

Impact of transition to an individualised funding model on allied health support of participation opportunities

Kristen Foley, Stacie Attrill, Sue McAllister & Chris Brebner

To cite this article: Kristen Foley, Stacie Attrill, Sue McAllister & Chris Brebner (2020): Impact of transition to an individualised funding model on allied health support of participation opportunities, Disability and Rehabilitation, DOI: [10.1080/09638288.2020.1725157](https://doi.org/10.1080/09638288.2020.1725157)

To link to this article: <https://doi.org/10.1080/09638288.2020.1725157>



© 2020 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Published online: 17 Feb 2020.



Submit your article to this journal [↗](#)



Article views: 1176



View related articles [↗](#)



View Crossmark data [↗](#)

Impact of transition to an individualised funding model on allied health support of participation opportunities

Kristen Foley^a , Stacie Attrill^a , Sue McAllister^b  and Chris Brebner^a 

^aCollege of Nursing and Health Sciences, Flinders University, Adelaide, Australia; ^bFaculty of Health Sciences, The University of Sydney, Sydney, Australia

ABSTRACT

Introduction: The National Disability Insurance Scheme is the new consumer-controlled funding system for people with disability in Australia, and is expected to enhance participation outcomes of people with disability. This research explored participation opportunities for people with disability during the formative period of transition to the scheme, through stakeholder accounts of changes in allied health service contexts.

Materials and methods: Qualitative data were generated during interviews, workshops and meetings with industry, policy, practice and education stakeholders involved in scheme services. Inductive coding explored key themes within the data. The International Classification of Functioning model was then applied as a deductive coding framework to illuminate how the scheme was perceived to be impacting participation opportunities for recipients of scheme funding.

Results and discussion: Using the International Classification of Functioning helped us illuminate whether changes resulting from scheme transition posed participation opportunities or barriers for scheme recipients. Research participants often framed these changes negatively, even when examples suggested that changes had removed participation barriers for scheme recipients. Some participants viewed changes as obstructing equitable and quality professional practice. We explore potential opportunities to resolve tensions that also optimise the participation outcomes of individuals who receive services through individualised funding.

ARTICLE HISTORY

Received 18 August 2019
Revised 15 December 2019
Accepted 30 January 2020

KEYWORDS

NDIS; Australia; disability; allied health; participation; ICF

► IMPLICATIONS FOR REHABILITATION

- The introduction of individualised funding has removed barriers to participation for many National Disability Insurance Scheme recipients.
- Efforts must be made to build the trust of stakeholders involved in National Disability Insurance Scheme service provision regarding how fee-for-service funding can lead to good participation outcomes for scheme recipients.
- Transparency around the shared processes of clinical governance and equitable service access operating in Australia's individualized disability funding scheme are suggested to build trust.
- A visible commitment to maintaining a broad range of services is also indicated to build trust for stakeholders involved in the scheme.

Introduction

Many countries are shifting from government managed to consumer-controlled funding to provide support for people with disability. This shift is motivated by a human rights framework, where people with disability are enabled to take up the 'full citizenship' they have been previously denied as a result of paternalistic and bureaucratic system design [1] (p. 4) see also [2–4]. This human rights narrative is evident in Australia's transition to the consumer-controlled National Disability Insurance Scheme (NDIS), which replaced a disability funding system that was described as "underfunded, unfair, fragmented, and inefficient" for people with disability who had "little choice, no certainty of access to appropriate supports and little scope to participate in the community" [5]. Providing choice and control to people with disability were key principles that underpinned the NDIS policy

reform, and are also reflected in other international examples of consumer-controlled funding for people with disability [6]. For example, in the United Kingdom, Europe and New Zealand disability funding policies similarly evolved from philosophies of consumer participation and autonomy [1,4,6–8].

In consumer-controlled funding schemes, mechanisms of marketisation and entrepreneurship are critical to ensuring the philosophical ambitions of policy reform are achieved. In Australia, the NDIS policy reform ambition was to provide people with disability the reasonable and necessary supports they need to live an ordinary life, and to participate socially and economically in society [9]. Providing funds directly to people with disability fosters autonomy to make decisions about services to meet self-identified needs, wants and goals. Service providers must respond directly to these needs and wants to gain and maintain

CONTACT K. Foley  kristen.foley@flinders.edu.au  College of Nursing and Health Sciences, Flinders University, Sturt Road, Adelaide 5001, Australia.

