A National Disability Insurance Scheme: What Social Work Has to Offer

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Abstract

This paper appraises key features of the recently proposed National Disability Insurance Scheme (NDIS) in Australia and explores underpinning conceptualisations of ‘disability’, ‘autonomy’, ‘choice’ and ‘assessment’. In particular, it examines the ways in which the Scheme reconfigures a continuation of individualised payments and care package policies. These proposals can be seen to have international significance in terms of how new policy is formulated and also implemented in this controversial field. It is argued that, by utilising embedded human rights perspectives, social work practice principles and social model understandings of disability, social workers can play a crucial role in reframing the opportunities presented by key policy changes.

Keywords: Disability, social constructionism, insurance, self-determination, choice

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Introduction

In July 2011, the Australian Government Productivity Commission released its report on Disability Care and Support (Australian Government Productivity Commission (AGPC), 2011) recommending the establishment of a National Disability Insurance Scheme (NDIS) by the Federal...
Government. The Prime Minister, Julia Gillard, announced a commitment to move towards implementation of the scheme, promoted as a radically new and progressive policy direction. An advisory group was established to work on detailed implementation planning and the scheme was endorsed as a key policy initiative for the government at the Labor party conference in December 2011.

This paper looks specifically at the proposed NDIS in Australia but has a much wider-ranging relevance in terms of exploring underpinning conceptualisations and policy and practice developments in this often ignored yet controversial area. Accordingly, it addresses two key questions. The first relates to access and equity implications given the emphasis on individual budgets and consumer choice. The second looks pertinently at what the social work profession has to offer in terms of influencing and implementing such schemes.

The NDIS proposal: the Australian context

At this point, it is useful to provide a brief overview of the NDIS as presented in the Productivity Commission report and to identify how the proposed scheme differs from the current system of disability support in Australia. However, we do need to point out that, as the Productivity Commission provides a detailed proposal for the NDIS in over 1,000 pages of report documents, it is clearly beyond the scope of this paper to examine the proposed scheme in its entirety. As a result, we have narrowed our focus to answering the two key questions highlighted above and, as part of this process, we examine conceptualisations of ‘disability’, ‘autonomy’, ‘choice’ and ‘assessment’, which are central to the NDIS and also to policy and practice in this field worldwide.

Whilst a national disability insurance scheme is a new development in Australia, the adoption of individualised payments as a central feature of the scheme can be seen to reflect the continuation of both national and international policy trends. Associated with this, the funding of budgets for individuals who are then able to purchase their own services, rather than the funding of government or non-government organisations to provide services, can be seen to retain a grounding in neo-liberal, consumer ideals that rely on responsive providers. Individual budgets clearly suit many but, we argue, also contain the inbuilt potential to further alienate marginalised groups. This potentiality can be seen to be of particular concern to the profession of social work. Accordingly, within this paper, we seek to draw attention to the opportunities and constraints posed by individualised budgets and the NDIS and to explore the different ways in which social work can be positioned and also exert agency in relation to these.
It is notable that, in Australia, the Productivity Commission presents the NDIS as an alternative to the current system for providing disability support services, with the prevailing system universally being seen as inadequate, inequitable and underfunded. Through the proposed NDIS and a substantial allocation of Federal revenue, people would be entitled to funding to engage non-clinical community support services if they have a permanent disability that leads to ‘significantly reduced functioning in self-care, communication, mobility or self-management and require significant ongoing support’ or would benefit from early intervention (AGPC, 2011, p. 174). Currently, community support services are provided by a myriad of government and non-government organisations across Australia funded mainly by state government block grants. Historically, these services have emerged in response to locally identified needs and organisations have been sustained by government funding allocations and grant programmes. The service system is fragmented with inconsistencies in the levels and types of services offered to different geographic locations and for different types of disabilities and support needs. Organisations apply a variety of assessment procedures and eligibility criteria that adds further to access and equity concerns.

The NDIS is proposed to operate alongside compulsory Workcover and Motor Vehicle Accident insurance schemes, although the creation of a National Injury Insurance Scheme (NIIS) is recommended to cover catastrophic injuries, including catastrophic but not routine workplace claims. This would mean that the NDIS would operate alongside the NIIS and no-fault, non-catastrophic Workcover arrangements, leaving room for possible dispute and contention.

