Inquiry into NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026

Response to consultation extension
10 July 2026

Recipient

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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 9,000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

The Accredited Practising Dietitian (APD) program is the credentialling program of Dietitians Australia. It provides an assurance of safe and quality dietetic practice and is the foundation of self-regulation of the dietetic profession in Australia.

This submission was prepared by members of the Dietitians Australia Disability Sector Expert Reference Group following the Conflict-of-Interest processes approved by the Board of Dietitians Australia. Contributors include APDs who are NDIS registered providers, with a full list detailed at the end of this submission including representatives from different States.

Response to Interim Report released 23 June 2026

Dietitians Australia provided an initial response (submission #642)[1] and **we would welcome the opportunity to present at the upcoming hearings in Canberra (30 and 31 July 2026) and Western Australia (6 August 2026).**

Given the potential impact on NDIS participants, we believe it would be vital to have Accredited Practising Dietitians, working at the coalface in Western Australia and across other states and territories, provide **practical and clinical insights** into how the proposed amendments will affect participants' access to safe, effective and disability-specific nutrition and dietetic therapy supports, particularly for people with complex feeding, hydration, swallowing, enteral nutrition (tube feeding into stomach or bowel), sensory, behavioural and functional capacity needs.

What can an Accredited Practising Dietitian do for people with disability?

Accredited Practising Dietitians support one of the most fundamental activities of daily living, eating and drinking, for people whose disability directly impairs their capacity to do so safely, adequately, and independently. The therapeutic support APDs provide enables and equips participants living with disability to engage in therapy, education, employment, family routines, and community participation. Nutrition and dietetic supports are functional, capacity-building, and disability-specific. When removed or reduced, the consequences extend across every domain of a participant's daily life, negatively impact the success of allied health therapies and will likely increase, not decrease long-term scheme costs. Figure 1 shows the typical therapy of an Accredited Practising Dietitian for people with disability and provides examples of risks associated with the Amendment Bill.

[1] DA Submission #642. https://www.aph.gov.au/DocumentStore.ashx?id=9ae04d6d-44d2-4859-a684-1938f539e208&subId=791705