© 2020 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

business in the disability sector [10,11]. In addition to having their needs met, this process means that people with disability also co-design services through a bottom-up approach [1,12,13]. Consumer-controlled funding therefore has two underpinning assumptions: a co-design process will reduce participation barriers to access and use of services experienced by people with disability, as services develop to respond to their wants and needs [13]; and, unwanted services will be removed from the market and the sector will become more cost efficient as a consequence of this change [14,15]. These assumptions must be explored as key deliverables of individualised funding reforms that involve market-driven approaches [4].

It is unclear exactly how service providers and the disability sector as a whole can operationalise these principles of participation and enable people with disability to participate fully in society. Whilst facilitating participation provided an impetus for the NDIS policy reform, “participation” is a complex outcome to evaluate as there are a lack comparative benchmarks or indicators of success [13,16]. “Participation” can be interpreted in a wide variety of ways [13], and limited evidence exists for how individualised funding models provide cost-effective services for people with disability that enhance participation [6,17]. We consider participation as an outcome of the dynamic relationship between a person and their environment, following the International Classification of Functioning, Disability and Health (ICF) [18,19]. The ICF identifies disability as a social and political phenomenon, where a person’s environment is “disabling” rather than an individual being “disabled” [20,21]. Consequently to enhance participation, schemes like the NDIS aim to alter aspects of the environment (i.e., funding, policy, service provision and access) to achieve a better person-environment fit for people with disability.

In this paper, we explore how introducing the NDIS has shaped participation opportunities for people with disability during the transition period to the scheme, from the perspective of stakeholders involved in implementing the scheme. Examining whether this Australian policy reform has enhanced participation opportunities will assist to determine whether the scheme is achieving its philosophical ambitions [22]. This will inform the continued rollout of the scheme in Australia and other large-scale public policy reforms internationally. We selected the ICF as a framework to explore how allied health services were enacted during the NDIS implementation, and how these were perceived to affect participation facilitators or barriers for people with disability from the perspective of those implementing the policy and providing services. The ICF can be used to analyse social policy or political reform that seeks to enhance individual participation [19,23]. Our research questions were:

How are allied health services for people with disability being enacted during the transition period of the NDIS implementation?

What do stakeholders involved in NDIS implementation perceive to be the participation opportunities, barriers and facilitators for people with disability as a result of this transition?

Materials and methods

Study design

This study used data generated from a workforce development project that investigated the scope for student involvement in allied health services for people with NDIS funding. The project used an action-research methodology that employed iterative cycles of data gathering and analysis to inform directions and processes undertaken during the project [24]. We engaged individuals involved in developing an allied health workforce to provide services for NDIS recipients in ways that achieve their participation goals. Stakeholders were NDIS recipients; allied health service providers; disability policy, practice and advocacy representatives; students and universities. Project methodology involved establishing a Project Advisory Group comprised of the research team, NDIS providers, recently graduated allied health practitioners and representatives from disability policy, practice and advocacy sectors who provided oversight and feedback throughout the project. We use the term “participant” throughout the paper to refer to research participants; and have adopted “NDIS recipient” or “recipient” to identify individuals who receive individualised funding.

Data collection

The data for the current study were derived from the project’s first stage which explored changes in the disability sector resulting from NDIS implementation. This first stage comprised eight in-depth individual interviews (see Table 1), two Project Advisory Group meetings, and one stakeholder workshop that considered how disability services had responded to NDIS implementation (see Table 2 for Advisory Group and workshop participants).

