PARKINSON'S AUSTRALIA

Submission to the Department of Health, Disability and Ageing

Public Consultation on NDIS Access Changes and Draft Guiding Principles

Date: 26 September 2026

1. Executive Summary

Parkinson's Australia is the national peak body representing the more than 150,000 Australians living with Parkinson's disease and Atypical Parkinsonism, of whom an estimated 13,400 are of working age (Mellick, 2024). We welcome the opportunity to respond to this consultation on the seven draft guiding principles and the design of the future NDIS access decision-making process.

This submission is grounded in Parkinson's Australia's *Your Voice, Your Needs* national community survey (N = 2,649), which captured the experiences of 1,692 people living with Parkinson's and 871 carers (Parkinson's Australia, 2026). We use this evidence, together with relevant case law and the provisions of the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Act 2026 (the Act), to respond to each of the seven draft guiding principles and to the consultation questions on process design and evidence requirements.

We note that the Act received Royal Assent on 20 August 2026, and that during its passage the Parliament adopted an amendment confirming that participants cannot be required to undertake a particular treatment, therapy or medication in order to access NDIS supports. Parkinson's Australia welcomes this safeguard. Our submission focuses on ensuring the guiding principles, the access decision-making process and the standardised evidence requirements give that safeguard practical effect for a progressive, fluctuating neurological condition.

Our core recommendations

- The guiding principles should state expressly that a person cannot be found to have unmet permanence because an available treatment is clinically inappropriate, unaffordable, geographically inaccessible or carries a disproportionate risk, consistent with NDIA v Davis [2022] FCA 1002 and the amendment adopted during the Bill's passage.
- A dedicated principle, or an explicit clause within Principle 5, should require assessment tools to capture fluctuating and progressive conditions across the medication cycle, not as a single point-in-time snapshot.
- Functional capacity assessments must recognise invisible disability, communication disability, autonomic dysfunction, sensory impairment, cognitive fatigue and other non-motor symptoms of Parkinson's. Assessments must reflect a person's ordinary level of function over time and must not be based solely on a temporary period of optimal symptom control or a participant's 'best day'.
- The functional capacity assessment developed by the Technical Advisory Group (TAG) should include a representative from Parkinson's Australia with experience and expertise in Parkinson's and Atypical Parkinsonism and should be piloted with this cohort before finalisation.
- Additions to the priority access pathway (that currently includes MND and childhood dementia) is needed for rapidly progressive Atypical Parkinsonism (Progressive Supranuclear Palsy, Multiple

System Atrophy, Corticobasal Degeneration and Dementia with Lewy Bodies), given the harm caused by standard assessment timeframes for these conditions.

- The early intervention access pathway must remain available to people with young onset Parkinson's. The new access process should not narrow or remove access where timely allied health and other supports can reduce functional decline, maintain independence and support workforce and family participation.
- Evidence requirements should give weight to treating specialist evidence and should not require participants to exhaust surgical options, such as Deep Brain Stimulation, or wait on public surgical waitlists, before their impairment is accepted as permanent.
- Sequencing safeguards are needed so that access thresholds are not tightened, and diagnosis-list eligibility is not withdrawn, until Foundational Supports are funded and operating in a person's local area.
- Carer evidence should be recognised as valid evidence of a person's functional impact, alongside treating specialist reports.
- Navigation support should be recognised as a disability-related support need in its own right, given how much of the burden of accessing services currently falls on people with Parkinson's and their carers.

2. Evidence Base: *Your Voice, Your Needs*

The *Your Voice, Your Needs* survey ran nationally between January and March 2026 and received 2,649 responses from people living with Parkinson's, carers, and people who are both (Parkinson's Australia, 2026). The results below describe a system that is already difficult to access and navigate for this cohort, and they underpin the positions taken in this submission.