The proposed NDIS provides three tiers of intervention. Tier 1 is targeted at all Australians by providing insurance and reassurance that, should a significant disability be acquired, they will be entitled to support services. In this regard, the scheme is universal. Through engagement with existing disability organisations, the promotion of opportunities for people with a disability, and awareness-raising campaigns, the Productivity Commission proposes that this tier of activity will ‘seek to minimise the impacts of disability for all Australians’ (AGPC, 2011, p. 159). It is argued in the report that Australians value insurance and, with appropriate promotion of the NDIS as an insurance product that ‘pays out’ if the risk of disability is realised, then taxpayers will support tax contributions to the scheme in the same way that insurance premium payments are supported. Whilst the Productivity Commission report advocates capacity building, community participation and the promotion of the social inclusion agenda for people with a disability, and refers to a range of existing projects, there is little in the way of strategy as to how these broader structural goals are to be achieved. In comparison to the individualised budget component of the NDIS, discussed below, ‘the associated costs would be small and in some cases would come from existing resources’ (AGPC, 2011, p. 159).
Tier 2 of the scheme would provide information and referral services to people who are affected by disability, but not at the level that would qualify for individualised budgets for support services. The types of services to which people would be referred include mainstream health, housing, education, employment and community-based services. Again, the costs for Tier 2 are not proposed to be high.

It is clear from the Productivity Commission report that Tier 3 of the NDIS is where attention has been focused and where most of the resources will be directed. Tier 3 entails a standardised approach to the assessment of the support needs of people with ongoing disabilities that have a significant impact, with the allocation of individual budgets to fund reasonable care and supports. It is estimated that around 410,000 people will have individual budget allocations to engage support services under Tier 3 of the scheme if it is implemented (AGPC, 2011, p. 160). Consumer choice is at the forefront of the Productivity Commission rationale for the provision of individual budgets, with individual decision making about service providers identified as an important source of personal power. Once an individual is assessed as requiring an individualised ‘care package’ or programme of support services, they are able to choose formal or informal providers using a voucher system and to switch providers when they wish. Individuals will also have the option to cash out their package (‘self-directed funding’), design their own support requirements and purchase them in a way that suits them best. Organisations providing services to people with disabilities would compete in the open market to attract the insurance-package dollars from individuals. If the individual is not able to manage a care package or engage providers themselves and does not have a suitable carer to do this, the NDIS would engage an independent broker. The argument presented by the Productivity Commission is that individual budgets operated by a voucher system offer the greatest control by individuals with a concomitant focus on the requirements of individuals rather than the requirements of organisations. There are, however, limits to consumer choice and the association between consumer choice and personal power is not a simple one. Before looking more closely at the limitations of consumer choice in relation to individual budgets, we outline the theoretical and value base that underlies our approach to disability followed by a brief overview of prior literature on personalisation and individual budgets.

**How we understand ‘disability’**

Although the term ‘disability’ is often applied in policy and practice settings in an unproblematic and straightforward manner, the disability literature highlights that this is far from being the case. Generally, clinically or individually orientated applications tend to equate disability with impairment and emphasise individual and pathological aspects and deficit. Many
medical sociologists also accept this individualised meaning and focus on exploring the consequences of disability and its causes at social and personal levels (Thomas, 2007). However, proponents of the social model of disability, as developed by key figures in the UK such as Oliver and Sapey (2006), Oliver (2009), Barnes and Sheldon (2010) and Morris (1993a, 1993b) challenge individualising/medicalised perspectives and emphasise instead how people with impairments are disabled by socially constructed oppressive barriers. Accordingly, disabled people are not disabled by impairments, but are subject to forms of ableism that serve to exclude, disadvantage and oppress (Abberley, 1987; Oliver and Sapey, 2006; Oliver, 2009). The social model of disability rejects interpretations which foreground on personal tragedy and the importance of coming to terms with and overcoming the effects of personal impairments and instead look to challenging and changing disabling social, political and economic barriers and campaigning for citizenship rights.

