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Don't blame autistic kids for these NDIS blowouts

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Don’t blame autistic kids for these NDIS blowouts

Katrina Norris

Recent commentary on the NDIS reflects a growing and valid concern about the scheme’s sustainability. But the way the conversation is unfolding, particularly in relation to autism, children, and clinicians is concerning.

Too often, rising participation in the NDIS is being framed as evidence of misuse. A key example is the repeated focus on the proportion of participants with autism, now sitting at around 40 per cent. This figure is being frequently presented as proof that the scheme is being overrun by people who do not “really” need it.

What is missing from this narrative is context. The NDIS itself reports that 73 per cent of participants with a primary diagnosis of autism experience severe or profound disability. This means they may have limited or no verbal communication and require physical support for everyday activities. These are not marginal cases. They are individuals with significant functional impairment, the very cohort the NDIS was designed to support.

Despite this, public commentary is increasingly pointing the finger at clinicians. Claims that psychologists and other professionals are “pathologising” normal behaviour, or deliberately inflating diagnoses to secure NDIS access, have been aired without evidence. These assertions fundamentally misrepresent how autism is assessed and diagnosed in Australia.

Worldwide, there has been a shift in how autism and other forms of neurodiversity such as ADHD, are diagnosed. As previous diagnostic criteria were incredibly narrow, many neurodiverse people were being missed or excluded from diagnosis and resulting supports.

Increased public awareness and destigmatisation of these diagnoses have also brought forward individuals who may otherwise have continued masking. As scientist-practitioners, psychologists are required to include novel research and change our practices to align with up-to-date guidelines.

Diagnostic reports require detailed clinical reasoning and must clearly document functional impairment. They are not based on a single practitioner’s opinion but typically involve input from multiple professionals.

To suggest that clinicians are broadly exaggerating diagnoses is to imply widespread professional misconduct. This is an extraordinary claim that demands evidence, not speculation.

The same pattern emerges in discussions about provider behaviour. Comparisons have been drawn between NDIS pricing and a so-called “wedding tax”, suggesting providers charge more simply because they can.

Comparing fees across the NDIS, Medicare and other schemes is not comparing like with like. Each scheme is designed for different populations, levels of complexity, administrative requirements, and service expectations.

NDIS participants often present with higher and more enduring support needs, requiring longer-term, multidisciplinary and co-ordination-intensive care and higher levels of insurance, alongside significantly greater compliance, reporting and audit obligations.

Framing this as a “wedding tax” is misleading. In reality, the fee structures reflect fundamentally different service models, risk profiles and system requirements.

The statistic that 94 per cent of providers are not registered with the NDIS has been used to imply a lack of qualifications or accountability. This overlooks a critical point; all psychologists are qualified and regulated by the Psychology Board of Australia, with established standards, codes of conduct and complaints processes.

It’s clear the NDIS requires reform. Costs are rising, and the system must be sustainable. But focusing on specific groups, particularly children and people with autism, as the source of the problem, risks oversimplifying a far more complex issue.

We have seen this pattern before across Australia’s social support systems; demand exceeds expectations, and rather than interrogating system design, funding models or broader service gaps, the response becomes one of tightening access and assigning blame.

The critical question is this; if people are pushed out of the NDIS, where do they go?

Public and community-based services are already under significant strain. Private care remains financially inaccessible for many. Without a co-ordinated plan, restricting access to the NDIS does not reduce need – it

simply redistributes it, often to systems that are even less equipped to respond and with less regulation, putting participants at risk.

What Australia needs is a long-term, multi-system approach to health and disability. We need well-planned, evidence-based, and consumer (lived experience) – driven programs and funding schemes that are sustainable, grow with need, and ensure people at every level are able to access the services relevant to their needs.

Reform must be guided by data, best practice and evidence, not assumptions – and by solutions, not scapegoating.

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