Figure 1 Accredited Practising Dietitians support people with disability

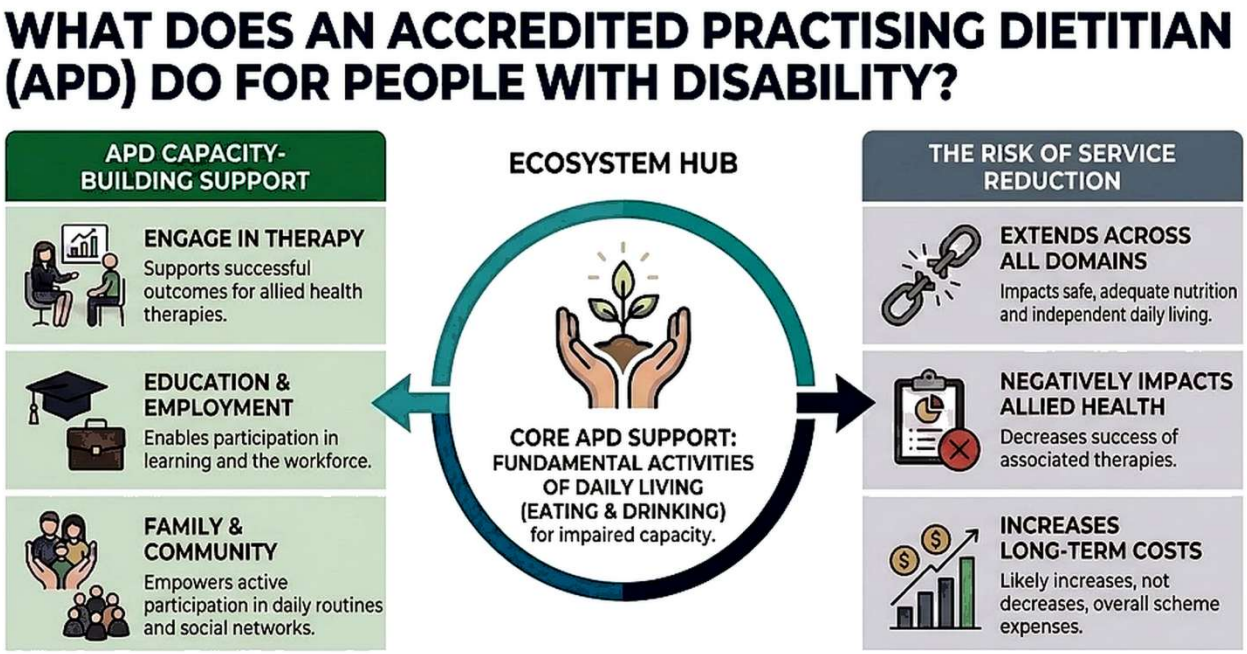


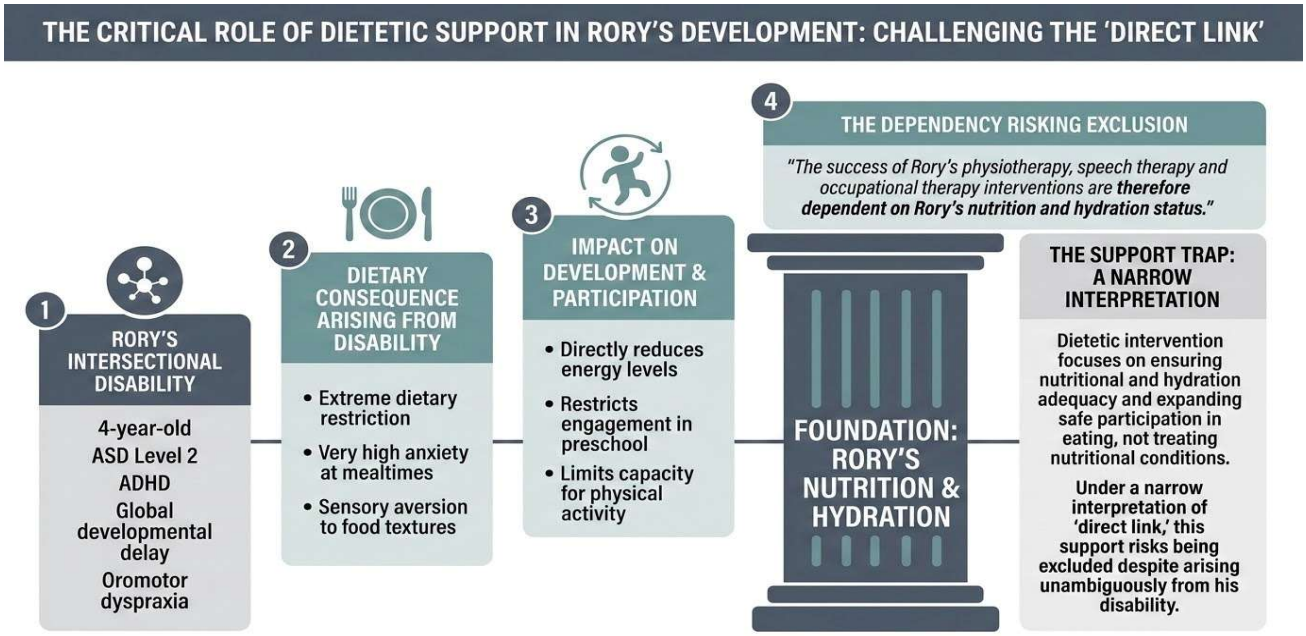
Figure 2 illustrates a case study of a young boy called 'Rory'[2].

Rory's life will be significantly impacted with the introduction of the current Bill due to the narrow interpretation of 'direct link' and the exclusion of dietetic therapy to ensure nutrition and hydration adequacy and expanding safe participation in eating. This dietetic support risks being excluded despite arising unambiguously from his disability. The success of Rory's physiotherapy, speech therapy and occupational therapy interventions is also dependent on Rory's nutrition and hydration status.

There are **many more such real-life examples to explain the complexity of dietetic care for people living with disability**. This complexity is often ignored or misunderstood.

[2] 'Rory' is a real life NDIS participant, however the case was de-identified for privacy purposes.