Impact measure	Survey finding
Access to healthcare difficulty score (0–100, where 100 is impossible)	55 / 100
Respondents who experienced delays in diagnosis or treatment	36.6%
Respondents needing help to navigate health and disability services	47.0%
Respondents needing daily living support	59.9%
Respondents reporting mental and emotional wellbeing strain	57.3%
Younger respondents have higher mental health, financial & navigation needs	66.7%

The survey also identified consistent inequities that are directly relevant to Principle 5 (equitable, inclusive and safe):

- Women report higher support needs than men across mental health (51.5% vs 41.4%), carer support (44.5% vs 31.1%) and financial planning (38.2% vs 20.7%), reflecting a higher cumulative burden of caregiving and coordination.
- Aboriginal and Torres Strait Islander and culturally and linguistically diverse respondents report lower confidence in GP understanding of Parkinson's (56 vs 59 out of 100) and higher mental health and financial support needs, alongside a high level of uncertainty about whether services are culturally safe (34.4% unsure).

- Respondents in regional, rural and remote areas report lower GP confidence, higher mental health support needs (53.3% vs 47.9%) and greater need for navigation support (50.0% vs 46.2%) than metropolitan respondents.

Respondents described the current system in their own words:

> *"Not having to fight with the NDIS all the time..."*
>
> *"NDIS very difficult to access."*
>
> *"Someone to help with the organisation and application process... patients are too tired to manage this alone."*
>
> *"They didn't tell me what services are available. I found out by chance."*

3. Response to the Draft Guiding Principles (Consultation Questions 1 & 2)

Parkinson's Australia supports the seven principles as a sound basis for the new NDIS access process. However, the principles need stronger requirements for fluctuating and progressive conditions. We recommend retaining all seven principles, strengthening Principles 1 to 7 as set out below, and adding an explicit requirement under Principle 5 that assessment tools and processes account for changes across the medication cycle, progression over time and complex support needs.

Principle 1 – Aligned to the NDIS Act & the human rights of people with disability

Principle 1 should explicitly protect a person's right to decline high-risk, invasive treatment without losing NDIS access or having their impairment reclassified as non-permanent. Deep Brain Stimulation illustrates the concern: it is not clinically appropriate for every person with Parkinson's, carries real surgical risk, and public surgical capacity is extremely limited and unevenly distributed across states and territories.

We welcome the amendment adopted during the Bill's passage confirming that a participant cannot be required to undertake a particular treatment, therapy or medication to access NDIS supports. This is consistent with the Federal Court's reasoning in NDIA v Davis [2022] FCA 1002, which held that 'available' treatment must be understood as treatment a person can, in reality, access, taking into account their financial and personal circumstances. Principle 1, and the permanence guidance that sits under it, should state this explicitly, including for treatment that is technically available but inaccessible because of cost, distance or a public waiting list.

Principle 2 – Informed by lived experience, including people with disability, families & carers

We ask that the Technical Advisory Group on NDIS Functional Capacity include a representative from Parkinson's Australia with experience in Parkinson's or Atypical Parkinsonism. Our survey shows that patients and carers are already carrying most of the burden of navigating the system (47.0% need help to do so); a process designed without this cohort's direct input is likely to reproduce that burden rather than reduce it. We would welcome the opportunity to support consultation with our community, including through focus groups with First Nations and culturally and linguistically diverse members, as flagged in our survey report.

Principle 3 – Evidence-based & consistent

Standardised assessment tools must not override the evidence of a person's treating neurologist, general practitioner, occupational therapist or physiotherapist, who understand the person's history and likely trajectory. We also ask that assessment methodology explicitly account for motor fluctuations across the medication cycle. As levodopa wears off, motor and non-motor symptoms re-emerge in a pattern well described in the clinical literature (e.g. Poewe, 2017); an assessment conducted only during

a well-medicated ‘on’ period will systematically understate a person’s functional impact. A person with Parkinson’s may appear highly functional during a 60-minute clinical "snapshot" while being unable to safely navigate their home two hours later. Parkinson’s Australia would like to see the insertion of an explicit principle or rule-based safeguard mandating that capacity be measured "over time."

Parkinson’s Australia is concerned that standardised assessments may unintentionally favour visible and stable disabilities over fluctuating neurological conditions. Assessment processes must specifically prohibit reliance on a person’s best day, best hour or temporary period of optimal symptom control.

Parkinson’s is characterised by fluctuating motor symptoms and a wide range of invisible symptoms, including fatigue, executive dysfunction, communication impairment, sleep dysfunction, autonomic symptoms, pain and sensory impairment. These symptoms may not be readily observable during a brief assessment but can substantially affect participation, safety and independence throughout the day.

