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Submission from

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Directors of

Queensland Premium Allied Health

Senate Community Affairs Committee Inquiry

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National Disability Insurance Scheme Amendment

(Securing the NDIS for Future Generations) Bill 2026

27 May 2026

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Executive Summary

We write as Monica Zidar and Hanna Bowler, Directors of Queensland Premium Allied Health (QPAH), and as allied health professionals with more than 40 years of combined experience across music therapy and speech pathology. Across our careers, we have worked with children, young people and adults in metropolitan, regional, rural and remote communities. We now lead a team of 28 providing services to approximately 700 people across the lifespan each year, most of whom are National Disability Insurance Scheme (NDIS) participants.

From that vantage point, we see both the life-changing value of the NDIS and the fragility of the service systems that make it work in practice. We support reform to strengthen the long-term sustainability and integrity of the Scheme. However, we are deeply concerned that key measures in this Bill, if implemented without robust safeguards, will reduce access to essential allied health supports, disrupt continuity of care, and further weaken provider markets that are already under strain.

Over many years, we have worked alongside families who spend months and sometimes years building the right support arrangements around a person with disability. Progress is rarely linear. It depends on trusted therapeutic relationships, regular therapy, responsive planning, carer capacity, school or community support, and whether there is a skilled provider within reach. In metropolitan areas, these systems can be difficult enough to coordinate. In rural, regional and remote communities, choice and control can quickly become theoretical if there is only one provider, a long waitlist, or no local clinician at all. When supports are reduced or delayed below a safe and effective level, risk does not disappear. It is shifted to families, schools, hospitals and crisis systems.

Our principal concerns relate to the practical operation of the Bill's access and planning reforms, particularly those concerning functional capacity in Schedule 1, Part 1, permanence and appropriate treatment in Schedule 1, Part 8, participant-requested reassessments in Schedule 1, Part 2, plan renewals in Schedule 1, Part 5, support determinations in Schedule

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1, Part 4, and changed decision-making parameters for reasonable and necessary supports in Schedule 1, Part 6. We are also concerned about the practical impacts of Schedule 2 fraud and compliance measures and Schedule 3 governance and automation measures if these are implemented without transparency, proportionality and accessible review pathways.

Given the scale of the proposed reforms and the extent to which key elements will be determined through future rules, legislative instruments and administrative processes, the practical impact of the Bill cannot yet be fully assessed. This uncertainty is heightened by the fact that the design, scope and accessibility of state-funded foundational supports in Queensland remain unclear. That makes strong governance, transparency, staged implementation and genuine co-design essential. It also means Parliament should be cautious about passing broad enabling provisions without clearer safeguards for participants and frontline providers.

These risks will be felt most sharply in outer-metropolitan, regional, rural and remote communities, where provider markets are already thin and continuity of care is harder to maintain. For that reason, we ask the Committee to recommend implementation safeguards that protect continuity of care, regional equity, participant access and the sustainability of frontline allied health providers.

Issue / Bill area	Summary recommendation
Functional capacity and access (Schedule 1, Part 1)	Ensure rules and guidance are transparent, co-designed and applied in ways that do not disadvantage participants in thin markets or fail to deliver genuinely equivalent access to supports in practice.
Permanence and appropriate treatment (Schedule 1, Part 8)	Build in practical safeguards for people who cannot access treatment or alternative supports outside the NDIS within

	reasonable timeframes, and do not assume future foundational supports in Queensland will fill gaps before their scope and accessibility are clear.
Reassessments, continuity and urgent needs (Schedule 1, Part 2)	Minimise disruption to existing effective supports and ensure urgent pathways remain available where needs change quickly or plans are incorrect and require timely correction.
Support determinations and funding reductions (Schedule 1, Part 4)	Require transparent evidence, participant safety assessment, workable transition arrangements and clinically appropriate safeguards before reductions take effect.
Fraud, compliance and record-keeping (Schedule 2)	Implement integrity measures in a risk-proportionate way that targets genuine participant-risk areas, avoids unnecessary duplication of existing professional accountability obligations, and does not deter reputable providers from the market.
Staged implementation and co-design (whole-of-Bill)	Adopt a staged implementation approach and ensure major reforms are not operationalised without genuine co-design, transparent consultation and adequate transition planning.

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Governance, oversight and automation (Schedule 3, Part 2 and whole-of-Bill implementation)	Ensure automated administrative action is transparent, accessible and contestable, and that pricing settings support provider sustainability, workforce retention and participant access.

About the Authors and QPAH

We are Directors of Queensland Premium Allied Health (QPAH), a multidisciplinary allied health provider delivering speech pathology, occupational therapy and music therapy to children, adolescents and adults across Queensland and Northern New South Wales. Our work spans clinic, community, education and residential settings, including regional outreach and service delivery in areas where provider availability is limited.