In Australia, as Fawcett et al. (2010) point out, the social model has not been as widely influential as it has been in the UK. As a result, in some settings, ‘social’ understandings of disability refer to the social dimension incorporated within clinical bio–psycho–social frames of reference rather than to challenging disabling constructions. The preferred term in Australia is ‘person with disabilities’ and, although this acknowledges that the person takes precedence over the ‘disability’, it does little to challenge the individual/medical/impairment frame of reference for understanding disability in Australia generally.

Differences can also be brought to the fore by looking at varying understandings of ‘independence’ and ‘autonomy’. Proponents of the social model view ‘independence’ as something which disabled people, located within clinical/individualised frames of reference, are exhorted to continue to strive for, even if this means spending long hours dressing or engaging in what can be seen as unproductive activity. Clinical/individualised conceptualisations place emphasis on a ‘person with disabilities’ living as ‘normal’ a life as possible, with ‘normal’ being continually defined by non-disabled people. This view reinforces incapacity and lack rather than highlighting capacity and opportunities. Accordingly, a focus on living a ‘normal life’ is seen to perpetually locate a ‘person with disabilities’ within a deficit-orientated space. In contrast, within a social model understanding, ‘autonomy’ and ‘self-determination’ are prioritised and it is the disabled person who unilaterally takes control, by defining what quality of life means to them, by utilising and directing personal assistance and by accessing other services where necessary.

Adding to this discussion on understandings of ‘social’, it is notable that Munford and Bennie (2009), from an Australian and New Zealand perspective, differentiate between a ‘social’ and a ‘political’ orientation. Although there are similarities in their definition of medical understandings, they equate a ‘social’ approach with the assimilation of disabled
people into the dominant culture with the consequent devaluing of disabling barriers. However, they view a ‘political’ model as one that challenges the disabling constructs that limit opportunities and autonomy. This perspective has a clear resonance with what we are referring to here as the social model of disability. We also acknowledge that a social model of disability needs to take account of differing experiences of impairment, but, like Shakespeare (2005), we recognise the importance of social and rights perspectives if social justice concerns are to be identified and addressed.

Different understandings of disability clearly have a bearing on policy as well as on policy implementation and on practice. The NDIS fits within a social model to the extent that a national insurance scheme brings entitlement to support, but critical to this will be the way in which eligibility is assessed. It is notable that the NDIS retains a clinical/individualised focus for Tier 3 whilst also utilising the language of social inclusion and overcoming discriminatory barriers in relation to Tier 1. This raises the question as to whether the NDIS, with its emphasis on determining individual budgets in line with standardised assessment of functional capacities and needs, will mark a shift in perspective in Australia or whether it will serve only to add a veneer of inclusivity to existing values and perspectives on disability that focus on medicalised, ‘impaired’ individuals, rather than disabling social barriers. The answer to this question can be seen to lie with the implementation details associated with assessment and with Tier 1 strategies that challenge disabling social barriers.

‘Personalisation’ and individualised payments

A national scheme that provides entitlement to disability support services would be a welcome shift in approach for Australia, as it is more closely aligned with a human rights stance. An injection of funds to build up the level and coverage of support services is also badly needed. Whilst the individual budget is a central feature of the proposed NDIS, individual budgets are not a necessary component of a national scheme. Individual budgets have, however, become the policy trend of the twenty-first century and the NDIS has fallen squarely in line with this. In this section, we offer a brief overview of literature on the history and issues associated with the implementation of individual budget schemes.

Most Australian states have adopted some type of individualised budget scheme, either as care packages or as Direct Payments to individuals, but these have largely been pilot projects with selective, voluntary participation by individuals (Chenoweth and Clements, 2009; Fisher et al., 2010). Individualised payment schemes have also been embraced in the UK, but, again, the ‘service as usual’ option to an individualised budget remains available (Riddell et al., 2005). Research into the effectiveness of Direct Payments
and individual budgets has shown some positive outcomes, including increased life satisfaction, well-being, independence and continuity of care (AGPC, 2011; Fisher et al., 2010; Netten et al., 2011), but the programmes that have been evaluated offered recipients a choice in taking up an individual budget rather than receiving services as a client of an organisation/s. In contrast, the NDIS proposes the adoption of individual budgets for all people in Tier 3 of the scheme. The choice would be between an individualised package of supports with vouchers to engage a choice of providers and a self-directed budget to purchase supports and services of choice. Research in the UK has found differences between groups in terms of the level of interest in and uptake of individualised payment schemes and in the levels of anxiety, control and well-being associated with individual budget uptake, raising concerns about whether a ‘one size fits all’ approach is appropriate (Netten et al., 2011; Riddell et al., 2005).