The three data collection activities had slightly different foci, but each explored how the disability sector transitioned to accommodate the individualised funding model of the NDIS and stakeholder perceptions of subsequent impacts on participation opportunities for NDIS recipients. Individual interviews that ranged from 25–45 min were conducted face to face by a sole researcher in the workplaces of interviewees between February and April 2017. These followed a semi-structured interview guide that aimed to explicate the experiences of service providers in transitioning from a block funding to fee for service model. The Project Advisory Meetings were each two hours long. The first meeting (February 2017) discussed the project intentions, the Project Advisory Group terms of reference, the planned project activities, the scope of the project and the current NDIS landscape. The second meeting (June 2017) comprised of a project update, the presentation of a model for conceptualizing student placements, and a roundtable discussion regarding emerging features of the NDIS landscape that may influence project progress. The workshop identified and recorded factors known to influence NDIS funded service provision that may also impact on the

Table 1. Stakeholders involved in research activities.

Data Source	Role	Scope of organisation	Discipline
Interviewee 1	General manager	Large allied health provider with OT/SP/ Disability Consultants	Speech pathology
Interviewee 2	Manager	Large, multidisciplinary practice	Occupational therapy
Interviewee 3	Principal AH professional in Private Practice	Specialised private practice, small scale	Speech pathology
Interviewee 4	Manager of AH Private Practice	Specialised private practice, small scale	Speech pathology
Interviewee 5	Policy advisor	Peak body for disability employment organisations	Project manager
Interviewee 6	AH Manager	Large allied health provider with OT/SP	Speech pathology
Interviewee 7	Senior AH professional	Large allied health provider with OT/SP/ Psychology	Speech pathology
Interviewee 8	Junior AH professional	Large allied health provider with OT/SP/ Psychology	Speech pathology

Table 2. Data gathering activities.

	Number of participants	Roles and disciplines represented	Purpose of activity
Workshop 1	15 (5 of which research team)	University placement Coordinators Project Managers Policy Development AH professional Speech Pathology Occupational Therapy Physiotherapy	Establish context and understand how services are enacted
Project Advisory Group 1	20 (5 participants were members of the research team)	Speech pathology Occupational therapy Physiotherapy Allied health executive management Policy development National advisor disability Heads of AH Faculties Placement Coordinators Skills and Employment	Collaborate regarding initial understanding of practice landscape
Project advisory group 2	11 (5 participants were members of the research team)	Placement coordinators Policy development Plan support coordinator, NDIA	Provide feedback regarding shifts in NDIS landscape and how this might shape project activities

capacity of providers to host student placements. The five researchers attended the workshop (April 2017) which did not follow a pre-set structure or topic guide and ran for three hours. Data from each data collection activity were audio-recorded and professionally transcribed.

Participants

Stakeholders who participated in the project were recruited through university networks and were often known to one or more researchers on the research team. Participants were approached because they were involved in providing allied health services in NDIS funded settings—either through direct service provision or in the training of allied health professionals. The discipline, role, affiliated organisation and experience of participants varied as shown below in Tables 1 and 2.

Ethical approval

This research was approved by the Flinders University Social and Behavioural Ethics Committee (Reference number: 7551). Participants involved in each data collection activity provided informed consent by signing a consent form, after discussing the research risks and benefits with one of the research team.

Data analysis

The data were initially analysed to inform subsequent action-research cycles to direct the workforce project. Inductive thematic analysis was conducted during this phase, with coding undertaken by three members of the research team (Authors 1, 2 and 4). This involved reading the transcripts for familiarity then noting key concepts across the transcripts—Author 1 completed this process in NVivo (v11) while Authors 2 and 4 completed this process via hard copy. Key concepts were tentatively labelled as themes. The themes identified during this inductive phase were discussed with the entire research team to reach consensus on a cohesive and comprehensive coding structure which was used to inform full coding of the dataset.

One of the key themes derived during the inductive analysis regarded the extent of service changes resulting from NDIS transition and implementation. We undertook a sequential secondary analysis to inspect how stakeholders perceived these service

changes to influence participation opportunities for NDIS recipients [25]. The ICF provided the conceptual framework to interrogate the idea that a shift to individualised disability funding would reduce barriers to participation for NDIS recipients. Data were coded deductively to the *a priori* categories of the ICF to identify how participation by people with disability was influenced by the individualised funding model.