Between us, we bring more than 40 years of combined experience as allied health clinicians in music therapy and speech pathology. That experience now sits alongside our responsibility for leading a team of 28 and supporting approximately 700 people each year, most of whom are NDIS participants. We therefore see the proposed reforms through two lenses at once: as clinicians concerned with participant outcomes and as service leaders responsible for workforce sustainability, regulatory compliance and equitable access.

Relevance to the Bill

This submission focuses on how the Bill's proposed changes to access, planning, support determinations, fraud and integrity settings, and governance and administrative arrangements may affect participant access, continuity of care, provider viability and equitable market capacity in practice. Our comments are grounded not only in review of the Bill and Explanatory Memorandum, but in daily experience of delivering allied health supports within the realities of workforce shortages, participant complexity, service fragmentation and geographically uneven markets.

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Key Provisions of Concern and Suggested Safeguards

Schedule 1 – Access and Planning Measures

Defining functional capacity. We are concerned that Schedule 1, Part 1, including proposed section 9B, introduces a definition of functional capacity framed around what a person can do without assistance and in a context that excludes, as far as possible, environmental and personal circumstances. Greater consistency is welcome, but if this concept is applied too narrowly it risks overlooking the real-world conditions in which disability is experienced. In our work, function is often shaped not only by impairment but by transport access, housing, communication environments, family capacity, workforce availability and whether there is a skilled provider nearby. In thin markets, assessing impairment and functional capacity without sufficient regard to the practical service environment may produce decisions that are administratively consistent on paper but do not result in genuinely equivalent access to supports in practice.

Permanence and appropriate treatment. We are particularly concerned by Schedule 1, Part 8, including proposed sections 24(5), 25(1B) and 25A, which tighten the meaning of permanence by requiring that a person has undertaken all appropriate treatment and that further treatment is unlikely to materially improve, reverse or alleviate the impact of the impairment. In practice, access to treatment is not evenly distributed, and access to services outside the NDIS is also highly variable. Families may face long waitlists, unaffordable travel, workforce shortages or simply the absence of local providers across health, specialist, early intervention and community-based systems. A framework that treats treatment as appropriate regardless of whether it is realistically accessible risks disadvantaging people for barriers outside their control. These provisions should not be implemented on the assumption that participants can readily access treatment, assessment or alternative supports outside the NDIS, because that assumption does not hold consistently across outer-

metropolitan, regional, rural and remote communities. This concern is compounded by the fact that the future design, scope and accessibility of state-funded foundational supports in Queensland is not yet clear and cannot safely be assumed to fill emerging gaps in access.

Limits on participant-requested reassessments. We note that Schedule 1, Part 2, including proposed section 48A and the extension of decision timeframes under section 48, introduces new conditions for participant-requested reassessments, including that changes must be significant and ongoing. We understand the policy intent of reducing unnecessary churn, but a rigid threshold may fail families who encounter sudden deterioration, carer burnout, escalating school exclusion, behavioural risk, communication breakdown, urgent equipment needs, or abrupt changes in caring capacity due to serious illness or hospitalisation. In our experience, urgent reassessment needs can also arise where NDIA administrative or process errors result in plans that are plainly incorrect and require timely correction to avoid immediate disruption to supports. A responsive Scheme must preserve timely pathways for participants whose circumstances change quickly, or whose plans are incorrect in ways that place their wellbeing, safety or continuity of support at risk.

Support determinations and plan renewals. We are concerned that Schedule 1, Part 4, including proposed section 34A, and Schedule 1, Part 5, including proposed section 50A, create mechanisms for determinations that can reduce funding for specified groups of supports across old framework plans and for plan renewal arrangements that replace administrative plan continuations. We appreciate the sustainability objective. However, broad reductions applied by support group risk unintended clinical and access impacts if they reduce therapy intensity below what is needed to maintain function, prevent deterioration or support safe participation in daily life. We are also concerned about funding assumptions that treat lower-cost therapy formats, such as group intervention, as interchangeable with individualised supports. While group programs can be valuable for some participants, they are not clinically appropriate or effective for everyone, including some autistic and other neurodivergent participants and people with sensory,

communication or regulation profiles that make group participation inaccessible, dysregulating or less effective. A budgeting approach that privileges lower-cost modalities over appropriate intensity and clinical fit may create false economy by delaying progress, reducing the effectiveness of early intervention, and increasing the likelihood that a person will require supports for longer. In thin markets, even one provider reducing NDIS work or leaving the market can turn a funding or administrative change into a practical loss of access.