Figure 2 How Rory's life is impacted by his disability from a nutrition and dietetic perspective



Participant and provider safety:

Dietitians Australia continues to hold serious concerns about the Bill and does not support it in its current form. The proposed changes create unacceptable risks for NDIS participants, particularly in relation to safety, access to allied health supports, and the availability of capacity-building supports (See Figure 1 above)

Further evidence provided by a variety of stakeholders during the Inquiry reinforced these concerns. The proposed reforms are likely to have wide-reaching harmful consequences for participants, allied health providers, families and communities. In particular, they will limit participants' ability to develop skills, increase independence, improve daily functioning, and participate more fully in family, education, work and community life.

Beyond this, Accredited Practising Dietitians hold deep concerns about the misunderstood functional benefits and risk protections that nutrition and dietetic therapy enable. The absence or significant reduction of nutrition and dietetic supports will reduce the functional capacity of a participant, their ability to function independently and confidently and participate in daily activities. The success of other allied health interventions is dependent on an NDIS participant's nutrition and hydration status and their physical ability to effectively participate in therapy interventions. For individuals who rely on enteral feeding (via a tube to stomach or bowel) or a combination of oral feeding (with texture modification and enteral tube feeding) it also means their feeding schedules and modifications need to be carefully planned and scheduled to ensure therapy interventions such as Physiotherapy or Occupational Therapy can effectively occur. More specifically, a person with disability who is undernourished or dehydrated will lack the energy and cognition to respond to therapeutic intervention, activity or instruction.

These safety concerns are not theoretical**. DA's de-identified case studies** describe participants whose reduced or absent dietetic support can **increase risks of choking, reflux-related deterioration, gastrointestinal bleeding, wound infection, delayed healing, unintentional weight loss, kidney failure, falls, behavioural escalation, restrictive practices, metabolic instability and avoidable hospitalisation**. Providers are concerned because, without appropriate dietetic assessment, planning and support-worker training, participants may be left relying on informal or non-clinical feeding, hydration and nutrition decisions in situations where small errors can lead to serious deterioration, acute care escalation, or increased reliance on high-intensity supports.

With a reduction in dietetic therapy supports, APDs have already observed NDIS participants experiencing significant deteriorations in their physical condition and functional capacity.

Workforce exodus – keeping existing expertise is more cost-efficient:

A workforce exodus is already occurring. There is significant risk that the Bill will weaken an already fragile allied health market. Many providers are already reporting pressures that may force them to reduce services, close their books, withdraw from NDIS work, or cease operating altogether. This would further reduce access for participants who already face long wait times and limited service options. The ongoing sustainability of dietetic workforce supply within the disability sector is causing deep concern. With access to dietetic therapy being restricted and inappropriately priced, the viability of practices has become untenable. Many dietitians are now forced to leave the sector and redirect their work to other sectors. This will result in a significant reduction in NDIS service delivery capacity and will leave participants with fewer safe and qualified providers. Dietitians Australia has over the last 2 years conducted surveys amongst Accredited Practising Dietitians (the majority are sole practitioners and small business owners) to understand the sentiment. It provided staggering findings. These are presented in the highlighted section below.

- **June 2024 – Price freeze. 25%** of APDs in the disability sector considering stopping some or all services to NDIS participants due to the ongoing pricing restrictions since 2019 (note pricing was frozen for 5 years prior and not indexed despite rising costs).
- **June 2025 -** Price reduction effective 1 July 2025. **64%** of APDs working in disability sector indicated that they were considering ceasing or reducing NDIS services. Dietitians reported business losses.
- **June 2026 -** Price reduction effective 1 July 2026. APDs have now informed Dietitians Australia that their businesses are no longer viable and they will cease to accept new NDIS clients. Furthermore, they indicated their intention is to leave the sector completely given that business losses are projected to triple due to ongoing rise in business operating costs.
- **A loss of skilled dietetic workforce within the sector will place participants at risk and diminish the efficiency and goals of the scheme.**

The assumption that reductions in capacity-building funding will be offset by improved plan utilisation is overly simplistic. It does not reflect the real-world barriers affecting therapy access, including provider shortages, service viability, travel demands and thin markets. These issues are especially pronounced in rural and remote areas, where participants often have fewer providers to choose from and face additional barriers to receiving timely and appropriate allied health support.