Scourfield (2010) traces the development of Direct Payments in the UK. Originally, at their inception in 1996, these were aimed at younger disabled people to promote independent living by engaging personal assistants and, although there were undertones of a market/liberal ideology, the social model of disability and human rights perspectives were foregrounded. Subsequently, both in Australia and in the UK, individual budgets have become enmeshed with policy principles about ‘personalisation’ or ‘person-centred care’ (Carr, 2010; Chenoweth and Clements, 2009; NSW Government, 2010). Placing the person with the disability at the centre of decision making about their lives sits well with social work practice and the principle of self-determination. It would be wrong to assume, however, that a direct individualised payment scheme necessarily equates with a person-centred approach. As the following discussion conveys, there is more to personal control than having a budget allocation and the choice of service providers. If personalisation becomes aligned with individual responsibility, at the expense of social responsibility, advocacy and community capacity building, then strong cause for concern emerges there is reason for concern.

**Does choice equate with control?**

An intended outcome of the NDIS, according to the Productivity Commission, is an increase in power and control for people with disabilities in Tier 3 of the scheme. In the NDIS proposal, power and control are linked primarily with the provision of opportunities to exercise consumer choice. Whilst it is recognised in the Productivity Commission report that consumer choice is only one aspect of power, a structural analysis of power is not evident and nor is a social or political perspective on disability and disablism. The NDIS proposal is grounded in an individualised view of disability that offers consumer purchasing power and choice as a means to empowerment. Shifting
the responsibility for choosing services to the individual, however, also carries the risk that the market will not deliver the required services.

Gabrielle Meagher (2010) looks at the concept of choice from liberal/market and human rights frames of reference. From both perspectives, choice is seen as ‘a good in itself’, although the origins differ. A liberal/market approach has a top-down emphasis, with a consumer being seen as an atomistic agent with wants, whereas the human rights perspective operates from the bottom up, viewing an individual as a person with rights. The current impetus for direct individual payments reflects these different underpinnings. Although it is not unusual for policy momentum to reflect differing ideologies and stances (this can be seen in the movement towards deinstitutionalisation in the 1980s and 1990s), with regard to the provision of direct individual payments or ‘cash for care’, differing perspectives can lead to very different outcomes.

When a liberal/market perspective is adopted and the individual is defined as a consumer, outcomes are likely to reflect the structural disadvantages and access inequities evident in wider free market systems. The market is under no obligation to respond to the wants and needs of individuals and will only do so if it is economically worth the effort. In relation to individual budgets, those who do well in negotiating with providers are likely to be those who are advantaged by education, English literacy, financial resources, gender, transport, geographic location, family supports and access to technology. The voluntary nature of individualised payment schemes in the UK has resulted in non-uniform levels of uptake and outcomes across different groups in terms of age, ethnicity and type of disability, suggesting that individualised payments schemes may be more attractive to particular groups and potentially place other groups at a disadvantage (Chenoweth and Clements, 2009; Dowse, 2009; Netten et al., 2011; Riddell et al., 2005). Whilst it appears that many will experience an improved quality of life as a result of controlling an individual budget or package, positive outcomes cannot be assumed for the marginalised groups who experience other structural disadvantages alongside disability. This question of who misses out in a free market model is of particular concern for the social work profession, which seeks to redress disadvantage and marginalisation. The NDIS proposal does recognise that there are particular historical disadvantages faced by the Indigenous Australian population in accessing services and supports. Specific strategies and programmes are recommended by the Productivity Commission to supplement or as alternatives to the individual budget scheme for Indigenous Australians. This does, however, beg the question as to whether there are other marginalised groups that would also benefit from more flexible, alternative strategies to address structural disadvantages in accessing mainstream programmes.

The broker system proposed for the NDIS is one way in which the rights of those less able to negotiate the service marketplace could be realised.
The brokerage option has also gained popularity in the UK (CSCI, 2006; Scourfield, 2010). The aim of brokerage is to support individuals to navigate and choose the assistance that best meets their needs with the individual retaining control. However, commentators such as Beresford (2007) have highlighted the possibility of slippage with regard to control, with brokers and ‘carers’ unintentionally and perhaps intentionally eroding autonomy and self-determination.