Reasonable and necessary supports. We note that Schedule 1, Part 6, including proposed sections 17B and 34(1A) to 34(1K), elevates additional parameters into the Act, including value for money considerations and an ordered approach to evidence about whether a support is effective and beneficial. Clarity can be helpful, but these provisions must still be implemented in ways that recognise individual outcomes, continuity, long-term prevention and the importance of accessible and inclusive decision-making. We have worked with families of very young children with high support needs who have had to implement extensive home safety measures to prevent absconding and serious harm, including modifying doors, taps and cooking appliances. In one such case, when the family sought support work to make daily care and supervision sustainable, this was characterised as ordinary parental responsibility despite the intensity of risk, the impact on parental workforce participation, and the absence of safe informal alternatives. Examples of this kind demonstrate why reasonable and necessary decision-making must remain capable of recognising the real intensity, complexity and disability-specific nature of some care arrangements, rather than reducing them to standardised assumptions about family capacity or ordinary parenting.

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Schedule 2 – Fraud Measures

We recognise the importance of measures to reduce fraud and strengthen integrity, given the harm fraud causes to participants and to public confidence in the Scheme. However, these settings must be risk-proportionate and workable for legitimate providers. As allied health professionals, we are already subject to multiple forms of professional and clinical accountability, including mandatory declarations, professional codes of conduct, continuing professional development requirements, recency of practice expectations, and discipline-specific governance obligations. Integrity measures under the NDIS should be designed with regard to these existing accountability settings so that they do not unnecessarily duplicate obligations that reputable providers are already meeting. We are concerned in particular about record-keeping and retention requirements, and about the cumulative unpaid administrative costs associated with repeated layers of compliance. If compliance settings become too burdensome, they will absorb time and resources away from direct clinical care, supervision and service sustainability, and may discourage reputable small and medium providers, particularly in regional markets, from continuing to operate in the NDIS. Our support for stronger integrity measures is also informed by direct experience of the risks that arise when providers misrepresent qualifications or offer therapeutic services without appropriate professional standards, accountability or oversight. In our view, this reinforces the need for fraud and compliance measures that are targeted, effective and focused on genuine areas of participant risk and potential harm.

Schedule 3 – Governance Arrangements, Pricing and Automation

We note that Schedule 3, including pricing and automation provisions, enables new pricing determinations and automated administrative actions. Administrative efficiency is important, but automated decisions must be transparent, contestable and accompanied by accessible explanations so that participants and providers can understand how an outcome was reached and what evidence is needed to seek review or correction. Automation safeguards must be designed so they do not compound disadvantage for people with

complex communication needs, limited advocacy support or low administrative capacity. Similarly, pricing settings must continue to support a diverse and sustainable allied health market, including rural and remote loadings where appropriate, so that reforms aimed at sustainability do not inadvertently reduce provider supply or participant choice. In our own practice, we have experienced a 20% reduction in the music therapy price limit, while speech pathology and occupational therapy rates have remained static for seven years despite rising workforce and operating costs. At the same time, the Health Professionals and Support Services Award is increasing, our rent is scheduled to rise by 5% each year over the next two years, and we have no practical capacity to increase fees beyond NDIS price settings. These pricing pressures are not abstract: they directly affect workforce retention, service sustainability, and the viability of continuing to offer specialised allied health supports within the Scheme.

Recommendations

- Implement the Bill in a way that minimises avoidable disruption to existing effective support arrangements and continuity of care, including through clear transition pathways and timely urgent-response mechanisms where needs change quickly.
- Ensure access-related rules and guidance, including those relating to functional capacity and appropriate treatment, are transparent, co-designed and applied in ways that do not disadvantage participants in thin markets or those facing real-world barriers to treatment and support.
- Require that any support determinations, funding caps or maximum-setting instruments are informed by transparent evidence, subject to robust participant safety assessment, and supported by workable transition arrangements and clinically appropriate safeguards, including appropriate modality and intensity of support.
- Implement integrity and compliance measures in a risk-proportionate way, aligned with existing clinical record obligations, so that administrative burden does not

displace clinical care or deter reputable providers from remaining in the NDIS market.

- Adopt a staged implementation approach and ensure that major reforms are not operationalised without genuine co-design, transparent consultation and adequate transition planning.
- Ensure the exercise of significant discretionary powers through future rules, instruments and implementation settings is supported by strong governance, transparency and oversight to maintain participant protections and public confidence.
- Ensure automated administrative action is transparent, accessible and contestable, with clear explanations and review pathways, and ensure pricing settings reflect actual delivery costs and support a sustainable allied health market.

Conclusion

We support reform that strengthens the long-term sustainability and integrity of the NDIS. But sustainability cannot be pursued through settings that diminish participant outcomes, weaken continuity of care, or destabilise the provider markets required to deliver supports safely and effectively.

A strong NDIS for future generations will depend on reforms that are fiscally responsible, operationally workable and centred on participant access, continuity, equity and quality. We thank the Committee for the opportunity to contribute to this Inquiry and would welcome the opportunity to provide further evidence, including practical examples of the Bill's likely impacts on regional access, provider viability and continuity of care.