The major domains of the ICF that are described in Box 1 were used as broad coding categories. Codes generated from the inductive thematic analysis were deductively re-coded under “environmental” or “personal” factors. Severity qualifiers generally used to “denote the magnitude or severity of the problem in question” [19] were not used for this analysis as stakeholders did not provide individual information about people with disability.

Box 1. Definitions of ICF Domains, adapted from WHO Practical Manual 2013 [19].

Environmental Factors in the ICF are aspects of the physical, social and attitudinal environment in which people live and conduct their lives [19] (p. 10). Environmental factors can either be barriers or facilitators to someone’s performance. For example, the “attitudinal environment” might support the participation of someone with a disability (i.e., awareness of disability might facilitate community engagement) or constrain it (i.e., negative stigma or stereotypes about disability might preclude community engagement).

Activity and Participation Factors are identified as difficult to separate [19] (p. 8). The ICF outlines that activities are “actions and tasks executed by individuals” whereas participation is “involvement in life situations” [19] (p. 35). In both the activity and participation domains there can be facilitators or barriers to participation outcomes. Activity and participation can be considered individually or collectively in the ICF [19] (p. 28) and is able to describe all areas of life for all people [19] (p. 35). We considered activity and participation as one category, to reflect our general interest in understanding participation opportunities.

Personal Factors are things intrinsic to the person which impact on activity and participation engagement that are not represented elsewhere in the ICF [19]. They may include gender, age, race, lifestyles, habits, education and profession.

Body Systems and Functions refers to physiological and anatomical features of the body [19]. By including these features, the ICF is able to capture any anomalies in body systems and functions and interrogate how they interact with one’s environment or other personal factors—to subsequently influence activity and participation. As impairment doesn’t relate to services provided under the NDIS we did not have data to code to this domain.

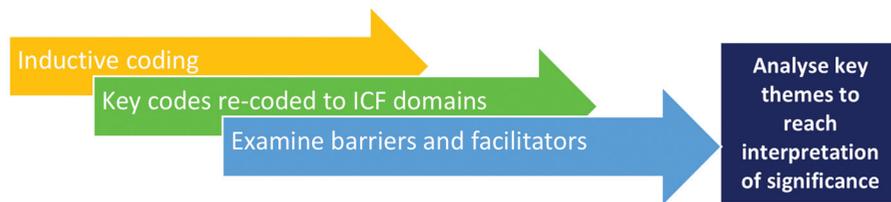


Figure 1. Coding process.

The deductive coding built categories arranged *via* the ICF domains, attributed as participation barriers or facilitators. For example, the inductive code “less funding for group therapy” from the initial analysis was coded to the environmental domain, and also as a participation barrier. The subsets of participation barriers and facilitators, clustered within each of the ICF domains, were then examined to identify themes which supported overall interpretation of the analyses (see Figure 1). Accordingly, “less funding for group therapy” became part of the theme “service design changes” within the environmental domain.

Rigour

As the ICF is a dynamic and integrated conceptual model [19], codes often applied to more than one domain. For example, service changes coded to the environmental domain may also have been a barrier/facilitator relevant to the activity and participation domain. This was managed by coding to both domains and then continually comparing codes across ICF domains. This supported an in-depth and integrated review of the data within each domain at the end of the coding process. The coding processes for the deductive ICF analysis were undertaken by Author 1 and reviewed in-depth by Authors 2 and 4. Themes from this analysis were identified by the research team through a consensus approach, with discordant views resolved through discussion. Author 3 provided further feedback on the interpretation of the deductive ICF analysis.

In addition to audio data recorded during interviews, workshops and meetings, the research team took field notes and memos throughout the first stage of the project. This served as an additional data source about the context and enactment of disability services in NDIS implementation, and perceived influence on participation opportunities for NDIS recipients. The Project Advisory Group were also asked to provide feedback on project findings and outputs throughout the project. These data were triangulated with themes identified during inductive and deductive coding to provide verification that the themes were grounded in the data [26]. Finally, combining inductive and deductive coding enabled cross-checking of the findings to ensure key ideas in the data were not overlooked [27].