Standardised assessment tools should explicitly evaluate:

- Cognitive fatigue.
- Executive dysfunction.
- Communication impairment.
- Sleep dysfunction.
- Autonomic dysfunction (including orthostatic hypotension, bladder and bowel issues, inability to temperature regulate).
- Pain.
- Sensory processing difficulties.
- Mental health impacts.
- Medication fluctuations.
- Delayed effects of physical and cognitive exertion.

Standardised, snapshot assessments systematically overlook:

- **Cognitive Fatigue:** The debilitating mental cost of performing basic tasks.
- **Medication Cycles:** The predictable but profound deterioration that occurs when dopamine replacement therapy wears off. People are taking 3 to 6 doses per day on average, with a wearing off period before and after each dose.
- **The "Personal Cost":** The physical distress and exhaustion following exertion, which often leads to multi-day deterioration. Relationship changes as roles change for care partners and their loved ones over time. Carer burden
- **Communication and Sensory Change:** Speech, swallowing, sleep and sensory symptoms that a single appointment is unlikely to reveal.
- **Autonomic and Participation Impact:** Blood pressure changes, pain and a reduced ability to take part in work, study and community life across the day.

As warned by the Justice and Equity Centre, standardised tools fail to capture the full range of disability.

Principle 4 – Person-centred & strengths-based

Support needs identified in our survey extend well beyond clinical care: 59.9% of respondents need daily living support and 57.3% report mental and emotional wellbeing strain. A person-centred process should recognise these needs as part of the functional picture, not treat them as separate from 'the disability', and should minimise repeat assessment for people whose functional impairment is already clearly and consistently evidenced.

Principle 5 – Equitable, inclusive & safe

We ask that a dedicated clause, either within Principle 5 or as an additional principle, require all assessment tools and eligibility workflows to accommodate on-off medication fluctuations, cognitive changes, motor fatigue, and progression over time. A single snapshot assessment cannot capture the functional burden of a fluctuating, progressive condition, and the equity data summarised in Section 2 shows that women, First Nations and culturally and linguistically diverse people, and people in regional, rural and remote areas already carry a disproportionate share of that burden.

This principle should also state that functional capacity is assessed with a person's ordinary mobility aids, home modifications and support in place, not in an unaided vacuum. Section 9B of the Act defines functional capacity as a person's ability to undertake an activity without assistance, equipment or modification, and in a context that excludes environmental and personal circumstances. For Parkinson's, that definition risks producing an assessment that reflects almost no one's daily reality, since capacity for this cohort depends heavily on mobility aids, home adaptation and carer support.

Principle 5 should also recognise invisible disability and provide practical accommodations for people with speech, language and communication impairment. These include the option to bring a support person to appointments, to respond in writing rather than only verbally, flexible appointment scheduling that accounts for fatigue and medication timing, and more than one assessment session where a person's presentation varies. Assessors should offer a range of communication methods and should not require applicants to use specific NDIA terminology to have their support needs understood.

Invisible Disability

Parkinson's Australia recommends that the access framework explicitly recognise invisible disability. Parkinson's frequently involves symptoms that are not immediately visible to an assessor, including cognitive impairment, fatigue, pain, bladder dysfunction, bowel dysfunction, sleep disorders, autonomic dysfunction, sensory dysfunction, orthostatic hypotension and executive dysfunction.

For many people living with Parkinson's, these symptoms are equal to or greater than the visible motor symptoms in determining everyday function, participation and safety. The assessment process should evaluate both visible and invisible impairments.

Communication Impairment

Parkinson's commonly affects communication through dysarthria, reduced speech volume, slowed verbal responses, language processing difficulties and reduced facial expression. The access process should provide accommodations including:

- Written responses.
- Support persons.
- Communication supports.
- Multiple assessment sessions.
- Extended interview times where required.

Communication impairments should not disadvantage a person during the access process.

Principle 6 – Transparent, proportionate & accessible

The Department should add rapidly progressive atypical parkinsonism, including progressive supranuclear palsy, multiple system atrophy, corticobasal degeneration and dementia with Lewy bodies to the Priority Access Pathway, which currently includes MND and childhood dementia. These conditions have no medication and treatment unlike idiopathic Parkinson's and develop complex motor, cognitive, autonomic, communication and swallowing needs. Reported cohort medians range from about six to nine years from symptom onset leaving a short period in which supports can prevent harm and sustain care at home. Standard assessment timeframes can be overtaken by falls, aspiration risk, loss of mobility, severe autonomic dysfunction, cognitive decline and rising carer needs.

