Annual Pricing Review for 2027-28 prices

Response to consultation: therapy supports
November 2026

Recipient

National Disability Insurance Agency
Annual Pricing Review for 2027-28 prices
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1 Summary and recommendations

Dietitians Australia welcomes the opportunity to respond to the National Disability Insurance Agency's (NDIA) Annual Pricing Review (APR) for 2027-28 prices. This submission responds to the therapy supports questions in the Provider Consultation Paper and to the initial scoping of the Therapy Pricing Review. It sets out why the June 2026 benchmarking decision does not establish an appropriate price for dietetic services (section 3), what it costs to deliver safe dietetic care to NDIS participants (section 4), how dietetic pricing should be set (section 5) and the evidence the NDIA should build before the Therapy Pricing Review reports (section 6). Appendix A shows where each of the eighteen therapy questions is answered.

Members report that current pricing does not cover the full cost of delivering dietetic supports: direct care, the clinical work that happens outside appointments, travel, supervision, compliance and business overheads. The submission asks the NDIA to work with Dietitians Australia on four problems:

1. Protect access to dietetic services through fair and sustainable pricing (section 3)
2. Price the true cost of safe, equitable dietetic care (section 4)
3. Design a transparent dietetic cost model (section 5)
4. Build the evidence base for the Therapy Pricing Review with the profession (section 6)

These are separate problems; fixing one does not fix the others, and the fact that practices keep operating is not proof that the price is viable, because many depend on unpaid work or on owners paying themselves less than their staff. Dietitians Australia's priority is an adequate base price for safe, effective APD services, supported by plan budgets that fund the clinically justified hours. This submission builds on Dietitians Australia's February 2026 recommendations concerning differentiated pricing, sustainable hourly and travel payments, sufficient funded therapy time, and independent pricing governance (Dietitians Australia, 2026, p. 4). It develops these priorities through updated cost evidence and analysis of participant access and addresses the implications of the Fair Work Commission's gender-based undervaluation review for dietetic pricing.

The NDIA's own payments data, analysed in section 3.5, show what the first price reduction has produced. In the year after it, 10 per cent fewer participants received dietetic therapy, numbers fell in 66 of 76 service districts and in nine of the ten largest disability groups, while occupational therapy and speech pathology grew and physiotherapy and psychology held. The reduction saved about $3.6 million on the dietitian item in a support category whose payments grew by $342 million. Participants have not stopped needing nutrition care. Either it is now being delivered by other professions, at a higher price limit and without dietetic training, or it is not being delivered at all. The first does not save the Scheme money; the second shifts the cost to participants' health.

Key recommendation

R1: Restore the dietitian price limit to $189 from 1 July 2027, index it annually and make no further reduction while the Therapy Pricing Review is under way

Dietitians Australia recommends that the pricing determination for 2027-28 restore the dietitian hourly price limit to its 2025-26 level of $189, reversing the reduction made in June 2026. That reduction rested on a comparison with Medicare and private health insurance claims that the NDIA itself acknowledges is not like-for-like; the data behind it predate the 1 October 2026 increases under the Health Professionals and Support Services Award that the APR Terms of Reference now require the NDIA to include; and the Therapy Pilot and Therapy Pricing Review that the NDIA says will validate its benchmarks have not reported.

The price limit should then be indexed each year for wage and operating-cost movements and should not be reduced again before the Therapy Pricing Review reports. Nous Group's cost-based modelling for Dietitians Australia places the indicative sustainable price for a dietitian with five or more years' experience at $191 to $209 per billable hour at 70 per cent utilisation, so $189 is a conservative floor rather than the price the evidence supports. Dietitians Australia will put the case for parity with the other therapy professions at $194, supported by a dietetic cost model, to the Therapy Pricing Review.

Supporting recommendations

Each supporting recommendation is numbered and is repeated at the point in the submission where the evidence for it is set out. The final column shows the questions in the NDIA's Provider Consultation Paper that the recommendation answers.

No.	Recommendation	Consultation questions
R2	**Benchmarking transparency and comparability.** Before relying on Medicare and private health insurance benchmarks for 2027-28, publish the dietitian benchmark dataset and method (transactions, schemes, dates, session-length assumptions, the percentile used and how the 2026-27 decision moved from a benchmark gap of more than 20 percent to a $10 reduction); verify that claims coded as dietetics were delivered by APDs; and provide Dietitians Australia a structured opportunity to test comparability before prices are finalised.	Q18
R3	**Award wages, gender-based undervaluation and indexation.** Give effect to the APR Terms of Reference commitment to include the impact of the Fair Work Commission's gender-based undervaluation review in therapy pricing: reflect the Health Professionals and Support Services Award increases that commenced on 1 October 2026 in the dietitian price limit from 1 July 2027, and index price limits annually for wage and operating-cost movements.	Q18
R4	**Savings against access.** Assess any proposed change to dietetic prices against its expected savings (dietetics was about 0.75 per cent of therapy payments in July to December 2025) and its consequences for participant access, using current evidence on waiting times, declined referrals and service availability, before the change is made.	Q7, Q17, Q18
R5	**Price the full cost of care, not just billable hours.** Dietitians Australia recommends that the NDIA adopt a costing approach that counts both billable and essential unbilled time. Pricing assumptions should reflect realistic utilisation, the full workload of disability-related dietetic care and the cost of maintaining a sustainable service: the total resources required to deliver quality care, not simply the time recorded as billable.	Q16
R6	**Base dietetic pricing on realistic, profession-specific utilisation rates and practice costs.** Dietitians Australia recommends that the NDIA incorporate realistic, profession-specific utilisation assumptions into a bottom-up pricing methodology. These assumptions should account for essential non-billable work and be validated against actual APD practice data, including differences in business structure and the complexity of disability-related service delivery.	Q9, Q10, Q11, Q12
R7	**Evidence on total working time, billed time and unrecovered work.** Dietitians Australia recommends that the NDIA collect current APD practice data on total working time, billed time and work that remains unrecovered. Costing should distinguish participant-specific clinical work, business administration and professional activities, including work undertaken personally by practice owners. This should inform realistic billable-time and	Q4, Q9, Q10, Q11, Q14

	overhead assumptions, without double-counting. Sustainable pricing should not depend on practitioners absorbing essential work without adequate remuneration.	
R8	**Account for participant-level and appointment-based administrative costs in dietetic pricing.** The assessment should distinguish administration undertaken for each participant, such as preparing an initial service agreement, from tasks that increase with the number of appointments, such as bookings and invoicing. It should determine whether dietetic prices adequately cover these costs when APDs provide relatively few hours of care per participant, using actual APD billed-hours and administrative-time data, and avoid double-counting overheads.	Q16
R9	**A transparent dietetic cost model.** Work with Dietitians Australia on a transparent, profession-specific cost model for APD services built on the five components the NDIA already uses for disability support workers: an experienced-APD salary benchmark, the full cost of employment, realistic utilisation that counts essential non-billable work, actual operational and corporate overheads, and a reasonable margin. Validate the model against current APD practice data.	Q10, Q15, Q16, Q18
R10	**Independent pricing advice.** In February 2026 Dietitians Australia recommended that NDIS prices be set on the advice of an independent pricing authority. The Minister's new power to make the pricing determination makes the independence, transparency and contestability of the advice behind it more important, not less.	Q18
R11	**Complexity through funded hours, not subjective tiers.** Recognise the complexity of disability-related dietetic care through an adequate base price and sufficient funded hours in participants' plans, rather than through complexity-based hourly pricing tiers. If loadings are considered, co-design and test the criteria with participants and APDs.	Q18; Therapy Pricing Review
R12	**Registration and quality.** Preserve an adequate base price for all providers; fund any registration-related payment only on demonstrated additional costs; support registration with practical templates, funded training, proportionate audit requirements and recognition of equivalent evidence; and use participant feedback to inform improvement rather than to determine payment.	Q18; Therapy Pricing Review
R13	**Travel and geography.** Review the 50 per cent travel payment limit against actual APD employment and operating costs and comparable schemes, so that home and community visits remain viable where they are clinically appropriate, particularly in rural and regional areas.	Q12, Q13, Q5
R14	**Evidence from the practices that deliver most dietetic supports** Dietitians Australia recommends that the NDIA fund complementary data collection or a dedicated pilot involving small and medium dietetic practices and sole practitioners that reflects the same quality as the current Quality Supports Program Therapy Pilot. This is consistent with AHPA's recommendation for a dedicated therapy pricing pilot for small and medium providers (AHPA, 2026, p. 4). This work should include registered and unregistered providers, rural and regional services, and practices supporting participants with complex nutrition needs. The NDIA should publish the sample characteristics, costing methods and limitations, and test whether salary, billable-time and overhead assumptions are appropriate for these businesses. The aim should be to establish the actual cost of delivering quality care, not to assume that smaller providers have lower costs or require a lower price.	Q4, Q9, Q10, Q11, Q14

2 About Dietitians Australia and Accredited Practising Dietitians

2.1 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 credential is Dietitians Australia's credentialling program. It provides assurance of safe, quality dietetic practice and is the foundation of self-regulation of the profession in Australia. Dietitians must hold the credential and meet continuing professional development and recency of practice requirements each year to provide services under Medicare, the National Disability Insurance Scheme, DVA, private health insurers, and other funded programs.

This submission was prepared by the Dietitians Australia Policy and Advocacy team following processes approved by the Board of Dietitians Australia. Stakeholder contributions, including experiences from Accredited Practising Dietitians and participants, were provided by Dietitians Australia members and members of Dietitians Australia's Disability Sector Expert Reference Group.

2.2 The role and value of Accredited Practising Dietitians in disability

Dietitians Australia's Disability Role Statement outlines the specialist role of Accredited Practising Dietitians (APDs) in providing comprehensive nutrition assessment, diagnosis, individualised intervention, monitoring and evaluation for people with disability. Disability-related dietetic care extends well beyond general nutrition advice and often involves complex clinical needs, including malnutrition, dysphagia, enteral (tube) feeding, gastrointestinal conditions, food aversions, sensory-related eating difficulties, medication interactions, cognitive and communication impairments, and dependence on others for food and mealtime support. APDs develop evidence-based interventions tailored to participants' functional capacity, preferences, goals and support environments, working collaboratively with families, carers, support workers and multidisciplinary teams to ensure recommendations can be safely and effectively implemented. This includes counselling, behaviour change support, mealtime planning, training, clinical monitoring and ongoing coordination of care. Experienced disability APDs also provide specialist oversight, mentoring and supervision to support workforce capability and safeguard quality of care. Importantly, the complexity of disability-related nutrition care frequently requires substantial assessment, coordination, implementation support and monitoring beyond direct consultation time. NDIS pricing and funding arrangements must therefore recognise the specialist expertise, clinical complexity and full scope of services required to deliver safe, effective and person-centred dietetic care.

3 Protect access to dietetic services through fair and sustainable pricing

Recommendation R2 Benchmarking transparency and comparability

Dietitians Australia asks the NDIA to publish the benchmarking dataset and method before relying on it. The Private Health Insurance (PHI) claims are typically low-intensity services: short telehealth consultations, insurer-funded health coaching programs and digitally delivered nutrition services. The comparison needs adjustment for consultation duration, clinical complexity, service scope and the cost of delivering disability-related care, and the NDIA should undertake service-specific costing and market impact analysis before external benchmarks are used to justify a price reduction.

3.1 What the NDIA decided and how

The June 2026 Annual Pricing Review calculated dietitian hourly rates of $155 and $152 at the 75th percentile of the PHI and Medicare datasets respectively (NDIA, 2026a, p. 86). These are hourly equivalents calculated from shorter, session-based Medicare and PHI claims, typically for low-cost, low-intensity nutrition support.

The NDIA acknowledges that PHI and Medicare rates are not identical to NDIS rates and that NDIS participants may have more complex needs, and for that reason uses a reference range between the median and the 75th percentile. It concludes that the NDIS dietitian price sits above even the upper end of that range: in effect, that the NDIS pays dietitians more than other funders do. Dietitians Australia challenges whether the NDIA has demonstrated comparability, and whether the resulting price can sustain quality disability-related nutrition care.