Results

Our findings are organised according to the three ICF domains that directed the deductive coding, in order of their prominence in the data: environmental factors; activity and participation factors; and personal factors. The themes identified for each domain describe the changes in disability service provision that were prompted by the NDIS and how stakeholders perceived these to influence participation opportunities for NDIS recipients. Overlap between domains is highlighted within and across domain sections.

Environmental factors

Many observations that stakeholders made about service provision changes resulting from the NDIS transition related to the environmental domain which was the most prominent domain in the data. The three themes identified in this domain were: the nature of the transition from block funding to recipient choice and control of funds initiated by NDIS reform; changes in service design; and attitudes of service providers and professionals.

The nature of transition

All stakeholders described the complexity of transitioning to the NDIS funding model and reported surprise at the extent and pace of change in services and systems within the sector. In particular, service providers identified that reduced availability of a skilled workforce and organisational lack of capacity to manage increased administrative activities were consequences of the rapid introduction of the funding reform. These environmental factors (complexity and speed) were features of the transition to the NDIS that providers’ felt impacted their capacity to optimise participation outcomes for NDIS recipients.

All stakeholders involved in direct service provision identified that transitioning to the NDIS introduced a high and unanticipated administrative burden. For example, service providers reported needing to adapt to new funding and reporting criteria to remain compliant and receive payments:

Interviewee 6:

...there’s more paperwork associated with an NDIS client... the student working with the privately paid one doesn’t have to worry about feeding into final reviews, to checking budgets and all of those kind of things.

In addition, regular NDIS policy level and bureaucratic reviews during the early implementation period often led to further changes and refinement of administrative processes. Stakeholders described the new learning in business and administration as challenging skill areas for allied health practitioners to develop and manage:

Interviewee 1:

It is a massive system that is forever changing. The requirements and guidelines are unclear and are challenging for therapists that are working in that system to keep up to date with and understand because of all of the inconsistencies that occur.

Service providers also identified that new bureaucratic processes intended to direct funds to the NDIS recipient rather than the service provider resulted in unplanned funding gaps that introduced potential participation barriers for NDIS recipients. For example, a service manager described how overlapping funding and communication processes during NDIS implementation had unintended outcomes of limiting service availability:

Interviewee 2:

Yeah, so one of the barriers we get is when plans run out and families can’t get hold of the NDIA to find out whether they’ve got a new plan.

So, you have to stop services for a while. Because what we found then is we just don't get paid and we've got all this unclaimed income that people are offering services and not getting any money for it. Which is a big concern for us at the moment.

One interviewee who held a clinical governance role viewed the pace of the transition as a potential participation barrier for NDIS recipients. She identified that the rapid change had precluded the development of a workforce skilled to meet the demands of the scheme, and connected this workforce environment to the participation goals of NDIS recipients:

Interviewee 3:

... the way that it's been rolled out so quickly is having such an impact on—there hasn't been the workforce there to be able to have people who understand the issues and can really engage in a positive way with families, or [recipients]. To really work with them to develop a plan that is actually anything more than just a package of funding.

Workforce concerns were raised by other service providers and organisational managers. Some participants reported increasing remuneration packages as a strategy to retain allied health staff as demand for their skills increased, which impacted on their business in other ways. Others identified that their organisation had not developed sufficient capacity to respond to the increased demand for services that resulted from the NDIS. Many stakeholders observed that while NDIS recipients are encouraged to choose services to meet their needs, workforce, organisational and practice structures and processes had not 'caught up' to reflect the number and range of services required. This limited service availability meant recipients at times had to accept less suitable services offered, which impacted their participation opportunities:

Interviewee 4:

The other thing is we've got such a massive waitlist that people are begging for anything. I don't mean that in an unethical way. But if we said to them this is the service that we can provide you—because we now can't accept anybody new. We're saying things like this is what we can do. We can do these workshops. Yes, yes, yes. They'll take anything because there is a limit.