Condition	Common symptom pattern	Typical prognosis	Why priority access is needed
Multiple system atrophy	May begin with parkinsonism or cerebellar problems, then develop early autonomic failure, including urinary urgency, retention or incontinence, erectile dysfunction and marked blood-pressure drops on standing. Falls, gait impairment, speech and swallowing problems and breathing complications can follow.	Median survival in published cohorts is about 7.5–8.6 years from symptom onset. Early severe autonomic failure, including early need for bladder catheterisation, is associated with shorter survival (Coon et al., 2015; Figueroa et al., 2014).	Bladder care, falls prevention, mobility equipment, home modifications and carer support may be needed early and can escalate quickly.
Progressive supranuclear palsy	Often presents with early unexplained falls, postural instability, stiffness, slowed movement and difficulty moving the eyes up or down. Speech, swallowing, cognition and behaviour can deteriorate, and levodopa response is usually limited.	A recent cohort reported median survival of 6.4 years from symptom onset. Survival varies by clinical subtype, with Richardson syndrome generally progressing faster than other progressive supranuclear palsy phenotypes (Marchand et al., 2024).	Early falls, visual limitations and swallowing risk can make a delayed decision unsafe and increase the need for rapid equipment, allied health therapy and personal support.
Corticobasal degeneration	Common early features include marked asymmetry, limb stiffness or slowness, clumsiness, dystonia and apraxia, where a person cannot carry out a learned movement despite having the strength to do so. Gait, speech, swallowing, cognition and behaviour may also decline.	A pathology-confirmed cohort reported median survival of 7.0 years from initial symptoms (Aiba et al., 2023). Earlier published cohorts reported similar survival estimates (Wenning et al., 1998).	Rapid loss of use of one limb and progressive gait or communication impairment can create urgent needs for assistive technology, home changes and support with daily activities.

Condition	Common symptom pattern	Typical prognosis	Why priority access is needed
Dementia with Lewy bodies	Core features include cognitive fluctuations, recurrent visual hallucinations, rapid eye movement sleep behaviour disorder and spontaneous parkinsonism. Falls, autonomic dysfunction and sensitivity to some antipsychotic medicines can add clinical risk.	Survival varies between cohorts and individuals. A 2023 cohort reported median survival of 6.0 years from disease onset (Gharbi et al., 2023).	Motor and cognitive impairment can progress together, creating rapid changes in supervision, behaviour support, home safety and carer needs.

We also ask that Section 25B, which allows a Minister to treat a class of impairment as ineligible where an alternative mainstream or Foundational Support is deemed to exist, be applied only once that alternative is actually funded, staffed and operating in the person's local government area. This mirrors the reasoning in NDIA v Sutherland [2026] FCA 3, in which the Federal Court confirmed that a person does not have to show that other systems cannot meet their needs before accessing the NDIS. Without this safeguard, people with Parkinson's risk being diverted toward aged care, which does not provide the neurological, exercise physiology and allied health supports this condition requires.

Survey findings demonstrate that navigating disability and healthcare systems is a major challenge for the Parkinson's community. Nearly half of respondents (47.0%) reported needing support to navigate services. Many respondents described fragmented care pathways, repeated evidence requests, difficulty locating services and challenges understanding eligibility requirements.

The reformed access process should reduce administrative burden, minimise duplication and ensure people with Parkinson's are not required to act as their own care coordinators in order to access support.

Finally, the Act permits the use of automated systems to assist NDIA decision-making, with a right for participants to seek human review. We support that review right and ask that it be stated explicitly within this principle, together with a commitment that automated tools are not used, even to assist, in decisions about permanence or functional capacity for people with incurable, degenerative or fluctuating conditions, given the evaluative judgement these decisions require.

Referral pathways under Principle 6 should include neurologists, movement disorder specialists, Parkinson's nurses and multidisciplinary Parkinson's clinics, alongside self-referral, so people are not required to move between multiple agencies to reach the right entry point. Where an access dispute arises, we ask for a more accessible, mediation-style option that lets decision makers resolve straightforward issues through direct conversation, rather than only through formal review.

