risk to women’s workforce participation, income and financial security. **Changes to support settings will reduce gendered productivity gains in three ways**:

- **Disabled women will lose supports that enable work:** Women with disability will be pushed to reduce hours, leave work or lose pathways into employment if funded supports are cut, capped or replaced with unsuitable alternatives.
- **Unpaid care will increase:** Parents, partners and carers, who are disproportionately women, will be pushed to reduce paid work or leave the workforce as more support shifts back to families.
- **Paid care work will contract:** The disability support workforce is highly gendered, 7 in 10 disability support workers are female[38]. Broad reductions to support funding will reduce paid care work, increase job insecurity and weaken women’s economic security across the care economy.

In addition to these risks, the Bill appears to create enduring powers that could be used across broader support categories, including supports that maintain daily living, personal care, safety and community participation. **This creates a structural safety risk because future determinations could reduce funding for whole classes of plans or participants without assessing individual circumstances.** The Bill also shifts the meaning of “reasonable” toward what the Scheme can sustainably fund, rather than what the person needs to access support in practice. Where funded amounts fall below actual support costs, the gap will be carried by participants, families and unpaid carers, with predictable gendered impacts. The minimum safeguards should protect safety and recovery-related supports, preserve individualised support where group or family-based options are unsafe, ineffective or promote segregation from the community, and require gender impact assessment before caps, class-based reductions or funding rules override assessed need.

Key Message #7: NDIS cuts shift unpaid care onto women.

The ABC have reported Penny Lalor entered the NDIS after a stroke[39]. The Scheme enabled her to live at home, walk short distances with assistance and use her wheelchair outside the house. After her plan was cut by about 50 per cent, her mobility regressed, she was hospitalised twice, and her daughter Caitlin cut back paid work and moved in to provide care. This shows what happens when funded support is reduced without removing the need for care. At scale, these cuts will push more unpaid care onto daughters, mothers, partners and sisters, reducing women's workforce participation, increasing carer exhaustion and result in worse outcomes for participants. **Where families cannot sustain that care, more people may enter residential or institutional settings, including younger people forced into aged care, resulting in higher overall costs and worse participant outcomes.**

Key Message #8: Isolation creates conditions for violence and neglect.

Ann Marie Smith's death shows why community participation is a safety issue. She had cerebral palsy, lived alone, received NDIS-funded care and had very limited contact outside one closed support relationship[40]. Police said she had been left in the same chair day and night, was malnourished, in septic shock and died in circumstances described as "likely preventable". Isolation was identified as a central risk factor, with advocates stating that safeguarding requires "multiple eyes" and "multiple people" in a person's life[41]. The Disability Royal Commission examined what had been learnt since her death and stated that individual cases must identify the "policy and regulatory issues" needed to give practical effect to Australia's human rights obligations[42]. Reducing social, civic and community participation supports risks cutting away the regular contact, visibility and informal safeguards that help people be seen, known and able to report harm. **For women with disability, who already experience higher rates of violence, these cuts risk deepening isolation and worsening conditions where violence, abuse, neglect and exploitation are hidden.**

Key Message #9: Blanket caps erase individual need.

Maximum intensity, ratio powers and support determinations could affect supports people rely on for daily living, including personal care, mobility, communication, behaviour support and community access. These needs cannot be safely reduced through assumptions about an "average" participant. Even within the same diagnosis categories, there remains significant variability in presentation. For example, research describes MS as "a very variable disease" and found NDIS package values ranging from $4,901 to $516,703, with core support for people with lower assessed disability ranging from $5,000 to $72,000[43]. The same risk applies across disability groups. Government analysis reported by The Guardian found proposed social, civic and community participation cuts would affect some participants more heavily, including people with visual impairment, psychosocial disability and Down syndrome, because some people need significant support to access the community even where they need less day-to-day support[44]. **Blanket caps, intensity limits and ratios risk cutting supports that make daily life safe, dignified and possible.**

Key Message #10: Whole-person support cannot be split into impairment silos.