Changes in service design

Service providers reported enacting structural changes to services as a result of NDIS reforms that were environmental facilitators or barriers to participation. Whilst service providers wished to safeguard quality for recipients through providing evidence-based practice, cost considerations and financial viability were often positioned as dominant drivers of service models. As described by this operating manager, services were designed to respond to the NDIS funding requirements:

General Manager 1, Project Advisory Group Meeting #1:

The realities are that if you don't get the income to cover your expenses, then you don't survive—working out what does that mean and what can we do?

Some service managers identified that they used NDIS funding information to guide and evaluate decisions about service provision. Whilst service providers reported the need to create 'good value services' for NDIS recipients, decisions were often compelled by practice costs:

Interviewee 4:

If we were to run a group we need two to three of us [practitioners] to manage it. The cost of that is just too high and you couldn't charge them for that.

There were no exemplars of service revision that had responded directly to a desire or request from an NDIS recipient.

However, some service providers reported they had considered how their service design could enhance participation opportunities for NDIS recipients. In the following example, a manager identified how optimising the timing of services for the business could also create participation for NDIS recipients:

Interviewee 2:

What we're finding—and this is very much a business model which is a new thing for us—school holidays are not a great business earning time for us. So, we've been trying to look at what sort of things can we offer during school holidays that are helpful.

Although the 'choice and control' principle underpinning the NDIS reform compels service providers to respond to 'market demand' driven by recipients through individualised funding, stakeholders sometimes portrayed services that emerged through this demand to conflict with 'good practice':

General Manager 1, Project Advisory Group Meeting #1:

NDIS funding took us away from good practice—just rolled out and now we're scampering to demand.

Many service providers suggested that the principles of "best practice" and/or "evidence-based practice" were important to prioritise in decisions about service design. However, some reported that these practices were challenging to implement in the new funding system and inhibited their ability to provide the best participation outcomes for NDIS recipients. For example, supporting best practices such as interdisciplinary services:

Interviewee 8:

... it's harder for clinicians at the moment to have that discussion of doing an interdisciplinary session... Having the opportunity for further... that's a discussion with the parent, that's a discussion with the other professional, that's a discussion with someone else... and how that's going to be funded...

Another service manager identified that the NDIS funding model hadn't considered all the necessary practice elements required to optimise participation and outcomes for NDIS recipients:

General Manager 2, PAG Meeting #1:

... there's an awful lot of stuff that goes into these successful outcomes that is not recognised by NDIA.

Attitudes of service providers and professionals

The environmental domain of the ICF considers how people's attitudes facilitate participation facilitators or barriers for people with disabilities. This encompasses attitudes that an individual with disability might encounter in all aspects of society [19], including those of service providers. Accordingly, attitudes about the NDIS comprise part of the environmental architecture that determine how NDIS funded services are enacted and may act as participation barriers or facilitators for NDIS recipients.

Stakeholders identified their own or others' attitudes as a dominant feature of the transitional NDIS environment. Service providers reported experiencing high levels of stress from the extensive changes in service delivery that they perceived to inhibit their ability to maximise participation outcomes for NDIS recipients. In the following example, a service provider identified that conflicting information about the NDIS required practitioners to provide bridging between 'the system' and 'good participation outcomes' for NDIS recipients:

Speech Pathologist, Project Advisory Group Meeting #1:

If you have a family saying 'what's going on?' You don't know how to handle that—if there's no opportunities for service provision you don't know how to help them. You know how to deal with the client when

you're in the room but everything outside is confusing, and changes daily...

Service providers identified that variability in how NDIS funding criteria were interpreted, limited capacity to work collaboratively, and a lack of knowledge about how funding was planned presented new and additional challenges for practitioners and NDIS recipients that were sometimes confusing. Funding plans that were insufficient or inappropriate to enable service providers to meet the participation goals of NDIS recipients were a source of frustration:

Interviewee 6:

So we might have had someone two years ago get \$16,000 and someone who's exactly the same now may not get that same funds... then as they get older, they moved into a multidisciplinary plan... which was a big jump from them having weekly speech pathology and now they've only got 10 hours of speech pathology for the whole year. So as we get older, there's less funding around it.