Principle 7 – Continuous quality improvement

We ask that the Department commit to a structured review of access outcomes for people with progressive neurological conditions within two years of implementation, using de-identified NDIA data alongside further community survey data, and that Parkinson's Australia and equivalent peak bodies for other neurodegenerative conditions be included as standing stakeholders in that review.

4. Access Decision-Making Process Design (Consultation Questions 3, 4 & 5)

In addition to the principle-specific comments above, we ask the Department to consider the following in designing the process itself:

- Minimise repeat evidence-gathering for people whose functional impairment is already well documented and unlikely to improve, consistent with a proportionate approach to assessment burden.

- Ensure referral pathways and evidence requirements are equally workable for people with communication, cognitive, degenerative, fluctuating or episodic support needs, not only those with stable, visible impairment.
- Require assessors undertaking functional capacity assessments for neurodegenerative conditions to receive specific training in the presentation of Parkinson's and Atypical Parkinsonism, including motor fluctuation, freezing of gait, and the invisible, non-motor symptoms such as sleep disorders, social isolation, cognitive fatigue, depression, autonomic symptoms, communication disorders and sensory dysfunction. See the Parkinson's Iceberg in the Appendix.
- Recognise, consistent with CEO of the NDIA v Eastham [2026] FCA 147, that a person's support needs frequently arise from the interaction of multiple impairments, and that supports should not be withheld on the basis that a need does not 'directly arise' from a single qualifying impairment where that impairment is a contributory cause.
- Recognise the evidence and knowledge of family carers as part of the information NDIA staff consider when determining functional capacity and support needs, alongside clinical reports, and ensure this evidence is formally accepted where cognitive impairment, communication impairment, executive dysfunction or reduced insight affects a participant's ability to self-report.
- Provide decisions and requests for evidence in plain language and ensure staff do not require applicants or health professionals to use specific NDIA terminology to have support needs understood or accepted.
- Build a disability-aware NDIA workforce, including through the employment of people with disability in decision-making roles, so that lived experience directly informs how these principles are applied.
- Ensure assessments are flexible and can be conducted across multiple sessions, accommodate medication schedules, allow breaks for fatigue and include telehealth participation where appropriate.
- Require assessment processes to accommodate communication disability through written responses, alternative communication methods and support persons where requested.

5. Evidence Requirements & Permanent Impairment (Consultation Question 6)

Parkinson's disease and Atypical Parkinsonism are incurable and progressive. Available treatments, including levodopa and Deep Brain Stimulation, manage symptoms; they do not reverse the underlying neurodegeneration (Poewe, 2017). We ask that:

A clear early intervention pathway is needed from diagnosis for people with young onset Parkinson's and atypical parkinsonism. Research supports rehabilitation from diagnosis across all stages of Parkinson's, and sustained exercise is associated with delayed disability. Early referral to Parkinson's-informed physiotherapy, occupational therapy, speech pathology, exercise physiology and psychosocial support helps people manage symptoms, build sustainable exercise and self-management habits, plan for changing needs and maintain independence, employment and family participation.

For atypical parkinsonism, which often progresses faster, emerging evidence supports early, multidisciplinary and condition-specific rehabilitation to protect mobility, communication and safety for as long as possible (Kamo et al., 2026; O'Shea et al., 2023). Delayed access can allow preventable deconditioning, falls risk, communication and swallowing problems, and loss of daily living skills to become established before support begins.