Another concern with the liberal/market perspective is that, whilst consumer choice is promoted, the limits to choice are inadequately dealt with. Choice making is a multi-faceted and complex process shaped by knowledge, values and other contextual factors. Choices are made in relation to a myriad of aspects of one’s life, some more meaningful than others (Rabiee and Glendinning, 2010). There is an assumption that, if consumers need and are willing to pay for a service, then the marketplace will respond by generating appropriate services to purchase. The reverse, however, can also occur where marketing strategies can shape consumers’ perspectives of what they need and hence work to rationalise service provision (Dowse, 2009). Overall, there is no guarantee that the scope and quality of services will be adequate to meet requirements. Some research indicates that when support services are opened to private enterprise, for-profit providers tend to be of poorer quality than not-for-profit and government services (Meagher, 2010). Even with an equitable distribution of individual funding packages across the nation, it may not be economically viable for organisations to provide certain services, such as in rural and remote areas, and consequently choice for consumers diminishes. The quality and diversity of services accessible to some people may be so limited that their ‘consumer choice’ is in fact meaningless.

The Productivity Commission report acknowledges the potential for ‘fake’ choices, and also choice ‘overload’ at the other end of the continuum. The report proposes a system of local area coordination and the development of personal plans as strategies to avert these scenarios. The approach taken to local area coordination will be crucial in addressing access, equity and marginalisation issues in the implementation of the NDIS. As discussed later in this paper, social workers have much to offer local area coordination roles, if an advocacy and rights framework is adopted.

The Productivity Commission proposes that the quality of services would also be monitored and addressed by a national data collection system and the publication of outcome results for consumers to appraise. How such strategies are implemented, including the practice principles that guide implementation and the level of resources, will determine whether the pitfalls associated with a free market model are adequately addressed. If the NDIS is rolled out, this is also an important area for input by the social work profession. In particular, there is room to balance the free market perspective, with a bottom-up human rights perspective that seeks real input and
direction from disabled people in the monitoring and development of services, moving beyond an individualistic consumer perspective.

Drawing from the previous discussion, the NDIS proposal has a clear resonance with liberal/market directives. The individualisation of service agreements and the privatisation of services do not necessarily provide avenues for consumer-driven approaches to service provision. Rather, the power of consumer choice is narrowed to ‘taking business elsewhere’ (if there are other options available). For the social work profession, this raises concerns about inadequate attention to the disability rights movement, the social model of disability and the role of lobbying and advocacy for those disadvantaged in a free market system.

There is the assumption that private for-profit providers will be more efficient and cost-effective, but this assumption draws more from ideology than evidence (Rosenau and Linder, 2003; Meagher, 2010). There is no guarantee that individual budgets will be sufficient or that individuals will have meaningful control as opposed to inadequate choice. The positive aspects of the NDIS include the attention that the proposal has directed towards the inadequacy of current service provision and the associated injection of funds that the new scheme would initially entail. It is anticipated that individual budgets will offer flexibility and control for many, but there are social, environmental, logistical, communication, cultural and organisational barriers that will affect the quality and adequacy of services for others (Witcher, 2005). Effective engagement with and advocacy for those who are marginalised and disadvantaged in mainstream systems are a fundamental concern for social work.

What social work has to offer the NDIS

As the NDIS proposal moves toward an implementation plan, social work could play a role in enhancing social/political/human rights perspectives in order to balance the concerns associated with the liberal/market emphasis and individualised budget schemes as outlined above. As we have argued through this paper, it is expected that not all will do well under a system that relies on a market model for service provision and that cultural, economic, gender, historical, educational, geographic and other sources of privilege and power in our society will impact on who fairs best under a market-based individual budget scheme. Three key aspects of the NDIS proposal could go some way to address these concerns, namely assessment processes, brokerage and local area coordination. It is in each of these three areas that we propose social workers could offer social and human rights perspectives that would enhance access and equity in the scheme. What social work has to offer in these three areas will now be discussed.
Binaries relating to self-determination and autonomy versus professional definitions of need and eligibility are pertinent in examining assessment within the NDIS. On the one hand, the Productivity Commission report claims that the NDIS model will facilitate a shift from an organisationally-driven approach to one in which individuals exercise choice regarding services and providers that will best meet their own needs. On the other hand, the development of standardised, rigorous national assessment tools to determine eligibility and required supports is also prioritised. In this section, we highlight the tension between these two goals and the principles in social work assessment that promote both rigour and client self-determination.