The Provider Consultation Paper confirms that therapy pricing "uses a benchmarking approach, not award wages", that benchmarking "converts these transactions to an hourly rate for a common comparison base" and that for this APR the NDIA "continues to refine its benchmarking approach" and "will test and validate benchmarks with data from the Therapy Pilot" (NDIA, 2026d). The Therapy Pricing Review Terms of Reference state the principle that "NDIS participants should pay no more than anyone else using comparable supports" (NDIA, 2026e). Dietitians Australia accepts that principle. The question this submission raises is whether the Medicare and PHI services in the benchmark are comparable supports, and whether the resulting price covers the cost of delivering them to NDIS participants.

3.2 Medicare and private health insurance are not appropriate primary benchmarks for NDIS dietetic pricing

Comparing NDIS dietetic prices with Medicare and PHI fees can be a reference point. It is not a basis for setting the NDIS price, because the three systems buy different services, at different levels of clinical complexity, with different obligations on providers.

Benchmarking disability-related dietetic services against those fees without adjustment for complexity, scope, provider obligations and the full cost of care undervalues them. Some private health insurers also pay nutritionists under the same benefit category as APDs. The NDIA should verify practitioner credentials and service codes rather than assume that every claim coded as dietetics is an APD service.

Members questioned whether fees from Medicare, DVA, aged care or compensable schemes can represent the cost of NDIS dietetic work, given differences in clientele, accountability, registration and service structure, and warned that benchmarking against schemes that are themselves underfunded reproduces underpayment rather than establishing a sustainable price. Other schemes are also moving: from 1 November 2026 the Victorian Transport Accident Commission pays up to $179 per hour for a

complex dietetic consultation and reimburses travel at the same rate (section 5.5), a change that postdates the data behind the June 2026 benchmark.

3.3 What the June 2026 APR analysis does not show

Dietitians Australia asks for transparency about the dataset and method: which transactions and schemes were used, over what dates, with what session-length assumptions and percentile, and how the 2026-27 decision moved from a benchmark gap of more than 20 per cent to a $10 reduction. It also asks how the NDIA established that the Medicare and PHI transactions represent services comparable to those delivered under the NDIS, and how assessment, multidisciplinary coordination, report writing, travel, clinical complexity and the needs of participants in regional and remote areas were accounted for. Professional bodies should have a structured opportunity to test this evidence and identify assumptions that need correction before prices are finalised.

3.4 Award wages and the historical gender-based undervaluation of the dietetic workforce

Recommendation R3 Award wages, gender-based undervaluation and indexation

Reflect the Fair Work Commission's gender-based undervaluation findings in NDIS dietetic pricing, and index price limits every year for movements in wages and in operating costs, including the cost of new regulatory obligations.

Changes to the Health Professionals and Support Services Award 2020 commenced on 1 October 2026, introducing a revised classification structure and higher minimum wages for health professional employees, including APDs. These changes arise from the Fair Work Commission's Gender-based undervaluation - priority awards review, which recognised that gender-based assumptions had historically undervalued health professionals' work and justified wage increases on work value grounds. The increases will be implemented in five phases, commencing on 1 October 2026, with further increases on 30 June each year from 2027 to 2030 (Fair Work Commission, 2026).

Box 1: A female-dominated dietetic workforce

Gender-based undervaluation is particularly relevant to dietetics. Jobs and Skills Australia (n.d.) reports that 94.7 per cent of dietitians are women, compared with 48.5 per cent of the Australian workforce. NDIS pricing should not perpetuate that undervaluation.

The NDIA's Annual Pricing Review for 2026-27 prices (p. 79) acknowledges that most therapists are employed under enterprise bargaining agreements or individual arrangements, with remuneration typically 36 per cent above award rates, but treats earnings as context rather than a pricing input and continues to favour market benchmarking (NDIA, 2026a). The Provider Consultation Paper for this review repeats that position: "While the HPSS Award is relevant to allied health professionals, Therapy Supports Pricing uses a benchmarking approach, not award wages" (NDIA, 2026d). Yet the Terms of Reference for this APR commit the NDIA, for therapy supports, to "include the impact of the Fair Work Commission's Gender-based undervaluation - priority awards review" (NDIA, 2026f). A benchmark drawn from fees set before 1 October 2026 cannot include that impact.

Relying on historical market fees without accounting for the revised award and actual employment costs would perpetuate the undervaluation the Commission has identified. NDIS pricing must reflect the qualifications, skills, responsibilities and experience of APDs and the cost of employing them, to support gender pay equity, workforce retention and access to care.

3.5 Dietetic pricing decisions must balance potential savings against participant access

The NDIA's APR for 2026-27 prices reports about $20 million in payments under the dietitian category for 23,429 participants in July to December 2025, 0.75 per cent of the $2.67 billion in total therapy payments over the same period (NDIA, 2026a, Table 12, p. 63). The share is small. It does not by itself show underfunding or unmet need, but it frames what a price cut can save.

A reduction in the dietitian price can therefore deliver only modest savings while putting individual services at risk. The APR should weigh any saving against the effects on provider availability, continuity of care, participant safety and participant choice, using current provider and participant evidence rather than assumption.

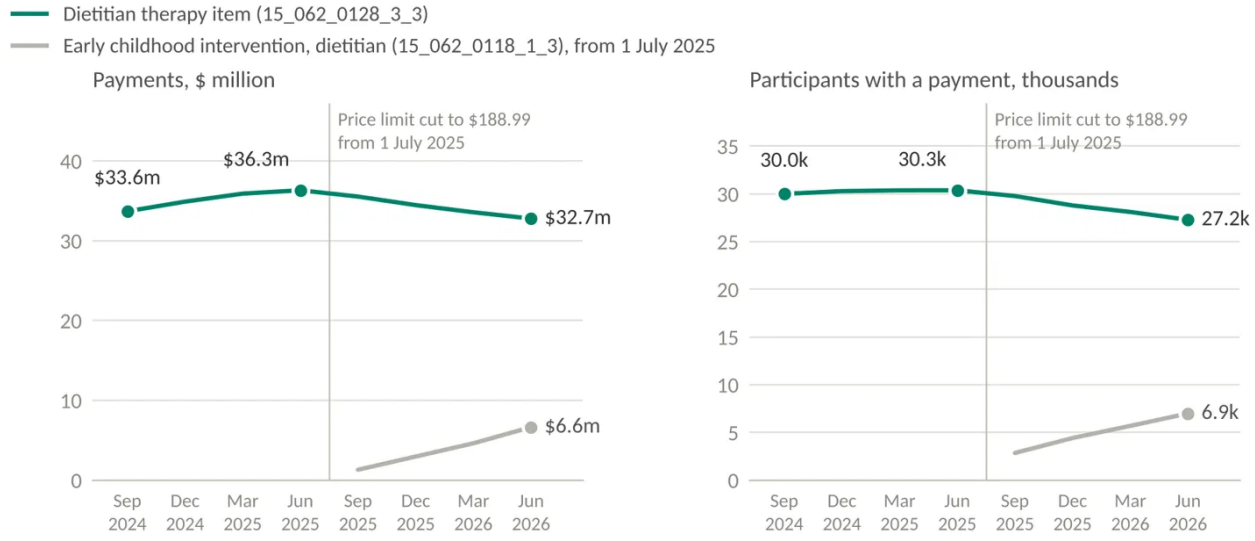
Dietitians Australia is not seeking a set share of therapy expenditure. It is seeking a price, and funded hours, that allow participants' assessed nutrition needs to be met safely.

What the NDIA's published payments data show

The analysis below uses the NDIA's published payments data to June 2026, before the July 2026 price reduction took effect. Main-item comparisons exclude the separate early childhood intervention items introduced in July 2025. The data show association, not cause: they do not by themselves establish why service use changed, but they show the pattern the NDIA needs to explain.

The NDIA's quarterly payments dataset reports, for each support item, the payments made and the number of participants with a payment in the preceding twelve months (NDIA, 2026g). Figure 1 shows the dietitian items. In the year to 30 June 2026, payments under the main dietitian therapy item were $32.7 million for 27,243 participants, against $36.3 million for 30,340 participants in the year to 30 June 2025: a fall of about 10 per cent in both, in the first year after the dietitian price limit was reduced to $189. Part of the fall is the new early childhood intervention item for dietitians ($6.6 million for 6,949 participants in the year to June 2026), and the NDIA can separate the two effects in its own data. The saving on the dietitian item was about $3.6 million. Over the same year, payments in the Improved Daily Living category grew by $342 million to $5.96 billion. All dietitian items together were $45.8 million, 0.8 per cent of the category, and participants using the main dietitian item were 3.8 per cent of the 708,593 participants with a payment in the category.

Figure 1: Dietitian support items in the NDIA's published payments data, payments and participants in the twelve months to each date (September 2024- June 2026)



Source: NDIA payments datasets, September 2024 to June 2026 releases (dataresearch.ndis.gov.au). National figures are sums of state and territory rows; cells with fewer than 11 participants are suppressed by the NDIA and excluded; participants are counted in each state in which they had a payment. Dietitians Australia's calculation.

Figure 2 compares the main therapy item for five professions in the year to 30 June 2026. The average payment per participant receiving dietetic therapy was $1,200, against $3,200 for occupational therapy, $3,400 for physiotherapy, $2,700 for speech pathology and $2,850 for psychology. At the 2025-26 price limits, and treating every dollar as a billed hour, $1,200 buys six hours of dietetic support a year, about half an hour a month, against twelve to eighteen hours for the other professions. The hours are upper bounds, because payments also cover travel, reports and short-notice cancellations, but the gap is far larger than those adjustments. Dietetic care is counselling and behaviour change as much as clinical prescription; like psychology, it cannot be delivered effectively in 30 minutes per month. The figure also

corroborates the member reports in section 4.4 that dietitians deliver fewer funded hours per participant, which is why participant-level administration weighs more heavily on each dietetic hour.

Figure 2: Dietetics received significantly less payment per participant compared to other therapy professions

Average payment per participant with a payment, main therapy item, twelve months to 30 June 2026, and the hours that payment buys at the 2025-26 price limit

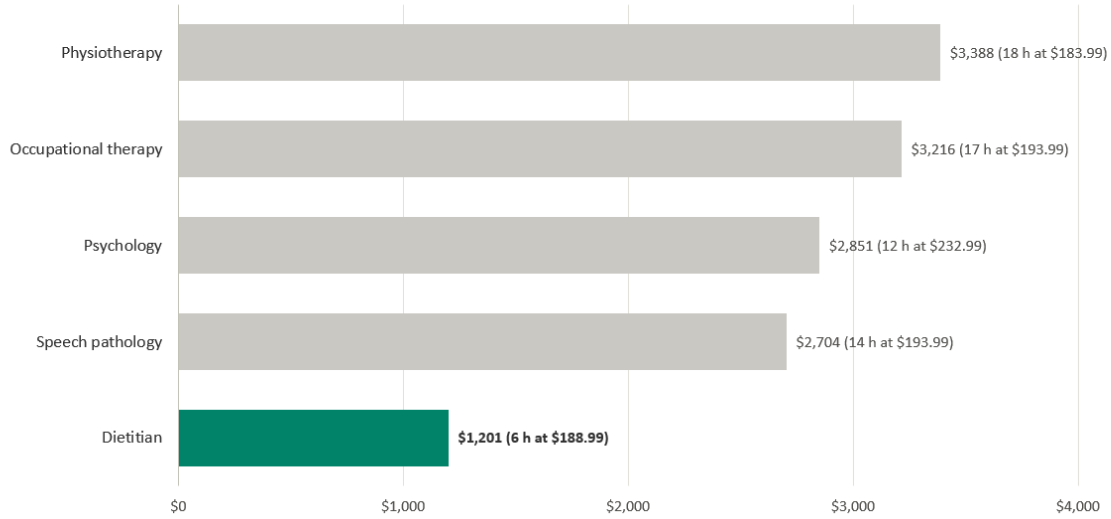
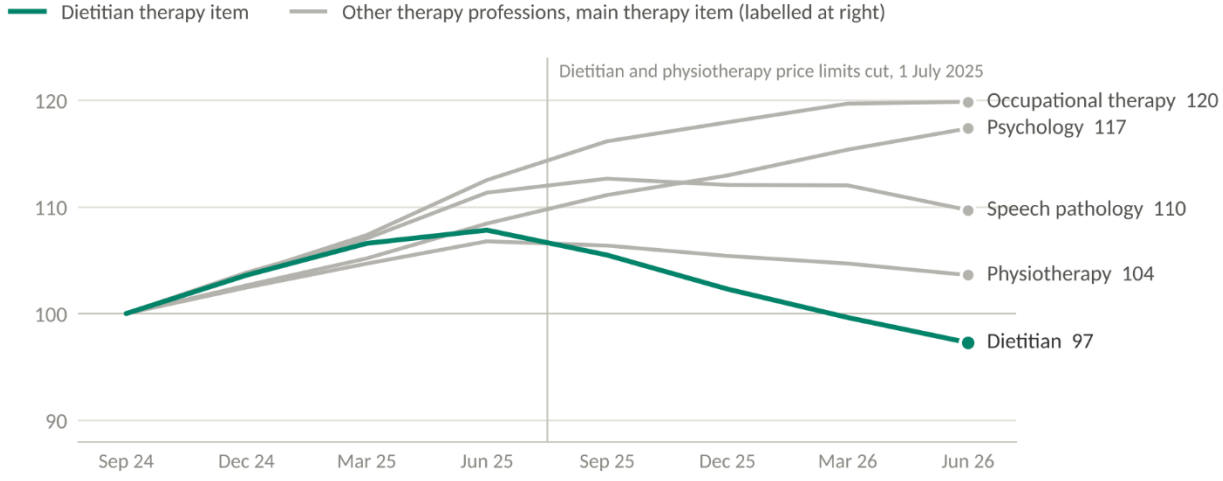


Figure 3 indexes each profession's payments under its main item to the year to September 2024. Dietitian payments were about 3 per cent lower in the year to June 2026 than in that baseline year, an index of 97. Payments for the other four professions rose by between 4 and 20 per cent (NDIA, 2026g).