- Treating specialist evidence is given primary weight in determining permanence, ahead of a generic checklist tool.
- The 'appropriate treatment' test in Section 25A is applied consistently with NDIA v Davis [2022] FCA 1002, so that a treatment which is not affordable, not geographically accessible, or not clinically appropriate for the individual is not treated as available.
- Participants are not required to exhaust surgical options or wait on public surgical waitlists before their impairment is accepted as permanent, given the extended and variable waiting periods for procedures such as Deep Brain Stimulation in the public system.
- Early access to evidence-based allied health therapy, particularly Parkinson's-specific physiotherapy, speech pathology, occupational therapy and exercise physiology, is recognised as critical to maintaining independence and workforce participation for people of working age, not treated as optional once core eligibility is established.
- Preserve the early intervention access pathway for people with young onset Parkinson's. Evidence should focus on whether timely supports are likely to reduce future functional decline, maintain or improve functional capacity, or support workforce and family participation. Access should not depend on the person first meeting the permanent impairment pathway where the early intervention criteria are met.
- Functional impact should be assessed cumulatively across physical, neurological, cognitive, sensory and psychosocial domains, considering how impairments interact rather than evaluating each symptom in isolation, so the combined effect of Parkinson's on a person's daily life is properly recognised.
- Evidence should also recognise participation restrictions arising from service navigation difficulties, reliance on carers, communication impairment, cognitive impairment, fatigue and fluctuating symptom burden.

The Department should recognise evidence describing navigation burden as relevant to functional impact. Survey findings indicate that 47.0% of respondents require support to navigate healthcare and disability services, demonstrating that service access itself is a significant participation issue for many people living with Parkinson's.

6. Recognising Recent Legislative Developments

This submission responds to the Act as passed, not to the Bill as originally introduced. We record, for the Department's awareness, the following developments that bear directly on our position:

- The Act received Royal Assent on 20 August 2026 and commences access reforms from 1 January 2028, with current participants reassessed over a three-year transition period.
- An amendment adopted during the Bill's Senate passage confirms that participants cannot be required to undertake a particular treatment, therapy or medication to access NDIS supports. We ask that this be reflected explicitly in the guiding principles, as set out under Principle 1.
- A further amendment confirms a right to human review of decisions supported by automated systems. We ask that this be reflected explicitly in Principle 6.

7. Consolidated Recommendations

- State explicitly, within Principle 1 and the permanence guidance, that a person cannot be found to have failed the 'appropriate treatment' test because a treatment is unaffordable, geographically inaccessible, clinically inappropriate or subject to a public waitlist.

- Include a representative from Parkinson's Australia with experience of Parkinson's and Atypical Parkinsonism on the Technical Advisory Group on NDIS Functional Capacity.
- Require assessment methodology to capture functional capacity across the medication cycle, not as a single point-in-time snapshot, and with a person's ordinary aids and supports in place.
- Require all assessments to evaluate invisible disability, communication impairment, autonomic dysfunction, sensory impairment, cognitive fatigue and medication-related fluctuations.
- Prohibit reliance on a participant's best day, best hour or temporary period of optimal symptom control when assessing functional capacity.
- Retain the early intervention access pathway for people with young onset Parkinson's where timely supports are likely to reduce functional decline, maintain or improve functional capacity, or support workforce and family participation.
- Legislate or otherwise formalise a Priority Access Pathway for rapidly progressive Atypical Parkinsonism, guaranteeing an eligibility decision within seven business days.
- Apply Section 25B only once an alternative mainstream or Foundational Support is funded and operating in the person's local area.
- Exclude decisions about permanence and functional capacity for degenerative or fluctuating conditions from automated decision-making, while retaining the right to human review for other automated decisions.
- Give treating specialist evidence primary weight in permanence determinations, ahead of generic checklist tools.
- Commit to a structured two-year review of access outcomes for people with progressive neurological conditions, with Parkinson's Australia included as a standing stakeholder.
- Formally recognise carer evidence and navigation support as part of a person's disability-related support needs, particularly where communication, cognitive or insight impairments affect a participant's ability to self-report, and not as separate from their functional impairment.
- Provide accommodations for people with communication and sensory impairment, including support persons, written submissions, flexible appointment scheduling and multiple assessment sessions where required.
- Include neurologists, movement disorder specialists, Parkinson's nurses and multidisciplinary Parkinson's clinics in referral pathways, alongside self-referral and a more accessible, mediation-style option for resolving access disputes.
- Build a disability-aware NDIA workforce, including through the employment of people with disability in decision-making roles, and communicate decisions and evidence requests in plain language.
- Require Parkinson's-specific training for all assessors and decision-makers responsible for functional capacity assessments.
- Assess functional impact cumulatively across physical, cognitive, sensory and psychosocial domains.

Conclusion

Parkinson's Australia supports a fair, transparent and evidence-based NDIS access process. The final guiding principles and access framework must accurately capture the impact of progressive and fluctuating neurological conditions and protect equitable access for the Parkinson's community.