The increased focus on billing and costs prompted a 'cultural change' that added to practitioners' stress by influencing their perceptions of the value of their own work. In the following example, a disability services advocate suggested that the greater visibility of funding and billing in practice may impact participation outcomes for NDIS recipients:

Interviewee 5:

The culture change that those organisations are having to go through is huge... they'd go out to do a physiotherapy visit and if it went 15 minutes over it went 15 minutes over. So be it. The person was getting great therapy. Now that 15 minutes costs money, lots of money. So it's that changing culture. It's changing that belief set. It's changing that I guess operating model and changing a person's own view of the value of their work, which is really—a lot of people are really struggling with it... In the eastern states it's probably been the most common reason for people leaving the sector—is 'I can't'—cognitive dissonance.

Activity and participation

Themes from the activity and participation domain referred to tangible or observed participation changes of NDIS recipients. These included participation outcomes that resulted from funding items; cross-sector collaboration; and plan uptake and management. Data coded and analysed to the activity and participation domain were a smaller section of our dataset compared to those coded under environmental factors, as the broader research had explored the transition to the NDIS (an environmental factor) in reference to workforce development.

Particular funding items

Service providers noted that changed funding for certain activities under the NDIS influenced the availability and nature of services for recipients. This funding was identified as a participation facilitator, as it had translated into new services for NDIS recipients with goals related to these activities, for example, for feeding supports:

Interviewee 6:

...our students support the groups that we run in school holidays, because a lot more of our clients are being funded for feeding support.

In contrast, a lack of funding for some activities was identified as a challenge for providers who perceived that this resulted in participation barriers for NDIS recipients. For example, many practitioners prioritised support for children's literacy skills to facilitate their participation in life activities, but this funding wasn't

supported under NDIS funding as it is considered an educational service:

Interviewee 6:

[T]he main challenge that they're having is literacy but literacy's not a specific area that NDIS supports. So that's been like an area... that's not NDIS supported. That's meant to be an (sic) education department supported area. That's where ... that's the teachers' main concern. That's my own opinion but... our world is literacy based. If you want children to be functional, they need to read and write.

Several service providers discussed the importance of capacity building with families or NDIS recipients to collaboratively identify priorities for therapy that support their participation goals, and strategies to meet these priorities. In the following example, practitioners perceived that restricted travel funding that limited service provision outside of practice settings, reduced opportunities to develop capacity for recipients to participate in their own community contexts:

Interviewee 3:

... perversely, their funding model with the lack of payment for travel, and the focus on key worker, has driven people straight back to a clinic based on non-community based service provision. So that there's just not recognition that there's—a big part of what we do is building capacity in families, just as part of our relationship with them... where that's part of the constant process is building capacity, and in the community around them.

Cross-sector and interdisciplinary participation outcomes

Many service providers identified that working across sectors and collaboratively between organisations were challenging as new systems and norms were established under the new funding guidelines. In previous government funded models of service provision, for example, an interdisciplinary session may have been provided if this facilitated the recipient's desired outcomes. In the new NDIS service context, interdisciplinary sessions remain a valued option for services, however, financial barriers may limit their uptake by recipients as they cost more than services provided by a single practitioner.

Interviewee 8:

...it's harder for clinicians at the moment to have that discussion of doing an interdisciplinary session. At the moment most of the collaboration that I do within our interdisciplinary team is quite informal. Having the opportunity for further, that's a discussion with the parent, that's a discussion with the other professional, that's a discussion with someone else and how that's going to be funded and all those sorts of things.

Stakeholders also identified that providing services across funding boundaries and between sectors was challenging in the NDIS transition. For example, providing services to children in school settings since the introduction of the NDIS were increasingly complex. Some stakeholders reported valuing service provision in naturalistic environments like the classroom, and families enacting their choice of preferred service provision had also increased practitioner numbers in schools. In some cases, schools responded by refusing site access by NDIS service providers, which generated unintended barriers to participation.

Interviewee 7:

... we do home visits, school visits, kindy visits, childcare visits... That certainly is reducing; there are more schools since the introduction of NDIS who are saying no to external service providers because they can't... There's so many of us. We pull kids out of class and they need to be attending a certain number of minutes of each class and all of those sorts of things.