Figure 3: Of five therapy professions, only dietetics is paid less now than in the year to September 2024.

Rolling twelve-month payments under each profession's main therapy item, index: year to September 2024 = 100



Source: NDIA payments datasets, September 2024 to June 2026 releases; Dietitians Australia's calculation. Main therapy items only (15_062_0128_3_3 dietitian; 15_617_0128_1_3 occupational therapy; 15_055_0128_1_3 physiotherapy; 15_622_0128_1_3 speech pathology; 15_054_0128_1_3 psychology). The profession-specific early childhood intervention items that apply from 1 July 2025 are excluded.

These figures clearly demonstrate why spending on one item is the wrong measure of a pricing decision. The $3.6 million saved on the dietitian item is one per cent of the $342 million by which therapy payments in the same category grew over the year, and the participants who stopped receiving dietetic therapy did not stop needing nutrition care. Lower dietitian payments do not show that needs have fallen or that the Scheme has saved money. The NDIA should examine whether the change reflects item

transfers, fewer recipients, lower service intensity or barriers to care, and should judge value for money on participant outcomes and the cost of the whole support package, including the other services required when dietetic care is unavailable.

3.6 The cost of getting the price wrong: provider exit and participant access

Recommendation R4 Savings against access

Dietitians Australia recommends that the NDIA assess proposed dietetic pricing changes against their expected savings and potential consequences for participant access. This assessment should consider current APD service-delivery costs, waiting times, referrals declined and changes in service availability, particularly for rural and specialist services. Pricing decisions should protect access to necessary care, rather than pursue savings without adequately assessing their consequences.

Price erosion is already driving APDs out of disability work. Providers report pressures that will force them to reduce services, close their books to new NDIS participants or leave the sector, in a market that the current NDIS reforms have already weakened and where participants face long waits and limited choice. More than 80 per cent of Dietitians Australia's private practice members are sole practitioners and small business owners, with little capacity to absorb losses. Workforce planning should address provider viability and continuity of care, not only recruitment.

Dietitians Australia has surveyed APDs working in the disability sector in each of the last three years:

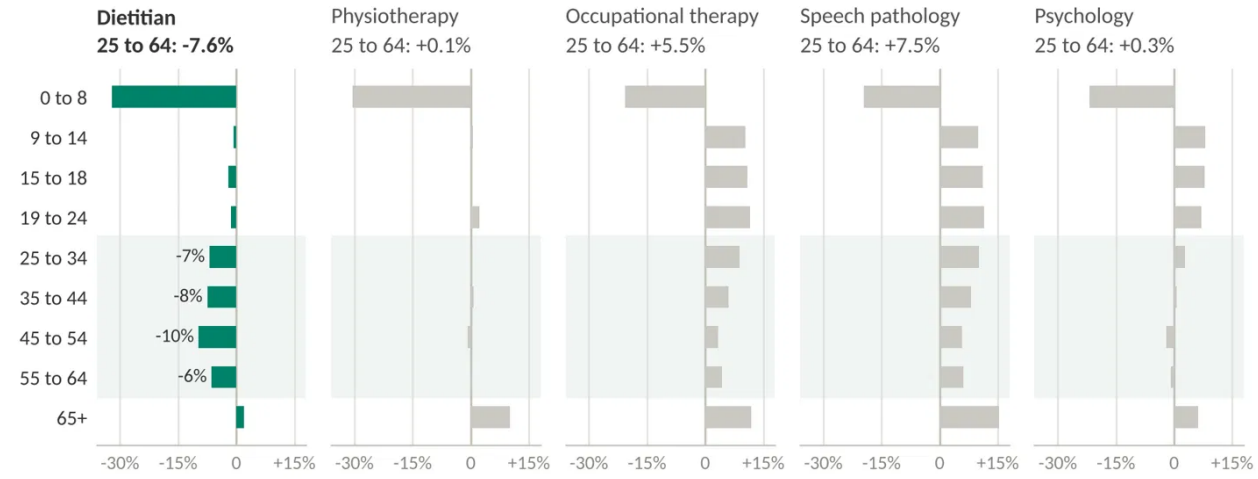
- **June 2024, after five years without indexation: 25 per cent were considering stopping some or all services to NDIS participants.**
- **June 2025, as the first price reduction was announced: 64 per cent were considering ceasing or reducing NDIS services, and many reported business losses.**
- **June 2026, as the second reduction was announced: APDs told Dietitians Australia that their businesses were no longer viable, that they would stop accepting new NDIS clients and, in many cases, that they intended to leave the sector as losses rise with operating costs.**

A loss of skilled dietetic workforce within the sector will place participants and their families at risk and diminish the efficiency and goals of the NDIS.

Figure 4 shows that between the years to September 2025 and June 2026, participants aged 25 to 64 with a payment under the main dietitian item fell by 7.6 per cent, while the counts for the other four professions held or grew. This adult comparison is unaffected by the transfer of young children to early childhood intervention items (NDIA, 2026g).It shows that the decline extends beyond the age group affected by early childhood item changes.

Figure 4: Of five therapies only dietetics lost working-age adults

Change in participants with a payment under each profession's main therapy item, by age band, year to September 2025 against year to June 2026. Shaded rows are the working-age bands (25 to 64).

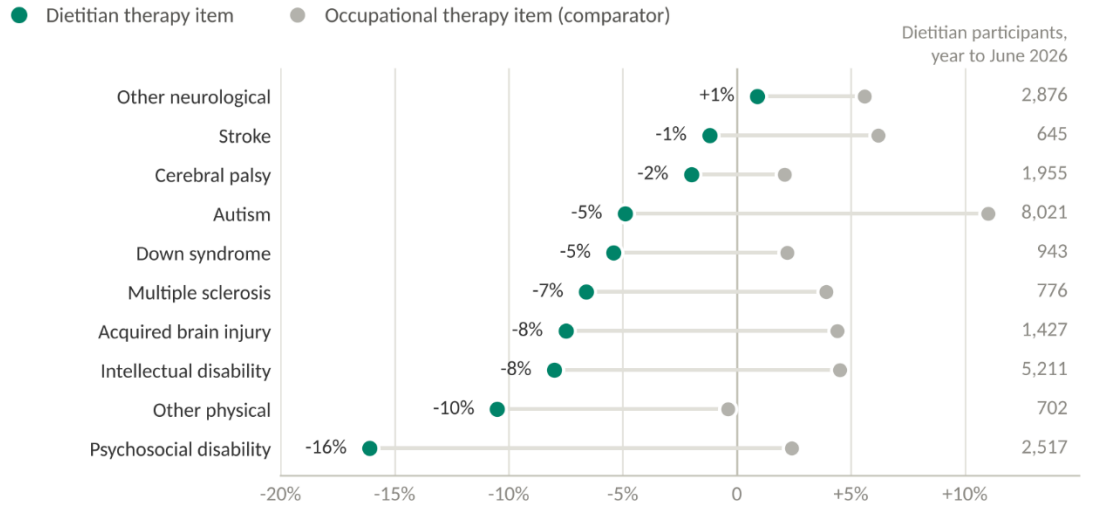


Source: NDIA payments datasets, September 2025 and June 2026 releases (the first to publish item-level age bands); Dietitians Australia's calculation. Rolling twelve-month counts, nine months apart. The fall under 9 years appears for every profession and reflects the move of young children to the early childhood intervention items that applied from 1 July 2025; the adult bands are unaffected by that change.

Figures 5 and 6 show that the decline runs across disability groups. Between the years to September 2025 and June 2026, participants with a payment under the main dietitian item fell in nine of the ten largest groups, with the largest fall, 16.1 per cent, in psychosocial disability. Over the same period occupational therapy grew in nine of the ten groups (Figure 5) and speech pathology grew in all ten (Figure 6). The groups in which dietetics fell furthest, psychosocial disability, intellectual disability, acquired brain injury and multiple sclerosis, are groups in which dietitians and speech pathologists share a caseload: swallowing difficulties, texture-modified diets, mealtime management and enteral feeding (NDIA, 2026g).

Figure 5: Dietetics lost participants in nine of the ten largest disability groups

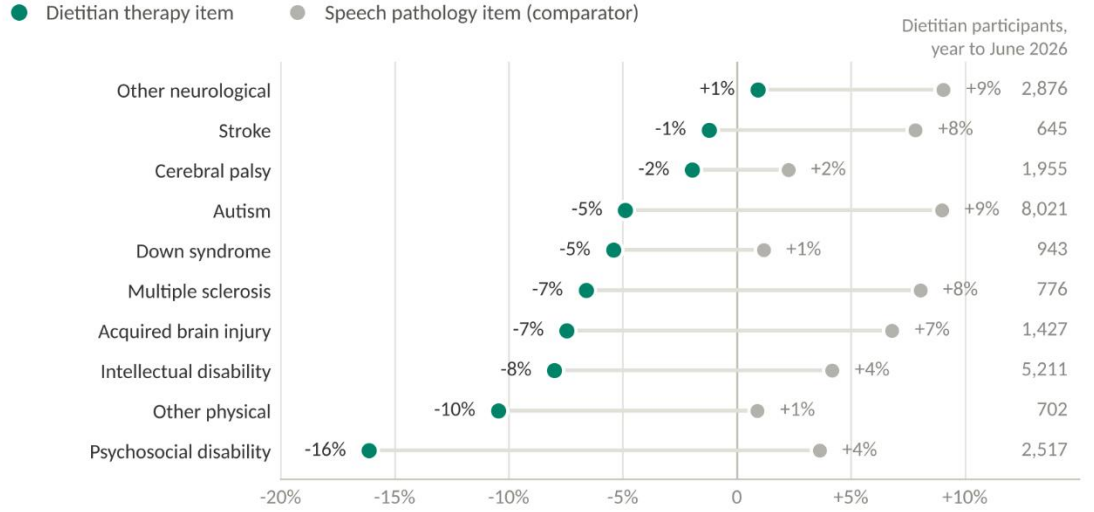
Change in participants with a payment, by primary disability group, year to September 2025 against year to June 2026. Occupational therapy, which grew in nine of the ten groups, is shown as the comparator.



Source: NDIA payments datasets, September 2025 and June 2026 releases; Dietitians Australia's calculation. Main therapy items (15_062_0128_3_3 and 15_617_0128_1_3), national rows by primary disability group; the ten largest groups by dietitian participants, excluding developmental delay groups, which moved to early childhood items. Rolling twelve-month counts, nine months apart.

Figure 6: Dietetics fell in nine of the ten largest disability groups; speech pathology grew in all ten

Change in participants with a payment, by primary disability group, year to September 2025 against year to June 2026.
Speech pathology shares much of the dietitian caseload (swallowing and mealtime support) and its price limit was not cut in July 2025.