For example, a participant may meet NDIS access through psychosocial disability and also have ADHD that does not meet access. They receive psychology support to manage distress, executive function, emotional regulation and daily routines. In practice, the psychologist must work with the whole person, not divide each session into minutes caused “directly” by one impairment or another. The same problem arises where a person has an eligible impairment (such as Autism) and chronic pain. Pain, fatigue, sensory distress, mobility, cognition and trauma can interact in ways that change how support must be delivered. The Bill risks replacing whole-person support with artificial attribution tests that practitioners cannot apply safely in practice.

Key Message #11: Crisis can make people “uncontactable”.

A participant escaping violence may leave home quickly, change phones, lose documents, move through crisis accommodation or avoid contact for safety reasons. Under the Bill, being “not contactable” could lead to plan suspension and revocation of participant status. This creates a serious safety risk. A person in crisis may lose the very supports that help them stabilise, communicate with services, attend appointments, secure housing and stay safe. Safeguarding steps must be required before suspension or revocation, especially where violence, homelessness, coercive control, hospitalisation or crisis accommodation may explain why a participant cannot respond.

Key Message #12: Supply delays should not erase approved supports.

A participant may have approved capital funding for home modifications, a hoist or essential equipment, but cannot use the funding before the plan ends because assessments, installation, quotes or suppliers are delayed. This does not mean the support is unnecessary. It means the system has not delivered it in time. Use-it-or-lose-it settings risk removing approved supports because of delays outside the participant’s control. This risk will be greater for women in regional and remote areas, women managing violence or unstable housing, and women balancing disability support with caring responsibilities.

Key Message #13: Crisis support should not have to become "ongoing".

A participant's support needs may change quickly because they are pregnant, parenting alone, leaving violence, losing informal care or moving through unsafe housing. Under the Bill, a participant may need to show that a change is "significant and ongoing" before a reassessment occurs. That threshold may miss urgent, time-critical support needs. **A person should not have to prove that crisis has become permanent before support is adjusted to keep them and their children safe.**

Table 3: Support safeguards

Bill lever	Gendered risk	Minimum safeguards
SCCP and capacity-building reductions	Class-based reductions may reduce supports that prevent isolation and enable safety, recovery, education, employment and civic participation. Substituting group supports may be unavailable in regional and remote areas or unsafe/ ineffective for people with trauma or psychosocial disability.	**Blanket cuts are contrary to the individualised design of the NDIS and create unacceptable risk**[45]. This is particularly the case for violence, safety and recovery-related supports. A comprehensive intersectional impact analysis must be conducted, and participants' individual circumstances must be considered, before reductions apply. Individualised and 1:1 supports must be preserved where group settings are unsafe, inaccessible, ineffective, or promote segregation.
Caps, maximum intensity/ratios and support determinations	Ministerial ceilings may convert assessed need into a lower funded amount for whole classes of participants, without plan-by-plan merits review. This may miss gendered safety, parenting, trauma, thin markets and interacting impairments.	No cap or class determination without an individual dedicated gender impact assessment, strengthened parliamentary scrutiny, an individual safety/complexity override, and intersectional monitoring of outcomes.

Bill lever	Gendered risk	Minimum safeguards
Reasonable and necessary definitional changes	Shifting “reasonable” toward what is reasonable for the Scheme to fund may allow funded amounts to fall below the actual cost of providing or acquiring supports. This can create a gap between assessed need and usable support, shifting costs onto participants, families and unpaid carers. Given unequal income, wealth and caring responsibilities, this gap will have gendered impacts.	Require any change to reasonable and necessary criteria to be tested through a dedicated gender impact assessment. Funding decisions must consider the real cost of accessing supports in practice, including market availability, regional costs, safety, informal care impacts and the participant’s economic circumstances.
Direct link to eligible impairment	Undermines a whole-of-person approach. Requiring each support need to be linked directly to a qualifying impairment may force artificial medical attribution when chronic illness, psychosocial disability, trauma, neurodivergence and physical impairment interact.	Restore or retain whole-of-person safeguards, or require decision-makers to assess cumulative functional impact and interactions between impairments rather than isolating one impairment per support need.
Informal supports and lower-cost alternatives	Reduced funded support will be absorbed by female and gender-diverse carers and may expose participants to unsafe family or group settings. This is a productivity risk: unpaid care reduces workforce participation and financial security.	Informal care must not be presumed available, safe or sustainable. Lower-cost alternatives must be assessed for safety, autonomy, access, trauma impact and prevention, not price alone.
Unspent funds, 90-day claims and suspensions	Use-it-or-lose-it settings may treat low utilisation as lower need, when women may underspend because supports are unavailable, unsafe, delayed, disrupted by	Blunt settings may disadvantage women in crisis and/ or treat low utilisation as lower need, when women may underspend because supports are unavailable, unsafe,