Recommendations

If the Bill proceeds:

- Dietitians Australia urges Parliament to include stronger protections before any reforms are implemented. This includes clear **parliamentary scrutiny, protected review rights, and safeguards** for participants.
- Any amendments must also **protect the clinical expertise** of allied health professionals, including Accredited Practising Dietitians. Decisions about participants' nutrition, hydration and dietetic needs should be informed by qualified dietitians and must not be displaced by generic tools, automated decision-making, standardised algorithms, or staff without appropriate clinical training.
- We also request that the **order** in which reforms are being pursued is adjusted. Major changes to NDIS access, eligibility or funded supports should not occur until alternative and complementary supports outside the NDIS are fully established, accessible, properly funded, and proven to meet participant needs.

The Dietitians Australia Disability Sector Expert Reference Group proposes the following amendments to Schedule 1 of the Bill that carry significant risks for participants whose disability directly impairs their ability to eat (nourish), drink (hydrate), prepare food, and sustain the nutrition required for daily function and participation.

Provision from Schedule 1	**Our concerns**	**Our recommendations**
Part 1: Defining Functional Capacity Item 4 / s.9B	Functional capacity assessed without environmental context may underestimate disability-related feeding and hydration impairments that are context-dependent or support-dependent.	Align with the WHO definition[3] that environment-dependent and caregiver-dependent functional feeding impairments remain valid expressions of disability-related functional capacity and are not excluded from assessment due to contextual variation.
Part 3: Strengthen link between impairment and need for support Item 28 / s.32K(3A)	A narrow interpretation of "directly arising" may exclude feeding impairments arising through cognitive, sensory, behavioural, or motor pathways.	Clarify that functional feeding impairments arising through cognitive, sensory, behavioural, or motor pathways are considered to arise directly from the participant's disability and remain eligible for support.
6—Reasonable and necessary supports Item 68 / s.33(2EA)	Uniform maximum therapy caps may restrict clinically necessary dietetic input without disability-specific evidence.	Consultation with peak allied health bodies; ensure exemptions for ongoing clinical risk and complex care needs; and allow clinician-led variation or override where functional need is demonstrated.
6—Reasonable and necessary supports Item 70 / insertion after 34 (1)(f)	Referring NDIS participants to Medicare for allied health services disregards the NDIS Bill and overlooks the limitations faced by hospital outpatient clinics and Medicare Chronic Disease Management Plans.	Consider the unique limitations faced by NDIS participants when deciding if referral to 'health services' is accessible and practical for the NDIS participant.
6—Reasonable and necessary supports Item 73 / s.34(1E)	The limited evidence base may disadvantage people with a disability; the migration of care to Medicare Chronic Disease Care plans is not fit-for-purpose for people with a disability.	Call for more research and consultation to address evidence gaps where population-level evidence is limited.
6—Reasonable and necessary supports Item 73 / s.34(1E)	Include all three components of Evidence Based Practice to determine whether a support is effective or beneficial for the participant: best available evidence; clinical expertise; and patient values and preferences.[4]	After 1E(a) add new (b): "(b) The *clinical expertise and professional judgement of an appropriately qualified health practitioner, including evidence about the participant's individual functional capacity, risks, support needs, disability-related circumstances and likely outcomes."*

We further recommend that the evidence framework be adjusted to ensure it is appropriate for disability-specific practice where population-level research may be limited but clinical need and functional outcomes are well established in practice. The evidence framework could be strengthened by:

- Recognising that the absence of generalisable research for a specific disability population does not indicate that an intervention is ineffective or inappropriate.

[3] World Health Organization. ICF. https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

[4] Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. BMJ, 312(7023), 71–72. https://doi.org/10.1136/bmj.312.7023.71

- Equally ranking demonstrated functional outcomes for individual participants (consistent with subsection 34(1E) (c)) with generalisable research where population-level evidence is limited.
- Requiring the NDIA to maintain clear guidance on disability-specific populations where the evidence base is acknowledged to be limited, but where there is strong clinical consensus and established practice supporting intervention.
- Require mandatory consultation with Dietitians Australia and relevant peak allied health bodies prior to commencement to avoid unintended consequences.
- Ensuring review and oversight by the Evidence Advisory Committee.
- Removing reliance on an open-ended discretion such as “any other matters the CEO considers appropriate,” to ensure transparency, consistency, and clinical accountability in decision-making frameworks.