Source: NDIA payments datasets, September 2025 and June 2026 releases; Dietitians Australia's calculation. Main therapy items (15_062_0128_3_3 and 15_622_0128_1_3), national rows by primary disability group; the ten largest groups by dietitian participants, excluding developmental delay groups. Rolling twelve-month counts, nine months apart. Groups with many young children (autism, intellectual disability, Down syndrome) include the move of children under 9 to early childhood intervention items from 1 July 2025, which affects the comparator in the same way.

These patterns match what members have reported for a few years: requests for dietetic support questioned or refused by planners and support coordinators on the basis that an occupational therapist, speech pathologist or nurses (see Box 2) could provide the care. The Scheme's own data now show the same thing. Only an APD is trained to assess nutritional requirements and to prescribe and monitor nutrition interventions. Where that work is picked up by other professions it is paid at a higher price limit, $194 against $179, and without the assurance that dietetic training provides; where it is not picked up, the participant goes without. In the first case the NDIA pays more; in the second the participant carries the risk, and in time so does the Agency. Planners and support coordinators need to understand the differences between the allied health professions and nursing, and pricing and planning decisions should support access to dietetic expertise within the participant's broader support package.

Box 2: Member case study: Dietetic support declined as 'duplication' despite the occupational therapist's recommendation

An APD reported supporting a participant with ADHD and autism whose significant sensory processing differences affected oral intake and weight. These difficulties were compounded by appetite suppression associated with ADHD medication. Although insufficient funding prevented the APD from preparing a separate report, the participant's occupational therapist recommended dietetic support, including feeding therapy, in their report.

Snippet from the NDIS email the support coordinator received:

Dietitian-
Decline Type: Full

Legislative Reason:
Rule 5.1(c) I haven't approved this support because it would duplicate other supports provided by the NDIS.

Decline Reasons:
Jane's Occupational Therapy report requests funding for 14 hours of Dietitian support to support meal recommendations and sensory sensitivities and to ensure Jane receives adequate sustenance.

It is identified that sensory sensitivities are an area that the Occupational Therapist indicates they will be working with Jane to build on her capacity. Dietic Supports would be a duplication of the OT Supports already covered in this Plan.

Implication: The decline rationale conflates overlapping concerns with duplicate services: the OT's work on sensory sensitivities does not establish that the recommended dietetic support to address nutritional adequacy, weight concerns and medication-related appetite suppression is already covered by the funded occupational therapy.

Source: De-identified APD account provided to Dietitians Australia. Name has been changed.

Box 3: Member case study: Clarifying the role of dietetic care alongside nursing and high intensity supports

An Accredited Practising Dietitian (APD) recently began supporting a participant with cerebral palsy (spastic paraplegia), dysphagia, epilepsy, autism and developmental hip dysplasia. The participant is non-verbal and receives nutrition through a combination of texture-modified oral intake and enteral feeding. Their medical history includes aspiration pneumonia and pressure injury.

The APD reported that the participant had an allowance of **six hours of dietetic support per year** and that they were seeking **16 hours annually**. During a review, the NDIA requested a letter from the dietitian addressing the following questions, reproduced as supplied:

1. Why is 25 hours per year required for direct intervention?
2. What is the dietician currently focused on managing or improving?
3. What functional outcomes are expected to be achieved for the Participant in comparison to his current functional capacity?
4. The Participant receives 24 hours per year of registered nursing supports to provide review, training and oversight of his dysphagia management and enteral feeding needs that are being delivered by high intensity support workers. What realistically will be achieved from the proposed increase to dietician supports when the Participant's needs are being met in this way?
5. Why aren't the Participant's unstable and ever-changing nutrition related concerns being managing by his medical team and the health system?

Implications for participant access

This example highlights the need for review processes to recognise the respective contributions of dietitians, registered nurses and support workers, and to assess requests for dietetic hours against the participant's individual disability-related needs and the APD's clinical rationale. In particular, question 4 raises how the additional contribution of dietetic care is assessed when nursing supports are already funded. The example also illustrates the need for clear guidance on the distinction between disability-related nutrition supports and health-system responsibilities. Limited understanding among NDIS planners and support coordinators of the scope and value of Accredited Practising Dietitians (APDs) can lead to inappropriate funding decisions, duplication of services and greater reliance on other, potentially more costly supports, ultimately increasing overall NDIS expenditure.

Source: De-identified APD account provided to Dietitians Australia. Clinical circumstances, allocated hours and Agency questions are presented as reported. The APD reported seeking 16 hours annually; question 1 refers to 25 hours and has been retained as supplied. This account concerns a request for clarification during a review; the review outcome was not provided.

The figures show association, not proof that participants have moved from dietetics to another therapy, but they are reason enough to investigate. The NDIA should examine whether planning decisions recognise when dietetic assessment and intervention are required, whether participants can access the right combination of professions, and what the substituted care costs and delivers.

Box 4: Member case study: Eight dietetic hours allocated following significant weight loss and hospitalisation

An Accredited Practising Dietitian reported supporting an 18-year-old man with Level 3 autism, intellectual disability and obsessive-compulsive disorder. He had recently moved into supported independent living following concerns about his safety in the family home.

The participant was referred for dietetic assessment after losing **12 per cent of his body weight over five months**, resulting in hospitalisation. The APD completed an assessment and prepared a report to support a change-of-circumstances request.

The practitioner reported the following therapy allocations:

Therapy	Hours allocated
Occupational therapy	54
Speech pathology	42
Dietetics	8

The explanation for the dietetic allocation referred to **"TAPIB Advice"** and stated **"max Dietician hours 8hr/year"**. It cited the responsibility of mainstream health services for health conditions, referring to section 34 of the NDIS Act and Schedule 1 of the NDIS (Supports for Participants) Rules.

According to the APD, no further explanation was provided about how the eight-hour allocation addressed the participant's assessed needs, and no further information about the cited TAPIB advice was supplied.

Implications for planning and pricing

This case highlights the need for transparent, individualised decisions about disability-related dietetic support. Participants and practitioners should be able to understand how funded hours relate to assessed needs, what care those hours are intended to cover, and how responsibilities between the NDIS and mainstream health services have been determined. Sustainable pricing must be accompanied by funding allocations that enable the necessary care to be delivered.

Source: De-identified member report provided to Dietitians Australia. Allocations and decision wording are reproduced as reported by the practitioner

4 The true cost of safe, equitable dietetic care

This section brings together the evidence on the time, utilisation, unpaid work, overheads and remuneration involved in delivering dietetic services. Much of it comes from the sustainable pricing research Dietitians Australia commissioned from Nous Group in 2026: a national survey of members in private practice (221 complete responses, closed 17 March 2026), a desktop review and sector benchmarking, published as a guidance report and pricing tool on 30 October 2026 (Nous Group, 2026). The survey covered all funding sources, not only the NDIS, and Nous presents its results as indicative ranges rather than prescribed fees.

4.1 Time: the total time required to deliver quality care is underestimated by billing

Recommendation R5 Price the full cost of care, not just billable hours

Dietitians Australia recommends that the NDIA adopt a costing approach that counts both billable and essential unbilled time. Pricing assumptions should reflect realistic utilisation, the full workload

of disability-related dietetic care and the cost of maintaining a sustainable service: the total resources required to deliver quality care, not simply the time recorded as billable.

Billing understates the time it takes to deliver dietetic care. APDs undertake clinical preparation, documentation, care coordination, follow-up and other professional work that their billing does not capture. The Nous survey found that about one-third of the total time spent on a consultation is unbilled (Nous Group, 2026):

Table 1: Median reported billed and unbilled time per consultation, private practice dietitians (all funding sources)

Type of consultation	Estimated time billed	Estimated time not claimed
Standard initial consultation	60 minutes	30 minutes
Standard review consultation	45 minutes	20 minutes
Complex initial consultation	75 minutes	40 minutes
Complex review consultation	60 minutes	30 minutes

Source: Nous Group (2026), Figure 3. Survey of Dietitians Australia members who own or work in private practice, closed 17 March 2026; 397 responses, 221 complete; median billed and unbilled minutes by consultation type across all funding sources.

Table 1 covers all dietetic services, not only disability work. In disability-related care, complex nutritional needs, communication difficulties, multidisciplinary coordination and reporting add further time. Across all sectors, respondents rated about half of consultations complex (n=234), and complex consultations take around 1.2 to 1.5 times the total time of standard ones (Nous Group, 2026, pp. 13, 27); the share is likely to be higher in disability.

In its February 2026 submission, Dietitians Australia advised the NDIA, on the basis of feedback from experienced disability APDs, that an NDIS initial assessment commonly involves 90 minutes face-to-face and a similar time in documentation and liaison (Dietitians Australia, 2026). Both figures are correct for what they measure: the survey describes the typical private practice consultation, the February figures an initial assessment for an NDIS participant with complex needs, which is the service the NDIA prices. Both should inform the time assumptions a dietetic cost model tests.

For the NDIA's purposes, the time not claimed in Table 1 needs to be separated into time that is not claimable under NDIS rules (business administration, supervision, professional development), time that is claimable but not funded in the participant's plan, and time that is claimable but not claimed. Section 4.3 and Recommendation R7 set out the data that would allow that separation.

4.2 Realistic utilisation rates are essential for sustainable dietetic pricing

Recommendation R6 Base dietetic pricing on realistic, profession-specific utilisation rates and practice costs

Dietitians Australia recommends that the NDIA incorporate realistic, profession-specific utilisation assumptions into a bottom-up pricing methodology. These assumptions should account for essential non-billable work and be validated against actual APD practice data, including differences in business structure and the complexity of disability-related service delivery.

Utilisation refers to the proportion of working time that can be billed to clients. Nous survey findings and practitioner consultations suggest that utilisation of around 60 to 70 per cent is realistic once non-billable activities are considered (Nous Group, 2026, p. 29). However, utilisation varies across practices and service types. More complex client needs may require longer consultations and additional non-billable

work, affecting the proportion of time available for billable services (Nous Group, 2026). Table 2 displays Nous survey data collected during the development of Dietitians Australia's sustainable pricing tool and demonstrates variation in utilisation rates across private practice business structures.

Table 2: Reported utilisation rates in private dietetic practices

Utilisation rate	Sole traders	Companies/corporations
Lower range (25th percentile)	57%	60%
Mid-range (median)	67%	69%
Upper range (75th percentile)	75%	75%

Source: Nous Group (2026), Table 1. Nous notes that a higher utilisation rate is not always better: very high rates can signal an unsustainable workload or unbilled time that is not being recorded.

Pricing models that assume unrealistically high utilisation rates understate the cost of service delivery. The reported ranges are evidence from private practice across all funders, not established benchmarks for NDIS-funded dietetic services, where clients are more complex. StewartBrown's allied health benchmarking reported utilisation of 36.2 per cent in FY2022 and 52.0 per cent in FY2023 (section 4.5, Table 6), well below the illustrative 65 per cent used in Appendix C.

4.3 Unpaid work: recognising the time required to deliver dietetic care

Recommendation R7 Evidence on total working time, billed time and unrecovered work

Dietitians Australia recommends that the NDIA collect current APD practice data on total working time, billed time and work that remains unrecovered. Costing should distinguish participant-specific clinical work, business administration and professional activities, including work undertaken personally by practice owners. This should inform realistic billable-time and overhead assumptions, without double-counting. Sustainable pricing should not depend on practitioners absorbing essential work without adequate remuneration.

Kirkegaard, Wright, et al. (2026) found that 67 per cent of surveyed private practice dietitians reported spending 1-10 hours each week on business-related activities, with a further 17 per cent spending 11-20 hours. Respondents also described difficulties balancing paid work with unpaid tasks, including communication with other health professionals, administration, appointment management, professional development and work before and after consultations. Donnelly et al. (2025) identified additional workforce development responsibilities, including supervision and mentoring, can create financial and time pressures for private practitioners. These findings reinforce the need for pricing methodologies to account for essential non-billable work.

This work weighs most on small practices. In the companion business study, 68 per cent of the 154 surveyed businesses were sole traders, only 31 per cent employed reception staff and 8 per cent employed a practice manager (Kirkegaard, Clark, et al., 2026). Essential clinical and business activity in these practices is done by the owner, not by staff whose wages appear as an expense. The absence of a separate staff cost does not mean the work has no cost, and a pricing model that overlooks the owner's time makes service delivery look cheaper than it is. Pricing analysis should count the owner's working time as well as recorded business expenditure.