Bill lever	Gendered risk	Minimum safeguards
	violence, or unsuitable for fluctuating impairment. Removing or suspending participants for contact issues could disadvantage women in crisis/ leaving violence.	delayed, disrupted by violence, or unsuitable for fluctuating impairment.

3. Delegated evidence and budget settings may entrench bias.

This section addresses how the Bill may embed gender bias through the evidence, rules and tools that will drive future NDIS decisions. The concern is not only whether the Bill refers to evidence, but whose evidence counts, which data informs the rules, and whether future assessment systems can recognise disability experiences that have been under-researched, under-diagnosed or under-documented.

This is a gendered issue because women, girls and gender-diverse people with disability already experience systemic gaps in diagnosis, research, clinical recognition and service access. Peer-reviewed research has found that gender was largely absent from the NDIS Review's findings and recommendations[46], despite the Review being used as a key basis for reform. If the Technical Advisory Group, future rules and assessment tools do not correct this gap, they may reproduce it. The TAG must include experts with experience working with lived expertise and the disability community.

The Bill relies on mechanisms presented as objective, including standardised assessment, published research, generalisable evidence and computer-assisted action. These mechanisms require careful scrutiny because their inputs may reflect gender bias in medical knowledge[47], delayed diagnosis[48], lower service use, thin markets and unequal access to specialist evidence. Evidence standards should not treat limited published research as evidence that a support lacks benefit. They should also retain scope to consider evidence that a support improves outcomes for an individual participant. The Minister's approach to accepting and weighing evidence should be transparent, reviewable and supported by published reasons.

The concern is particularly acute where future rules allow the budget method to shape the identification of support needs, not only the funding amount. The Explanatory Memorandum states that a needs assessment report is "not required to identify needs for NDIS supports" and that needs may be identified through either "the support needs assessment tool" or "provisions included in the budget method"[49]. Recent concerns about the aged care Support at Home model show the risk of formula-based tools producing support levels that do not meet daily needs[50]. Government should not delegate this design power before publishing and testing the budget method and support needs assessment process. A gender impact assessment must test how any formula, classification or budget rule will account for understated need, incomplete records, fluctuating disability, co-occurring impairments and safety-related supports. Minimum safeguards should require gender expertise in rule-making and technical advice, allow lived and practitioner evidence, protect longitudinal evidence of fluctuation, and require bias testing, transparency, human accountability and review rights before automated or computer-assisted systems affect participants.

Key Message #14: New evidence rules can make women pay for research gaps.

A woman with a fluctuating, pain-related or trauma-related disability may have years of practitioner evidence showing that a support helps her maintain function, avoid hospital, parent safely or remain in work. If future rules prioritise published, peer-reviewed and generalisable evidence over participant outcomes, decision-makers may discount the evidence that best explains her actual support needs. **These risks treating under-researched disability experiences as unsupported, even where a support is demonstrably effective for the person.**

Table 4: Evidence safeguards

Bill lever	Gendered risk	Minimum safeguards
Reliance on NDIS Review and future TAG	The Review is cited as a key basis for reform, yet research finds it gave limited attention to gender inequities. The Joint Standing Committee has also called for action on NDIS gender disparities. Without gender expertise in future rules, tools and TAG advice, the Bill risks carrying those gaps into implementation.	The Technical Advisory Group should be appointed through a transparent public EOI process. Require TAG membership, terms of reference and rule-making processes to include gender, disability, violence, chronic illness, psychosocial, First Nations, CALD, rural/remote and leaders experienced working with lived expertise. Publish advice, assumptions and gender impact modelling.