We thank the Department for the opportunity to contribute to this consultation and would welcome the opportunity to discuss this submission further.

Yours sincerely,

Olivia Nassaris, CEO
Parkinson's Australia

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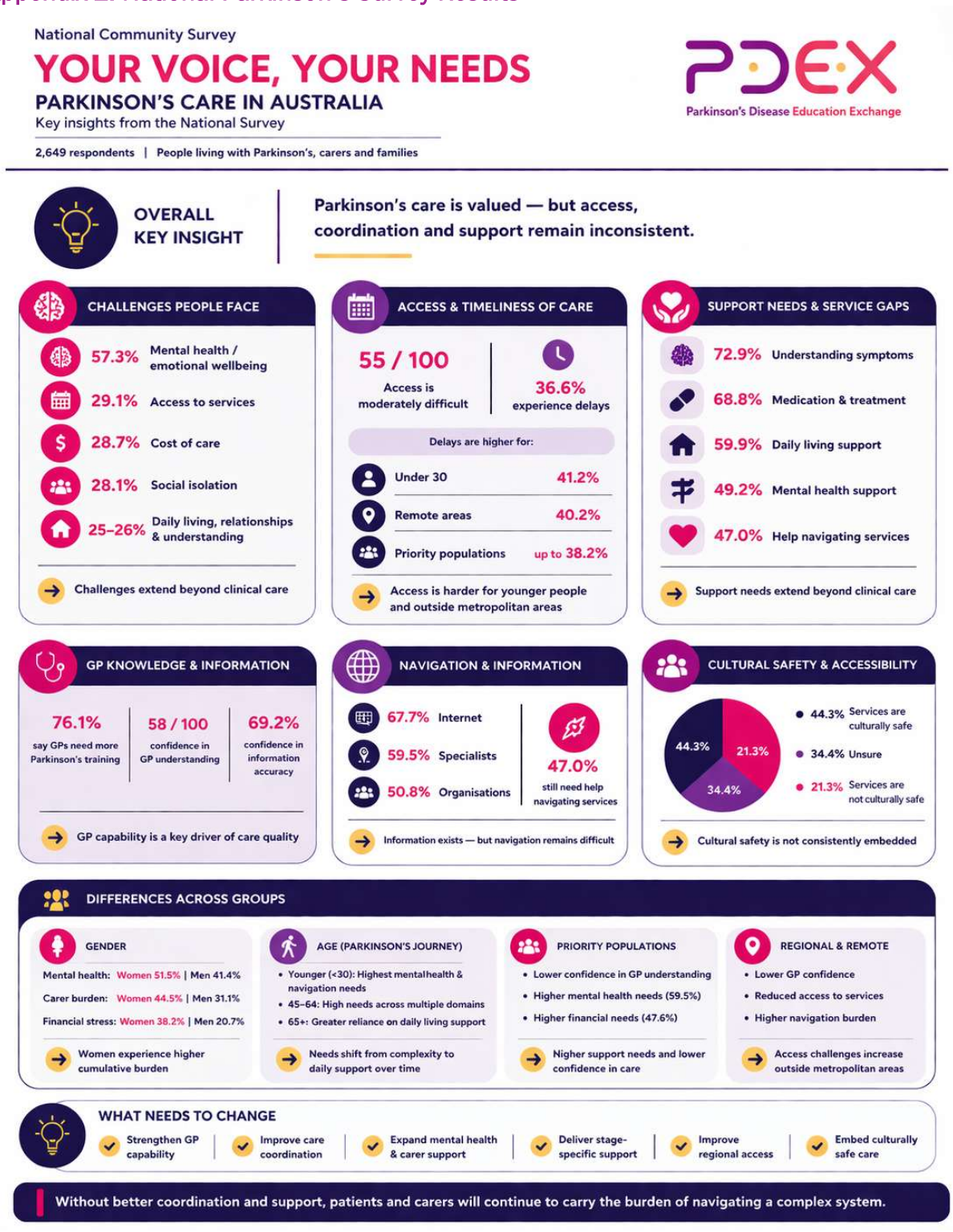
Appendix 1. Parkinson's Iceberg

Appendix 2. National Parkinson's Survey Results