4.4 Participant-level administration must be reflected in dietetic pricing

Recommendation R8 Account for participant-level and appointment-based administrative costs in dietetic pricing

The assessment should distinguish administration undertaken for each participant, such as preparing an initial service agreement, from tasks that increase with the number of appointments, such as bookings and invoicing. It should determine whether dietetic prices adequately cover these costs when APDs provide relatively few hours of care per participant, using actual APD billed-hours and administrative-time data, and avoid double-counting overheads.

Members report that participant-level administration is hard to recover when an APD delivers few hours of care to a participant. One practitioner reported indicative annual allocations of 10 to 20 hours for dietetics against about 48 hours for physiotherapy or occupational therapy; these are unverified observations, not averages or evidence of hours delivered. The concern is not that allocations differ between professions but that some tasks, such as developing and explaining a service agreement, are required however little care is funded. Recovered across fewer billable hours, that cost is higher per hour, and whether existing prices cover it needs assessment.

The NDIA's Annual Pricing Review for 2026-27 prices, Table 12, reports the following payments and participant numbers for July-December 2025. Dividing payments by the number of recipients gives an approximate payment per participant receiving each therapy (NDIA, 2026a).

Table 3: Payments and participants by therapy category, July to December 2025, from the Annual Pricing Review report for 2026-27 prices

Therapy category	Payments during the six-month period	Participants receiving the therapy	Calculated average payment per recipient
Dietetics	$20 million	23,429	Approximately $854
Occupational therapy	$554 million	267,211	Approximately $2,073
Physiotherapy	$211 million	99,986	Approximately $2,110

Source: NDIA (2026a), Table 12, p. 63. Average payments are Dietitians Australia's calculations from the published, rounded totals.

Average payments per dietetic recipient are far lower. The figures do not show hours allocated or delivered, they include travel, and they are not matched comparisons of participants with equal needs. The NDIA's payments data show the same pattern over a full year and across five professions (section 3.5, Figure 2).

4.5 Allied health services are showing long-term losses in disability service provision

Independent benchmarking shows allied health providers making growing losses on disability work. StewartBrown's annual financial benchmarking shows average financial performance deteriorating between FY2022 and FY2024. These are pooled allied health results, not dietitian-specific estimates, and changes in the sample and cost classifications limit direct comparison (StewartBrown, 2022). Tables 4, 5 and 6 show financial performance, revenue and costs per participant, and workforce metrics; Table 7 shows the ratios derived from them.

Table 4 shows that about two in three services reported an operating loss in each of the three years. The median operating result per client worsened each year, from a loss of $490 in FY2022 to $784 in FY2023 and $827 in FY2024, and the average moved from a $1,462 surplus in FY2022 to a $759 loss in FY2024.

Losses this widespread warrant investigation of whether pricing recognises the cost of delivering the service.

Table 4: Financial performance, allied health services (StewartBrown benchmark)

Metric	FY2022	FY2023	FY2024
Allied health services in the reported sample	11	15	Not stated
Average operating result per client per year	$1,462 surplus	$387 loss	$759 loss
Median operating result per client per year	$490 loss	$784 loss	$827 loss
Operating margin: operating result / revenue	13.4%	-4.6%	-9.7%
Number of services making an operating loss	63.6%	66.7%	62.5%

Sources: StewartBrown 2023 (FY2022); StewartBrown 2024 (FY2023); StewartBrown 2025 (FY2024).

Table 5 shows that covering direct clinical costs does not necessarily mean a service is financially sustainable. In FY2024, revenue exceeded direct costs by $2,412 per client, but recorded overheads were $3,171 per client, resulting in the $759 operating loss. This demonstrates why assessing service costs solely through clinician wages or direct clinical expenditure provides an incomplete picture.

Table 5: Revenue and costs per participant, allied health services ($)

Revenue or expense	FY2022 (1)	FY2023 (2)	FY2023 (3)	FY2024 (3)
Operating revenue	10,943	8,390	8,390	7,809
Direct staff expenses	5,906	5,712	5,712	5,048
Other direct expenses	171	241	241	279
Workers compensation	44 indirect	76 indirect	76 direct	70 direct
Total direct costs	6,078	5,953	6,029	5,397
Revenue remaining after direct costs, before overheads	4,865	2,437	2,361	2,412
Corporate recharge	771	628	628	410
Administration and support staff	1,461	1,107	1,107	1,529
Other indirect expenses, grouped for comparison (note 2)	1,124	1,013	1,013	1,232
Total indirect costs/overheads	3,403	2,824	2,748	3,171

Sources: (1) StewartBrown 2023; (2) StewartBrown 2024; (3) StewartBrown 2025. Note 1: The FY2024 report states that prior-year comparisons were restated to reflect its current cohort. Note 2: For FY2022 and original FY2023, the separately reported other administration/support expenses and depreciation have been added together. The FY2024 report presents a combined other-indirect-cost category. Totals are retained as published; rounding can produce minor differences.

Table 6 shows average base hourly pay of $51.29 in FY2022 and $59.84 in FY2023, and utilisation of 36.2 and 52.0 per cent on a denominator that excludes leave and training. These are useful historical, pooled figures, but not current APD salary benchmarks, and they are not comparable with an assumption that 65 per cent of all paid hours are billable. Therefore, salary, billable-time and utilisation assumptions need to be tested against dietetic practice data.

Table 6: Workforce metrics, allied health services

Allied health workforce metric	FY2022 (1)	FY2023 (2)	FY2024
Average base hourly pay: allied health front-line workers	$51.29	$59.84	Not reported
Clients per allied health front-line worker, full-time equivalent	25.2	34.9	Not reported
Utilisation/productivity rate (3)	36.2%	52.0%	Not reported

Sources: (1) StewartBrown 2023; (2) StewartBrown 2024; (3) called utilisation in FY2022 and productivity in FY2023. The denominator excludes leave and training.

Table 7 shows that the cost of providing allied health services extends beyond paying clinicians. In FY2024, surveyed services reported approximately $58.80 in overheads for every $100 of direct service-delivery costs (StewartBrown, 2025). These historical findings are not dietitian-specific, but demonstrate why overheads need to be considered when assessing the full cost of care. The Nous survey of dietetic practices points the same way: mid-range operating costs were 40 per cent of gross revenue for both sole traders and companies (Nous Group, 2026, Table 4), close to the 40.6 per cent overhead ratio StewartBrown reports for FY2024.

Table 7: Ratios derived from the StewartBrown benchmarks

Metric	FY2022 (1)	FY2023 (2)	FY2023 (3)	FY2024 (3)
NDIS revenue as a % of operating revenue	64.1%	85%		
Overheads as a % of operating revenue	31.1%	33.7%	32.8%*	40.6%*
Direct staff costs as a % of operating revenue	54.0%	68.1%		
Overheads as a % of direct costs	56.0%	47.4%	45.6%*	58.8%*

Sources: (1) StewartBrown 2023; (2) StewartBrown 2024; (3) StewartBrown 2025. * Calculated from the published figures; for example, the FY2024 overhead-to-direct-cost ratio is $3,171 / $5,397 x 100 = 58.8%.

4.6 What the Nous survey and model show about sustainable prices

Dietitians Australia engaged Nous Group to develop an independent pricing tool, available to APDs since October 2026, to help members set sustainable fees for private dietetic services. The guidance report that accompanies it sets out a nine-step method that builds a price from a wage, on-costs of 24 per cent (superannuation, sick leave and annual leave), utilisation, operating costs and a margin. It is the bottom-up approach this submission asks the NDIA to adopt, and it produces three results relevant to this review.

Wages. Nous combined survey responses and employment listings to estimate median annual salaries of $75,203 for dietitians with less than two years' experience, $83,392 at two to under five years, $96,831 at five to under ten years and $115,080 at ten or more years (Nous Group, 2026, Table 2). Survey findings identified wages as the primary cost driver for 76 per cent of respondents (p. 29).

Break-even rates. Working each respondent's own wage, utilisation and operating costs through the model, Nous reports break-even rates per billable hour of $133 (25th percentile), $168 (median) and $217 (75th percentile) for sole traders, and $128, $155 and $241 for companies (Nous Group, 2026, Table 7, p. 22). A break-even rate covers the wage and all business costs with no margin at all.

Indicative sustainable prices. Table **8** reproduces Nous's modelled prices by experience and utilisation. At 60 per cent utilisation the current NDIS price limit of $178.99 is below the mid-range indicative price for every experience band; at 70 per cent it is below the mid-range for practitioners with five or more years' experience.

Table 8: Indicative sustainable prices per billable hour by years of experience and utilisation, mid-range inputs, 20 per cent illustrative margin

Utilisation	Under 2 years	2 to under 5 years	5 to under 10 years	10 or more years
60%	$181	$191	$207	$229
70%	$168	$176	$191	$209
75%	$163	$170	$184	$202

Source: Nous Group (2026), Table 10, mid-range column for each experience band (lower and upper ranges are also published). Nous describes these as evidence-informed indicative ranges for practitioners to test their own calculations against, not recommended fees; the 20 per cent margin is an illustrative assumption, equivalent to a 25 per cent mark-up on break-even costs.

Nous is explicit that its resources "do not recommend or prescribe specific fees" and that current pricing "does not consistently reflect the true cost of delivering dietetic care" (Nous Group, 2026, pp. 1, 8). Members made a related point in consultation: data on what practices currently charge can demonstrate financial strain, but a price built from current fees risks reproducing underpayment. The Nous model avoids that trap by building the price from costs rather than from fees. Its results bear directly on whether $179 is an appropriate price limit, and they are the reason Recommendation R1 treats $189 as a floor rather than a target.

4.7 The cost structure of a registered multi-site practice

Appendix C provides practical evidence from an established multi-site dietetic practice on the costs of delivering NDIS services, organised around the five components of the Disability Support Worker Cost Model: salary, direct on-costs (including about $2,400 per clinician a year for clinical supervision and $1,200 for professional development), operational overheads (premises and utilities alone can exceed $80,000 a year for a medium-sized practice), corporate overheads (including about $8,000 to obtain NDIS registration and about $3,000 per clinician a year for insurance, memberships and credentialling) and margin. The figures are one practice's, not profession-wide estimates, but they show the kinds of cost that a benchmark drawn from Medicare and PHI fees never sees.

5 Designing a transparent dietetic cost model

5.1 A transparent dietetic cost model, built the way the NDIA already prices support workers

Recommendation R9 A transparent dietetic cost model

Dietitians Australia recommends an independently developed dietetic cost model and an adequate base price, supported by participant budgets that allow the clinically justified service to be delivered. All five components of the current pricing model require review using a transparent, evidence-based cost model that reflects:

- Different reference points to determine an experienced APD salary input, including sensitivity analyses.
- The full cost of employment, including statutory on-costs, supervision and professional development.
- Realistic billable utilisation, including the impact of essential non-billable clinical and business activities.
- The actual operational and corporate costs of providing safe, compliant disability dietetic services.
- A reasonable commercial margin to support workforce retention, reinvestment and long-term service sustainability.

The model should allow for variation in business structure, participant complexity, service delivery setting and provider obligations. The NDIA should work with Dietitians Australia on a cost model for APDs.

The NDIA already prices disability support workers from five components: base salary, direct on-costs, operational overheads, corporate overheads and margin. There is no reason an equally transparent, profession-specific costing should not inform the price of a qualified allied health profession.

The DSW Cost Model does not set therapy prices, but its components are the right framework. Businesses differ, but every practice that employs qualified health professionals carries the costs of clinical governance, NDIS registration or equivalent quality systems and sustainable operation. The price must recognise them, particularly given the complexity of disability dietetics and the need to retain experienced clinicians.

Members cautioned against anchoring a new price to fees that already reflect underpayment or unpaid work. The model should be tested with sole traders, small practices, larger and hospital-based services, rural providers and experienced clinicians, so that no single business type or career stage stands for the whole profession. Clinical work should be funded through the relevant service arrangements and general overheads recognised in the price.

5.2 Independent pricing advice

Recommendation R10 Independent pricing advice

Dietitians Australia restates its February 2026 recommendation that NDIS prices be set on the advice of an independent pricing authority. The Minister's new power to make the pricing determination makes the independence, transparency and contestability of the advice behind it more important, not less.

Since that submission, the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026, passed on 19 August 2026, has given the Minister the power to make the pricing determination on advice from the NDIA (NDIA, 2026d). A determination made by the Minister

rests on the quality of the advice behind it. That advice should be independent of the agency that funds the supports, transparent in its data and assumptions, and open to scrutiny by the professions it prices before it is finalised. The gaps described in section 3.3 would not survive that scrutiny.