Bill lever	Gendered risk	Minimum safeguards
Peer-reviewed and generalisable research	Published research may under-represent women, girls and gender-diverse people with disability. Limited published evidence must not be treated as evidence that a support lacks benefit, particularly for fluctuating, chronic, psychosocial or trauma-related disability.	Evidence standards must allow participant outcomes, practitioner evidence and practice evidence. The Minister's approach to accepting and weighing evidence must be transparent, reviewable and supported by published reasons. Decision-makers must test evidence sources for gender and intersectional bias.
Limits on external/ practitioner evidence	If future rules prescribe what assessors must or must not consider, participants with delayed diagnosis, incomplete records or complex co-occurring impairments may lose the evidence needed to explain functional impact. This is a particular risk where women have been under-diagnosed or disbelieved in health systems.	Guarantee consideration of participant evidence, treating practitioner evidence, support worker observations, safety context and longitudinal evidence of fluctuation. Require reasons where relevant evidence is excluded or given limited weight.
Automation/ evaluative computer action	Automated or computer-assisted action can reproduce bias from historical claims, diagnosis, under-utilisation, missing records, unsafe service access and advocacy disparities. "Objective" criteria may still reflect unequal access to evidence and support.	No automated evaluative action without bias testing, public criteria, human accountability, reasons, correction rights, review rights and independent monitoring by gender and intersectional variables. Require systemic remediation where patterns of error are identified.
Budget method identifying support needs	Future budget rules may help decide what a person needs, not only how much funding they receive. Aged care	Publish the budget method, assumptions and evidence base before commencement. Require gender impact

Bill lever	Gendered risk	Minimum safeguards
	reforms show the risk of formula-based tools producing support levels that do not meet daily needs[51].	assessment, individual assessment safeguards, participant correction rights, reasons, review rights and monitoring of gaps between need and funding.

Conclusion

The Bill's technical complexity and broad delegation of powers create material and potentially irreversible harms that disproportionately affect women, girls and gender-diverse people with disability. The current short consultation timeframe prevents meaningful lived-experience engagement, intersectional data analysis and the drafting of targeted safeguards. The Bill should not progress in the absence of a rigorous gender impact analysis that can: (a) identify who will be harmed, (b) quantify those harms, and (c) produce concrete legislative and rule-level solutions to prevent discriminatory and safety-critical outcomes.

The bottom line: The primary gender risk is not confined to any single provision. It arises from the interaction between narrower eligibility tests, impairment-specific attribution, delegated funding caps, restricted reassessment pathways, and reliance on service systems and unpaid carers that already operate unequally for women, girls and gender-diverse people with disability. If the Bill proceeds it will embed high-risk settings before the Government has shown how it will prevent gendered exclusion, violence risk, care-shifting and biased evidence from determining access and budgets.

Language note

This submission reflects the overlapping experiences of marginalisation experienced by women, girls, nonbinary and gender-diverse people in our membership and broader community. Though these groups will experience gender discrimination and marginalisation, not all identify as women. WWDA's submission may reflect the specific experiences of trans, non-binary and gender-diverse people with disability. However, the experiences of trans, non-binary and gender-diverse people with disability warrant specific and direct exploration, particularly how they intersect with employment. WWDA recognises the limitation in aggregating our submission at a broader level of gender-marginalised people. WWDA aims to work in coalition with, rather than replicate the core work of organisations who represent and advocate for LGBTQIA+ people with disability. This submission uses 'person first' language (for example: women with disability). We acknowledge people describe their experience of disability in different ways, and for many people, ‘identity first’ language is a source of pride and resistance.

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