A social model perspective on disability clearly places the individual in the driving seat. However, person-centred approaches, aligned with individualised payment schemes including the NDIS, are predominantly predicated on the professional assessment of functional capacity rather than individual control. In Australia to date, the largely fragmented nature of services, with service providers often being dependent on short-term targeted government contracts, has left service users with little option but to contend with a stretched service-orientated system and rigorous gatekeeping mechanisms. It is therefore a real possibility that with the liberal/market-led agenda, from which the NDIS and individual budgets have emerged, prioritising the cutting of costs, via restricted eligibility and the provision of fixed, non-negotiable payments, will continue to dominate over social model and human rights considerations. It is through the assessment process that this tension will play out.

Earlier in this article, we looked at the different interpretations of ‘independence’ and ‘autonomy’ associated with individual/clinical and social model conceptualisations of ‘disability’. These different interpretations are central to the way in which assessment is understood and implemented. The NDIS proposes that, in order to meet the goals of national equity and consistency, national eligibility criteria and an assessment toolbox will be developed. In the proposed scheme, Allied Health professionals will be trained as assessors to ensure a standardised approach to assessment, meaning that ‘regardless of location, people with equal disability status and traits/natural supports would receive the same entitlements based on need’ (AGPC, 2011, p. 14). The concept of ‘need’ is, however, open to interpretation and is aligned as much with personal and social experiences and contexts as it is with functional capacity. Whilst consumer decision-making power is at the forefront in the NDIS proposal in terms of choice of provider, power in defining one’s own needs and the level of support required to address these will be in the hands of professionals using standardised tools. The assessment process proposed for the NDIS will be a
gate-keeping process that protects limited government resources and offers accountability for the use of public funds.

Whilst the Productivity Commission report focuses on locating and developing valid and reliable tools to assess functional capacity and hence support needs, the principles and approaches that guide assessment processes will also influence the way in which needs and requirements are defined for individuals in the scheme. A ‘tick the box’ approach to assessment may work for uncomplicated situations, but is likely to further alienate those who experience marginalisation in accessing organisations for a range of historical, cultural, mental health and a variety of other reasons. A social work approach to assessment that prioritises personal engagement and relationship building as the basis for a thorough and meaningful assessment is likely to produce better insights into personal experiences, relationships and contextual factors that influence needs. From a critical social work perspective, the assessment process can be used as a limiting, gate-keeping exercise, but it can also be used as an engaging and empowering process that identifies disabling social barriers and individual interpretations of need. The social work profession could have a role to play in shaping the way in which assessment is approached in the NDIS. A social work assessment moves beyond what an individual can and cannot do, addressing the social context in which individuals strive to achieve goals that have meaning to them and the disabling social dimensions of individuals’ experiences that impact on well-being and capacity to participate in society. Social work assessment places the individual within relational and social contexts, providing a framework that begins with an individual’s interpretation of their own situation, but also recognises the structural disadvantages that impact on their lives. Starting from a human rights value base, a social work approach to assessment for the NDIS could assist in fairly assessing those who face multiple challenges and need to be assessed using a flexible but well-grounded framework, rather than an overly standardised assessment tool.

Personal engagement and relationship building are central skills used in social work assessment as practitioners seek to understand an individual’s unique experiences in their relational and social contexts. It is the complex ‘cases’ in which people fall outside the standard criteria or face multiple and complex challenges where social workers are called upon to clarify and interpret needs and requirements in many organisations, so as to negotiate systems and advocate for the accommodation of and response to individual circumstances. This role for social work is well established in health settings in Australia and also in Centrelink, the government income support agency. Similarly, social workers should be well suited to the management of complex assessments for the NDIS.
Brokerage