5.3 Complexity

Recommendation R11 Complexity through funded hours, not subjective tiers

Dietitians Australia recommends that the NDIA explicitly account for the complexity of disability-related dietetic care when evaluating therapy pricing and comparing services across funding schemes. Pricing methodologies should recognise the additional clinical time, professional expertise, documentation and coordination required. Rather than introducing potentially subjective complexity-based hourly pricing tiers, the NDIA should ensure that the base price reflects the full cost of delivering quality dietetic services and that participants receive sufficient funded hours to meet their individually assessed needs.

Funding effective services based on participants' needs

Dietitians Australia advocates a base price that funds safe and effective APD services based on participants' needs. Additional payments should respond to demonstrated differences in delivery costs, not to registration status, diagnosis or subjective quality ratings alone.

Members favoured identifying individual needs and funding the hours required at a sustainable rate. Complexity can arise from communication, cognition, feeding arrangements, changing clinical needs, social circumstances and the number of people involved in implementation, and more time may be needed for assessment, liaison, training and follow-up. A higher hourly rate cannot compensate for insufficient funded hours.

If additional complexity loadings are considered, criteria should be co-designed and tested with participants and APDs. Decisions should draw on appropriate clinical evidence, allow timely review when needs change and preserve access to the participant's chosen provider.

Complex care

Analysis of responses to the Nous 2026 sustainable pricing survey identified ten common factors contributing to consultation complexity. Table 9 lists them, with Dietitians Australia's description of what each means for dietetic care.

Table 9: Factors contributing to consultation complexity reported by private practice dietitians

No.	Complexity factor	Implications for dietetic care	Disability
1	Multiple comorbidities and conditions	Managing interacting health conditions that influence nutritional needs and treatment.	Where disability affects a person's ability to manage several health conditions or implement dietary advice, the APD must adapt recommendations to their functional abilities, medications, feeding arrangements and available support.
2	Disability and NDIS-related needs	Adapting interventions to functional limitations, support requirements and individual circumstances.	Disability may affect shopping, preparing food, eating, drinking or managing nutrition independently. APDs assess these difficulties and develop practical strategies with the person, carers and support workers to support daily functioning and participation.

No.	Complexity factor	Implications for dietetic care	Disability
3	Mental health concerns	Addressing psychological and behavioural factors affecting eating, nutrition and engagement with care.	Where psychosocial disability affects planning, motivation, daily routines or engagement, dietetic care may require flexible approaches, achievable steps and involvement of the person's chosen supports to help implement nutrition recommendations.
4	Specific clinical conditions	Managing conditions requiring specialised nutritional assessment, intervention and monitoring.	Examples include nutrition management where a person has disability-related swallowing difficulties, relies on tube feeding or cannot independently follow a specialised diet. APDs coordinate implementation and monitoring with carers, support workers and relevant clinicians.
5	Eating disorders	Providing specialised assessment and treatment, often requiring ongoing multidisciplinary collaboration.	When an eating disorder coexists with disability, cognitive, communication or sensory needs may require adapted assessment and intervention. Coordination between health professionals and disability supports helps ensure consistent implementation of the care plan.
6	Paediatric complexity	Addressing growth, development, feeding difficulties and changing nutritional requirements.	Children with disability may need support with food acceptance, feeding skills and participation in mealtimes. APDs work with families and other professionals to support nutritional adequacy and growth, with consistent strategies across home, education and care settings.
7	Social and psychosocial factors	Considering family circumstances, financial disadvantage, food insecurity and the availability of appropriate support.	A person may depend on others to purchase food, prepare meals or provide mealtime assistance. Nutrition plans must account for affordability, accessible food options, living arrangements and whether reliable support is available to implement recommendations.
8	Time and documentation requirements	Completing comprehensive assessments, clinical reports, nutrition care plans and other necessary documentation.	Reports may need to explain how disability affects nutrition, daily functioning and participation, and identify the assistance required. Care plans and support-worker instructions must be clear, accessible and updated when needs or support arrangements change.
9	Multidisciplinary team and care coordination	Communicating with families, carers, support workers, allied health professionals and medical practitioners to support safe implementation of nutrition interventions.	Several people or services may implement a participant's nutrition plan across different settings. APD input may include joint planning, training, clarifying responsibilities and reviewing implementation when staff, services or the person's needs change.
10	Communication challenges	Adapting consultations and interventions for participants with cognitive, communication, behavioural or sensory support needs.	Accessible information, visual supports, additional processing time and supported decision-making may be needed so the person can express preferences, participate in assessment and understand recommendations. This may require additional preparation, consultation time and collaboration.

These factors overlap and add to the time required. An NDIS participant requiring enteral nutrition may also have dysphagia, gastrointestinal complications, communication difficulties and several support workers, so dietetic management involves assessment, individualised nutrition planning, training for support workers, multidisciplinary liaison and regular monitoring. Complexity should be assessed against the person's functional needs, support environment and the work required to implement and monitor the plan (section 4.1 gives the Nous estimate of the additional time).

Complexity cannot be determined by diagnosis alone. Two participants with the same disability may need very different levels of dietetic input depending on their functional needs, nutritional risks, support arrangements and changing circumstances, and the same participant's needs change over time, so the frequency and duration of intervention have to be able to change with them.

Beyond clinical care: food insecurity adds to complexity and cost

Box 5: Two out of three people with disability or a health issue experience food insecurity

The Foodbank Hunger Report 2026 found that 65 per cent of Australian households affected by disability or health issues experienced food insecurity, compared with 28 per cent of other households, and almost half (48 per cent) experienced severe food insecurity. People with disability are therefore at high nutritional risk, and the APDs who support them carry that added complexity.

Food insecurity raises the complexity and cost of disability-related dietetic care. Participants who cannot afford or obtain nutritious, appropriately textured food face higher risks of malnutrition, weight loss and functional decline, and prescribed interventions fail unless the APD adapts them, monitors more closely and coordinates with carers, support workers and other services. Transport barriers and geographic isolation compound the problem.

Addressing food insecurity falls outside the NDIS remit, but pricing must recognise the additional clinical and service delivery work it creates for participants with complex nutrition needs and not further disadvantage participants.

5.3 Quality and participant experience

Members said participant feedback should be accessible, with supported communication where needed and a clear distinction between participant and representative views, and should inform improvement alongside other evidence. Payment should not depend on satisfaction scores alone: members identified risks of pressure to provide clinically inappropriate care, unequal opportunities to give feedback and incentives to avoid difficult work.

Members felt very strongly that any quality framework should consider safety, person-centred care and meaningful outcomes, including maintenance of function and prevention of deterioration. It should account for factors outside the APD's control and avoid penalising providers serving people with substantial support needs.

5.4 Registration costs and obligations

Recommendation R12 Registration and quality

Dietitians Australia recommends practical templates, funded training and implementation assistance, proportionate audit requirements and recognition of equivalent evidence. APD credentialling and NDIS provider registration serve different purposes and one should not be described as identical to the other. Any registration-related payment should reflect demonstrated additional costs and preserve an adequate base price for all providers. Members also requested that the NDIA provide ready-to-use templates to streamline NDIS registration for allied health professionals. Participant feedback should inform improvement rather than determine payment.

Members reported that registration can strengthen governance, documentation, risk management and business processes, and it brings substantial preparation and compliance work that sole traders and small practices find hard to absorb. Unregistered providers may already invest in credentials, insurance, supervision, policies and quality assurance, so registration status alone does not describe the quality of a dietetic intervention. Where registration, specialised expertise, clinical supervision or governance obligations create additional cost, that cost should be measured and funded, and any transition should come with practical support and proportionate requirements rather than excluding capable sole traders. Appendix C sets out one registered practice's estimate of the time and cost of registration and of operating as a registered, professionally governed NDIS provider.

5.5 Geographic implications and travel

Recommendation R13 Travel and geography

Dietitians Australia recommends reviewing the 50 per cent travel payment limit against actual APD employment costs and comparable schemes to ensure sustainable home and community-based services, particularly in rural and regional areas.

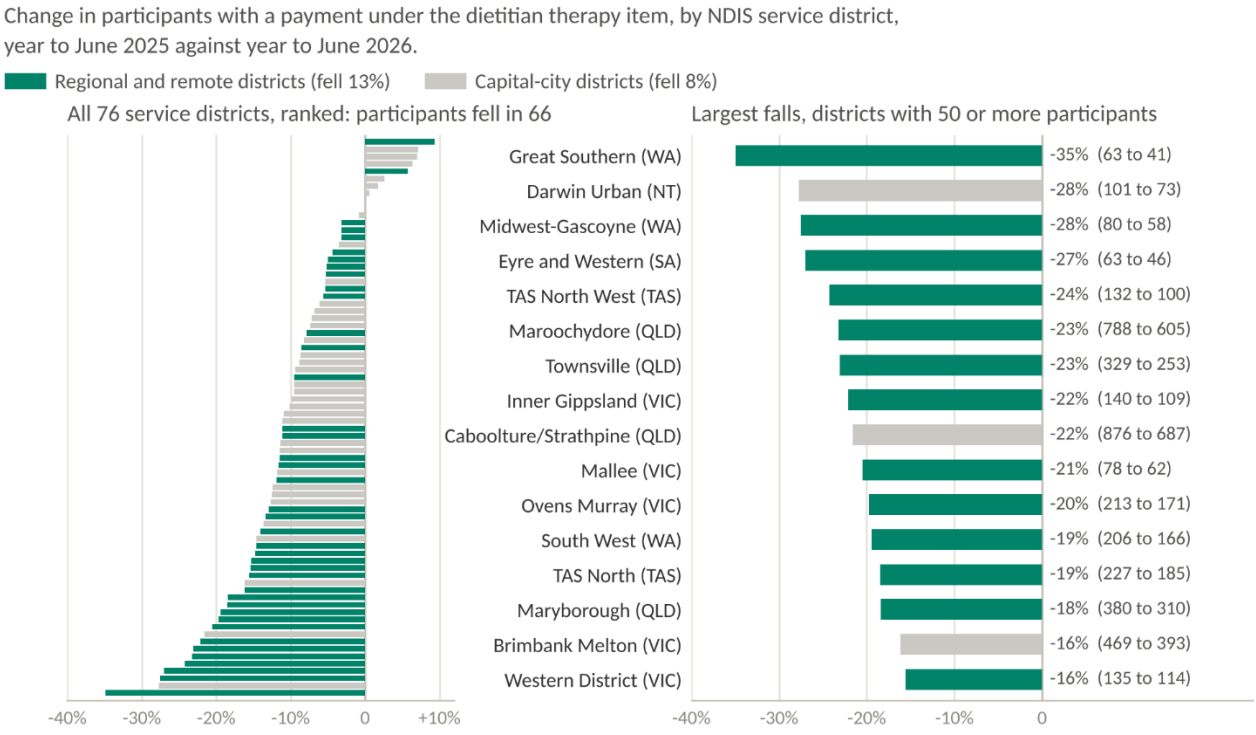
NDIS pricing must recognise geographic differences in the cost of service delivery: travel, workforce recruitment and access to experienced APDs. Telehealth cannot replace all in-person dietetic assessment and intervention, particularly for participants with complex nutrition and feeding needs. Members also described the difficulty of attracting APDs outside the capital cities and the need to pay above the HPSS Award to do so.

Rural retention is already fragile. In a study of public-sector allied health employment in regional, rural and remote southern Queensland from 2010 to 2021, dietitians had one of the shortest median stays in a location of any profession, 0.92 years against 1.53 years for social workers and 2.19 years for pharmacists, with half of those employed leaving within about a year of starting (Fallon et al., 2026).

Members described rural and regional services operate across several funding systems and carry longer travel, dispersed caseloads, specialised equipment, access to supervision and the need to maintain broad clinical skills. A rural provider may have a small NDIS caseload while being an important local source of experienced care.

Figure 7 shows that between the years to June 2025 and June 2026, participants with a payment under the main dietitian item fell in 66 of the 76 service districts analysed, and fell further outside the capital cities (13 per cent against 8 per cent). The largest falls were in regional districts: Great Southern and Midwest-Gascoyne in Western Australia, Eyre and Western in South Australia, north-west Tasmania, Townsville and Maroochydore (NDIA, 2026g). These are the communities with the fewest alternative providers, and the areas from which members report the greatest difficulty recruiting and retaining APDs. Participants there are also the most exposed when nutrition care is delayed, delivered outside dietetic scope or not delivered at all.

Figure 7: Dietitian participants fell in 66 out of 76 service districts analysed, and fell furthest outside metropolitan cities.



Source: NDIA payments datasets, June 2025 and June 2026 releases; Dietitians Australia's calculation (item 15_062_0128_3_3; districts with fewer than 20 participants in 2025 are omitted). Capital-city districts are the NDIS service districts covering Sydney, Melbourne, Brisbane, Gold Coast, Adelaide, Perth, Hobart, Darwin and Canberra; all others are counted as regional and remote. Over the same period occupational therapy participants fell in two districts.

Members reported that low or no compensation for travel limits home visits and participants' choice of setting. One practice owner reported in January 2026 ceasing site visits for about 65 per cent of clients after the travel changes; this is one provider's account, not a profession-wide estimate. Moving care to a clinic can shift costs onto participants and the Scheme, because some people need a support worker for the journey and the appointment. The cost of employing a clinician, and the practice's premises and other fixed costs, do not fall while the clinician travels, so lower travel payments reduce revenue without reducing the cost of delivering the service.

Box 6: Example - John

John has cerebral palsy, requires enteral feeding and needs Karen, an APD, to visit his home to assess feeding practices, equipment, nutritional risks and how support workers implement the nutrition care plan. Karen can use telehealth to support follow-up consultations but not for all consultations. Karen sometimes needs to visit John in his home for direct observation, hands-on training and assessment. In rural areas, reduced travel funding may limit access to these essential services, particularly where no alternative APD is available locally.

From 1 November 2026, Victoria's Transport Accident Commission (TAC) reimburses APD travel at $179 per hour, its hourly consultation rate, where the client cannot travel or treatment at home is clinically justified, and it pays reports separately (Transport Accident Commission, 2026). The same schedule replaces the TAC's previous highest dietitian item, a prolonged consultation of up to $121.68 for 45 to 60 minutes, with a complex consultation of up to $179 per hour, alongside an initial consultation of up to $112 and a standard consultation of up to $90 (Nous Group, 2026, Table 7; Transport Accident Commission, 2026).

The NDIS limits therapist travel payments to 50 per cent of the hourly price limit, about $89.50 for dietitians (NDIA, 2025). That does not cover the full employment and operating cost of an APD's travel, particularly after the Health Professionals and Support Services Award increases of 1 October 2026: superannuation, leave, insurance and overheads continue while the clinician is on the road. Members report clustering appointments and sharing journeys across participants to limit the loss.

6 Building the evidence base for the Therapy Pricing Review

6.1 Expand the Quality Supports Program Therapy Pilot to represent small practices

Recommendation R14 Evidence from the practices that deliver most dietetic supports

Dietitians Australia recommends that the NDIA fund complementary data collection or a dedicated pilot involving small and medium dietetic practices and sole practitioners that reflects the same quality as the current Quality Supports Program Therapy Pilot. This is consistent with AHPA's recommendation for a dedicated therapy pricing pilot for small and medium providers (AHPA, 2026, p. 4). This work should include registered and unregistered providers, rural and regional services, and practices supporting participants with complex nutrition needs. The NDIA should publish the sample characteristics, costing methods and limitations, and test whether salary, billable-time and overhead assumptions are appropriate for these businesses. The aim should be to establish the actual cost of delivering quality care, not to assume that smaller providers have lower costs or require a lower price.

Sole traders and small businesses represent over 80 per cent of the dietetic workforce; 74 percent of respondents to the Nous survey were sole traders (Nous Group, 2026, Figure 2) and 68 per cent of the 154 businesses in the national private practice dataset were sole traders (Kirkegaard, Clark, et al., 2026). Dietitians Australia supports the collection of provider financial and service-delivery data to inform pricing. The NDIA's Quality Supports Program Therapy Pilot began in March 2026 with 27 registered providers (NDIA, 2026a, p. 19), which have supplied financial reports, questionnaires, case studies and participant feedback. The NDIA will consider pilot findings alongside APR submissions, administrative and utilisation data, external benchmarks and targeted engagement in future pricing reviews (NDIA, 2026b).

However, findings from the pilot should not automatically be assumed to represent the costs of small dietetic businesses and sole practitioners. Important limitations and issues requiring further testing include:

- **Representation of small and unregistered providers.** The pilot comprises registered providers selected through a closed, non-competitive grant process (NDIA, 2026c), so it does not directly capture unregistered businesses, which the Provider Consultation Paper says are just over 90 per cent of therapy providers (NDIA, 2026d). Allied Health Professions Australia (AHPA) raised the pilot's focus on large providers in its February 2026 submission and called for funded research involving small and medium providers (AHPA, 2026, pp. 3-4).
- **Different ways of organising and paying for essential work.** Cost testing should examine how small practices manage administration, clinical supervision, professional development, compliance and service coordination. Where an APD personally does appointment management, invoicing and business administration, the absence of an administrative employee is not the absence of an administrative cost; the model should count the time and its effect on billable hours, without counting the same cost twice.
- **Unclear representation of dietetic services.** The NDIA's published pilot update names the participating organisations but not how many APDs, dietetic services or dietetic hours they represent (NDIA, 2026b). The NDIA should show that sufficient dietetic data have been collected,

including from small specialist practices and not only multidisciplinary organisations, before applying the findings to APD pricing.

The resources required to contribute reliable data. Participating pilot providers receive grant funding to offset the costs of working with the NDIA and collecting operational data (NDIA, 2026c). Complementary data collection involving small businesses should also provide practical support and proportionate compensation; otherwise the time required to prepare detailed financial and activity information will discourage participation and leave gaps in the evidence.

6.2 Priority data requests

Dietitians Australia has encouraged members to complete the NDIA's provider survey and has given them tools to do so. It asks to receive the raw survey data relating to APDs, so that it can assist the NDIA with interpretation and with future data collection.

Two further requests follow from the evidence in sections 3 and 4. The NDIA holds the only dataset that can show how many participants, providers and payments sit under the dietitian category over time and, since the 2026-27 claiming changes separated non-face-to-face activity, how much report writing and other non-face-to-face work is claimed. Publishing dietitian-specific results, alongside the analysis of provider exit that the June 2026 report gave physiotherapy, would answer the gaps identified in section 3.3. Salary, billable-time and overhead assumptions should then be established and validated against current APD practice data, with clear cost definitions, before they are used in any model (section 4.5).

7 Conclusion

NDIS pricing must reflect the cost of delivering safe, high-quality disability-related dietetic care. An hourly price limit is not a wage. It has to carry professional wages and on-costs, supervision, workforce development, administration, infrastructure, insurance, compliance, clinical governance and a reasonable margin, and it has to be indexed each year or its real value erodes.

The NDIA's own data show what happens when the price is set too low. In the year after the first reduction, 10 per cent fewer participants received dietetic therapy, numbers fell in 66 of 76 service districts and in nine of the ten largest disability groups, while occupational therapy and speech pathology grew and physiotherapy and psychology held. Participants did not stop needing nutrition care; it moved to professions paid at a higher rate and without dietetic training, or it stopped.

Adequate nutrition is the base on which the other supports the Scheme funds depend. Physiotherapy, occupational therapy, exercise programs and capacity building are less effective, and cost more, for a participant who is malnourished, dehydrated or losing weight. Undervaluing dietetic care undermines that wider investment, and the cost falls on participants through reduced access, fewer providers, disrupted care and poorer health, most heavily in regional and remote communities.

Dietitians Australia therefore asks the NDIA to restore the dietitian price limit to $188.99 from 1 July 2027, index it annually, make no further reduction while the Therapy Pricing Review is under way, and use that review to build, with the profession, a transparent cost model that prices the full scope and complexity of disability-related dietetic care.

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Appendix A: Specifically addressing the NDIA consultation survey

The NDIA's Provider Consultation Paper asks eighteen questions about therapy supports. Dietitians Australia is a peak body rather than a provider, so the operational questions are answered for the profession as a whole. The table shows where each question is addressed in this submission.

Q	NDIA question (abridged)	Where it is answered
1	Does your organisation provide therapy supports?	Section 2.1. Dietitians Australia is the peak body for the dietetic profession; its members deliver dietetic therapy supports to NDIS participants.
2	Which therapy supports does your organisation provide?	Section 2.2: dietary support, delivered by Accredited Practising Dietitians (APDs).
3	Which therapy support items does your organisation provide?	Section 2.2 (assessment, recommendation, therapy and training supports delivered by dietitians).
4	How many therapists (FTE) did your organisation employ in 2025-26?	Sections 3.5 (Table 3), 3.6 and 6.1: most dietetic providers are sole traders and small practices.
5	Do you provide therapy supports in rural, remote or very remote areas?	Section 5.5.
6	In which settings do you mostly provide therapy supports?	Sections 2.2 and 5.5.
7	What is the typical wait time for an NDIS participant?	Section 3.6.
8	Average face-to-face session length	Section 4.1, Table 4.
9	Average time billed per session, including travel and report writing	Section 4.1, Table 4.
10	Average percentage of paid hours billed to NDIS participants	Section 4.2, Table 5; Section 4.5, Table 9.
11	Percentage of billable hours spent face-to-face	Sections 4.1 and 4.3.
12	Percentage of billable hours spent travelling	Section 5.5.
13	Changes since the 2025-26 travel provisions	Section 5.5.
14	Percentage of billable hours spent on report writing	Sections 4.1, 4.3 and 4.4.
15	Does NDIS price guidance reflect the cost of delivering therapy supports?	Sections 1 (R1), 4.6 and 4.7.
16	Which costs do NDIS prices not cover?	Sections 4.3 to 4.7 and Appendix C.
17	Has your organisation not provided supports because of the price?	Sections 3.5 (Table 2) and 3.6.
18	Anything else about pricing for therapy supports	Sections 1, 3, 5 and 6.

Appendix B: Disability Role Statement for APDs

Source: Dietitians Australia, Disability Role Statement. This role statement was developed by members of the Disability Interest Group. It lists the knowledge and skills of an Accredited Practising Dietitian (APD) working in the disability area.

Knowledge

- Nutrition-specific evidence relating to a specific disability and implementation of evidence informed practice including regular review and reflection on outcomes.
- Impacts, interactions and side effects of medications, diet modifications, particular foods, fluids, nutritional supplements and thickeners that may be commonly used in the care of people with a disability.
- Popular diets and nutrition misinformation relating to specific disabilities.
- Policies, procedures and guidelines relating to health care in disability in line with the mandatory organisation/site specific, state and federal policy directives (for example, use of restricted or restrictive practice).(1-4)
- Disability-related funding that may impact an individual's access to health and dietetic care (for example, National Disability Insurance Scheme) and requirements of dietitians in relation to this including realistic implementation within community settings.(5)
- Awareness and utilisation of the International Classification of Functioning to inform nutrition assessment, care plans and decision making.(6)

Skills

- Consideration of accurate and relevant data, unique features of the client's disability, and related nutrition impact symptoms, physical and cognitive limitations, and communication difficulties when conducting a nutrition assessment and developing a plan.(7,8)
- Ability to determine health priorities for complex disability clients with multiple comorbidities using evidence base and clinical experience to inform practice.
- Ability to ethically work with clients with a disability who have intellectual/cognitive/memory impairments, behavioural disturbances and mental health co-morbidities. For example, working within scope of practice as part of an interdisciplinary team, delivering person-centred care using social justice principles, understanding informed consent and supported decision-making, and that behaviours are a form of communication.
- Assess the capacity and capability of people with a disability and/or their carers to follow dietetic recommendations and adjust interventions accordingly.
- Collaboration with clients, families, group homes, client support networks and interdisciplinary disability related health teams working within the person-centred practice paradigm, considering the individual's needs, abilities, preferences, choices and aspirations.
- Confident identification of the most appropriate method to effectively communicate with clients, families and/or support workers with a range of cognitive abilities to deliver disability-specific nutrition recommendations using evidence-based reasoning.

Activities entry level APDs would conduct

- Nutrition assessment utilising the most appropriate methods, intervention and monitoring considering key disability-specific issues (for example, dysphagia, mealtime behavioural issues, menu choice, supports in day-to-day life, cognition, fluctuating health, level of intellectual

impairment and client capacity to self-monitor, client access to services, communication or environmental stressors).