The brokerage feature of the NDIS is designed to assist those who, due to cognitive impairment or other barriers, are unable to engage providers or manage a care package. Brokerage could be approached as a commercial relationship that secures the best value for the client’s dollar or could also be the vehicle by which greater autonomy and control is facilitated. There is potential for the brokerage system to facilitate access for those who experience barriers to accessing services and, as such, an advocacy dimension to the broker role would be useful. However, the appropriate professional education, skills and value base are required by service brokers if they are to facilitate autonomy and control by disabled people and advocacy for appropriate services. A ‘person-centred’ approach does not flow automatically from the provision of an individual package and professional skills are required to avoid paternalistic, controlling case management approaches. Social work ethics and practice principles could contribute to effective service brokerage approaches that emphasise engagement, rights, self-determination, autonomy and individuals defining what are worthwhile and meaningful experiences in their own lives. Effective skills in conducting holistic assessments would again be required in order to broker appropriate services. It is expected that a family or systems approach to assessment would be needed in many situations in which a broker is engaged. A social work approach could also move beyond an individualised focus to facilitate community networking and advocacy in order to access appropriate services, promoting community responsibility for alleviating disabling social barriers.

Local area coordination

This leads on to the third key aspect of the NDIS where social work could make a contribution, namely the local area coordination feature of the scheme. Community work skills and approaches in social work could inform this critical aspect of the NDIS. Handled poorly, the local area coordinator could function simply as a mediator between government policy directives and communities, monitoring compliance and facilitating information exchange and networking. Handled well, this is where the goals of a social model of disability could be pursued through ensuring consumer groups have a voice in the development, access, diversity and quality of services; the promotion of advocacy in relation to resources, practices and policies; and the foregrounding of community awareness raising and capacity building with regard to disabling social structures. With the appropriate knowledge, practice principles and values, there is potential for local area coordinators to engage with the politics of disability, rather than just
the mechanics of service coordination. Of particular concern for social work would be to develop strategies to ensure that marginalised groups are included and not further alienated through the implementation of a market-based individual payments scheme. This could involve developing targeted programmes and supporting community-based services that assist in overcoming cultural and other structural barriers. Sufficient funding would be needed to achieve these goals and, as the Productivity Commission has recognised in response to the barriers and marginalisation experienced by Indigenous Australians, the block funding of some services may be required. In their evaluation of outcomes from individual budget schemes in the UK, Netten et al. (2011) state that a variety of creative and flexible approaches will be required, particularly during the planning and establishment stages, to support different groups to achieve their desired outcomes.

Conclusion

Whilst a national scheme to standardise the level and provision of care services to people with disabilities is new for Australia and an injection of funds is to be welcomed, the degree to which the proposed NDIS will reflect a social model of disability is uncertain. Individual budgets, care packages and self-directed payments dominate the proposed scheme. There are benefits to promoting the scheme as national insurance, including moving from the conceptualisation of services for people with disabilities in a paternalistic charity-oriented way to a universal programme that could be utilised by anyone in the future. This has the potential to challenge values that marginalise people with disabilities as being outside the mainstream. Beyond the insurance and population risk-management depiction of the scheme, however, details of the proposal sit squarely in line with individual/medicalised orientations, with care package policies, including ‘cash for care’ reflecting liberal/market rather than human rights perspectives.

The focus on choice and control, although largely located within a liberal/market scenario, does, however, have the potential to be an empowering outcome for many people and an injection of funds can only be of value to a service sector that is currently underfunded and fragmented. Just how the scheme will ensure that those who experience inequity in terms of education, income, language, gender, family support, geographic location and access to resources are not further disadvantaged by the scheme, requires closer attention. It can be argued that, unless social model underpinnings are understood and taken on board, politically and socially, the changes could merely serve as ‘inclusive’ window dressing, with real change being reflected in the cutting of costs. As a way of addressing this concern, we have outlined the important roles and practice principles that social work could contribute to the design and implementation of the assessment, brokerage and local area coordination features of the
scheme. The NDIS proposal has positioned disability as a key policy issue for the Australian government. This presents an opportunity for the social work profession to contribute by way of commentary and input. As Netten et al. (2011) propose in the UK context, social workers are likely to be at the forefront of implementing policies relating to individual budgets. The goal of social work, we suggest, is that social responsibility and human rights are recognised as central to the NDIS and not overlooked in the passion for consumer choice. This goal clearly will continue to have an international as well as an Australian resonance.

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