- Provide nutrition therapy for individuals with disabilities without complex comorbidities (for example, enteral feeding regimens, food fortification, healthy eating, food aversions, food allergies, mealtime management plans).
- Referral to and coordination with specialist/support services available for people with disabilities.
- Ability to work within scope as part of an interdisciplinary team, and appropriately identify when to refer on and/or be guided by more experienced clinicians (for example, inborn errors of metabolism or management of a ketogenic diet for epilepsy).
- Provide consultation and recommendations for meal planning in disability-related residential and respite facilities.

Activities APDs working at a higher level would conduct

- Provide nutrition therapy for individuals with disabilities who have complex comorbidities (for example, eating disorders, psychiatric illness with behaviours of concern, metabolic conditions including phenylketonuria (PKU)).
- Intuitively utilise advanced nutrition and dietetic skills acquired, and recognise other clinicians' knowledge and skills to successfully problem solve and implement effective interventions.(7,8)
- Facilitate a transdisciplinary approach when working with individuals with disabilities to implement holistic strategies that promote wellbeing.
- Design, develop and actively participate in research that informs policies and best practice for people with disabilities.
- Ability to confidently communicate at organisation and government levels to advocate for disability-specific nutrition priorities with evidence-based reasoning.
- Act as a nutrition resource to dietitians and members of the interdisciplinary team on application of disability related nutrition protocols and guidelines to an individual client or population. This includes the mentoring/supervision of students or less experienced dietitians as well as other health professionals.(7,8)

Activities APDs working in this area of practice do not usually undertake

- Assessments of swallowing or making food texture and fluid thickness recommendations.
- Assessments of safety and functioning while cooking.
- Assessments of physical activity capacity.
- Assistance with feeding at mealtimes.

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Appendix C: Cost components of an established multi-site dietetic practice, mapped to the DSW Cost Model

This is an example only and further consultation should occur with Dietitians Australia and senior APDs with extensive experience in disability. The numbers provided below represent one organisation. This appendix sets out the costs of delivering NDIS dietetic services as reported by an established multi-site dietetic practice, organised around the five components of the Disability Support Worker Cost Model. The figures are indicative business costs for one organisation and will vary according to the size, scope and registration requirements of individual providers.

1. Base salary cost component

The base salary assumption should reflect the remuneration required to attract and retain experienced APDs working in complex disability services. Modelling should include a base salary using an AQF Level 9 qualification benchmark and a clinician with seven or more years of professional experience, reflecting the senior workforce required to provide complex disability nutrition care. This should be a workforce pricing benchmark rather than a claim that every dietitian is legally classified at AQF Level 9.

Disability dietetics requires advanced clinical reasoning, complex assessment, risk management, communication with multidisciplinary teams, and experience supporting participants with significant functional, cognitive, behavioural and medical complexities. Experienced clinicians are essential for managing complex presentations, providing supervision to junior staff and maintaining quality and continuity of care.

The 2026 Fair Work Commission review of the Health Professionals and Support Services Award is particularly relevant. It recognised historical gender-based undervaluation of health professional work and introduced revised classification and remuneration arrangements, with staged wage increases. NDIS pricing must respond to these changes and recognise the true cost of employing and retaining skilled health professionals. Using a lower-level salary benchmark risks creating an ongoing gap between NDIS funding and the remuneration required to sustain an experienced disability workforce.

2. Direct on-costs

The full cost of employing an APD extends considerably beyond their base salary. Employment costs include:

- Employer superannuation contributions, currently 12%.
- Annual leave, personal leave, compassionate leave and other statutory leave entitlements.
- Leave loading where applicable.
- Workers compensation insurance.
- Payroll tax where applicable.
- Recruitment, induction and mandatory employment training.
- Continuing professional development and clinical supervision.

In one organisation, they budget approximately $2,400 per clinician annually for clinical supervision, together with $1,200 annually for professional development. These are necessary investments in clinical competence, quality, staff retention and safe service delivery, particularly for clinicians managing complex disability presentations.

The model must also recognise the impact of paid leave and professional development on available billable hours. Employees continue to incur employment costs during periods when they are unable to generate revenue. Clinical supervision, training and professional development are particularly important

for maintaining a skilled disability workforce and should be adequately recognised within the pricing structure.

3. Operational overheads

Operational overheads are substantial for organisations delivering community-based disability dietetic services. For a medium-sized allied health practice, premises and utilities alone can exceed $80,000 annually. Other costs include:

- Client care and reception staff.
- Appointment scheduling, cancellations and rescheduling.
- Practice management and clinical documentation software.
- Telehealth systems and secure communication.
- Clinical resources, assessment equipment and consumables.
- IT hardware, maintenance and technical support.
- Secure storage and management of participant health information.
- Travel coordination and community service delivery.
- Clinical administration and service coordination.

Costs for IT subscriptions and systems supporting secure patient records exceed $2,000 annually per clinician, before accounting for all associated equipment, hardware and other technology expenditure.

A significant issue is the assumption of billable utilisation. A standard full-time clinician works approximately 38 hours per week, but only a proportion of these hours can realistically be billed. Using an illustrative 65% utilisation rate, a clinician would generate approximately 24.7 billable hours per 38-hour working week. The remaining time is required for clinical preparation, documentation, team meetings, supervision, professional development, administrative tasks, service coordination and other essential activities. For sole practitioners, billable utilisation may be even lower because they must also undertake invoicing, bookkeeping, marketing, appointment administration and business management.

In disability dietetics, the complexity of participant needs can increase the time required for communication with support coordinators, families, carers, support workers and other treating health professionals. Some of this work may be billable when it meets NDIS requirements. However, substantial operational and administrative activities remain necessary and cannot consistently be recovered through participant billing. The pricing model must be based on realistic, evidence-informed utilisation rather than assuming that most paid working hours generate revenue.

4. Corporate overheads

The current pricing structure must adequately recognise the cost of operating a registered, compliant and professionally governed NDIS provider. Registration creates significant financial and administrative obligations. Based on one organisation's experience and size, initial NDIS registration involves approximately:

- $5,000 in internal staff and management time preparing documentation, systems and evidence.
- $3,000 in initial registration-related fees and external costs.
- Ongoing expenses associated with maintaining and updating policies, procedures, quality systems and compliance documentation.
- Approximately $2,000 in re-registration-related costs every three years, in addition to internal preparation and management time.

These are indicative business costs and will vary according to the size, scope and registration requirements of individual providers. There are also ongoing costs for professional indemnity and public liability insurance, professional memberships, and maintaining appropriate professional credentials. At an individual level it would cost per clinician approximately $3,000 annually for insurance and relevant professional memberships and registrations. Other essential corporate expenses include:

- Legal advice and professional services.
- Accounting, bookkeeping and financial reporting.
- Human resources and employment law advice.
- Payroll and employment compliance systems.
- NDIS quality and safeguarding compliance.
- Worker screening and associated administration.
- Incident management and complaints handling.
- Privacy, data security and cybersecurity.
- Policy development, internal audits and continuous quality improvement.
- Business management and clinical governance.

These expenses are required to operate responsibly and comply with the expectations placed on registered NDIS providers. The cost of compliance should be recognised as a legitimate component of service pricing, rather than absorbed entirely by providers through reduced financial returns.

5. Margin

A sustainable commercial margin is essential for the ongoing viability of NDIS dietetic services. Margin needs to be calculated after accounting for fair clinician remuneration, employment on-costs, operational expenses, corporate overheads and realistic billable utilisation. It supports:

- Reinvestment in clinical services and equipment.
- Workforce recruitment, retention and development.
- Financial reserves for periods of reduced demand.
- Managing cancellations and unexpected expenditure.
- Expansion into underserviced communities.
- Investment in quality improvement and service innovation.
- Maintaining continuity of care for participants.

Private practice providers assume substantial financial and operational risks, including employing staff, maintaining premises, meeting regulatory requirements and managing fluctuations in participant demand. A sustainable margin allows organisations to manage these risks and continue investing in their workforce and services. Pricing that only allows a business to break even creates significant vulnerability and limits the capacity to maintain and expand access to quality disability dietetic care.

Conclusion

Without appropriate recognition of these costs, NDIS providers face increasing pressure to reduce investment in staff, supervision, professional development and quality systems, or to reconsider their capacity to continue providing disability services. This ultimately creates risks for participants, including reduced access to experienced APDs, longer waiting times, reduced provider choice and disruption to continuity of care.

Appendix D: Enteral feeding

Source: Dietitians Australia, Enteral nutrition.

Key points

- Enteral nutrition is used when a person has trouble meeting their nutrition needs orally.
- Enteral nutrition comes in the form of liquid formulas given through a feeding tube.
- Tube feeding delivers nutrition directly into the stomach or small intestine.
- Common reasons for tube feeding include swallowing problems, critical illness, and treatments affecting the ability to eat like radiotherapy to the head and neck area.

Details

Enteral nutrition or tube feeding is a method of supplying nutrition through a feeding tube. This tube goes directly into the stomach or small intestine, bypassing the mouth and oesophagus. It is an option when adequate nutrition cannot be taken by mouth. But otherwise, a person's gut is still working normally to digest and absorb food. Enteral nutrition may make up a person's entire nutrition needs or can supplement what they eat and drink by mouth.

Enteral nutrition formulas are a liquid food that are high in energy, protein and other nutrients that complement a person's normal diet. There are commercial enteral formulas available and they can also be homemade.

Interest in blenderised tube feeding (BTF) is growing. BTF is feeding by the use of blended foods and liquids given directly into the feeding tube. The food could be homemade, commercial formula mixed with pureed baby food or any of the variety of commercially available ready-to-use BTFs. There are potential drawbacks to the use of BTF including the increased risk of bacterial contamination, greater risk of clogged feeding tubes and more effort involved in the preparation of the feed. This is where dietitians can help advise on the most appropriate type of food or formula for a person and tailor the advice to the needs of the individual.

If a person can't absorb nutrients because of problems such as blockage or disease in parts of the gastrointestinal tract, then nutrition needs to be given directly into the bloodstream. This type of feeding is called parenteral nutrition.

Reasons for enteral nutrition

A person needing tube feeding usually has a condition or injury that prevents them from eating an adequate regular diet by mouth. Common reasons for using this type of nutrition include:

- stroke or other neurological conditions which impair swallowing
- after some types of operations to the head, neck or stomach
- after radiotherapy to the head and neck area
- being unable to consume adequate nutrients
- severe illness or injury which reduces the ability to eat
- poor growth (failure to thrive) or inability to eat in young children or infants.

Types of feeding tubes

There are two different groups of feeding tubes.

Nasogastric and nasojejunal feeding tubes

The first type makes use of the nose to pass a feeding tube into the stomach (nasogastric tube) or small intestine (nasojejunal tube). Specialised liquid nutrition formulas or blenderised tube feeds can then be given through the tube. This type of feeding is generally used for short-term situations where the person is likely to return to oral eating within weeks.

Gastrostomy and jejunostomy feeding tubes

The second type delivers nutrition through the abdominal wall into the stomach (gastrostomy tube) or small intestine (jejunostomy tube). This type of feeding is used when it is likely that a person's ability to eat will not recover quickly or may not recover at all.

Feeding tubes are usually inserted during a person's hospital stay. But feeding through the tube may continue after a person returns home or to a nursing facility. If tube feeding support is provided at home, this is known as home enteral nutrition (HEN).

Dietitians are normally involved in all stages of the enteral nutrition process. A dietitian will assess a person to see if enteral nutrition is suitable for them. Dietitians are also involved in the monitoring of the feeding and supporting the person if they return home and still need tube feeding.

Risks to do with tube feeding

Even when it is medically appropriate to use, enteral nutrition is not without its risks. People with a feeding tube are at risk of complications such as aspiration where the feed goes into the airways. There can also be the risk of infection of the feeding tube at the place it is inserted. The physical presence of a feeding tube can also be a source of irritation or pain. Diarrhoea, constipation, nausea and bloating are also common problems that a person may experience.

When to see a dietitian

Enteral nutrition needs the help and support of a professional. An Accredited Practising Dietitian (APD) can help you meet your individual needs. We recommend seeing a dietitian if you:

- would like advice on whether you need tube feeding
- need advice to help ensure you're meeting your individual nutrient needs
- are experiencing problems with your current enteral nutrition regimen
- would like personalised advice and support from a professional.

APDs are university-trained nutrition experts. They can help you with personalised, easy-to-follow and evidence-based advice.