Plan Uptake and Management

Planning, accessing and receiving NDIS funded services are new activities for NDIS recipients. Service providers identified that NDIS recipients required the capacity to execute activities associated with managing their plan as important for achieving their participation outcomes. They suggested that families with reduced “function” levels including those from socially disadvantaged backgrounds or with reduced health literacy, may have reduced access to the full range of NDIS services and funds.

Interviewee 1:

There’s probably some families that are on [NDIS] who have got packages in place whose family supports are not functioning quite well enough for them to be able to access that.

For example, a policy advisor observed that NDIS recipients in a socioeconomically disadvantaged area had low rates of funding uptake. She suggested this posed significant participation barriers for NDIS recipients:

Policy Advisor, Project Advisory Group Meeting #2:

... in the northern suburbs, there are people that are still not utilising their plans. For example in (named suburb) 32 kids could be on a plan, but only 2 have taken it up.

Some service managers identified that NDIS transition provided opportunities to address these disparities, through organisations tailoring services that are accessible to recipients with a broad range of needs, and ensuring that service access and funding effectiveness is maximised to support achievement of participation goals.

Interviewee 2:

... we want to get an office further north [to] encourage families to use their local provider so they don’t have to pay so much for travel ... what happens is you get a package and the travel just comes out of the package ... at the moment, our families that live further north are very disadvantaged, because we travel from here to see them. Whereas if you live at [named suburb], you don’t pay a thing. So, for us it’s better for our clients if we’re further out north as well.

Key themes identified by service providers as part of the activity and participation domains were the funding status of specific items, the ability of providers to work across sectors, and the capacity for plan uptake and management by NDIS recipients. Each theme included features related to NDIS funding transition that facilitated or generated barriers to participation outcomes of NDIS recipients.

Personal factors

Personal factors are intrinsic to a person; something within them that influences the person-environment fit. Data were coded to this domain when factors were viewed to impact on activity and participation engagement [19], but originate within the person rather than the environment. The capacity to enact choice and control is integral to accessing services in the NDIS, as recipients must choose and organise services that support their intrinsic participation requirements.

Key themes identified in this domain were factors related to individuals’ capacity to enact choice and control over how their NDIS funds were spent. These included the capacity of recipients to self-manage funds and recipients who were from a culturally and linguistically diverse background. Rather than considering these characteristics a barrier to participation, service providers identified that these factors added complexity that influenced how appropriately the scheme could meet recipients’ needs.

The ability to enact choice and control

Service providers identified that participation outcomes were facilitated when recipients could exert choice and control about the nature and extent of services because they had capacity to self-manage their funds. Conversely, NDIS recipients who were agency-managed were reported to have more “rigidity” and less control over their funding. This idea overlaps with the findings from the activity and participation domain around perceived capacity for NDIS plan uptake and management:

Interviewee 4:

If the families are self-managed or plan managed, they can ... we can bill them whenever we choose. They can pay whatever they choose, as long as it seems reasonable and necessary and they can justify that. When they’re agency managed, which means that we send our funding request into the NDIS; we bill the NDIS ... Then it’s a lot more rigid in terms of cost.

Stakeholders viewed the lack of NDIS funding for interpreter services as a threat to service access and ultimately participation outcomes for culturally and linguistically diverse NDIS recipients. Consequently, stakeholders viewed this as a barrier to enacting choice and control:

General Manager 1, PAG Meeting #2:

... can’t claim for interpreter services ... Delivering services who need people to interpret will be increasingly challenging.

Some stakeholders raised further concerns about being able to work appropriately and effectively to optimise participation for populations with diverse cultural needs, particularly those living in rural communities and from Aboriginal and Torres Strait Islander communities. The scope for NDIS recipients to exert choice and control was portrayed to be constrained when service (or engagement) processes and options were limited by a funding model based on the assumptions of a cultural majority.

Summary of key themes: sector changes and participation impacts

Stakeholders each reported individual experiences of transitioning to the NDIS funding model and the ensuing change within the disability sector and this was a dominant theme in their accounts. Practitioners identified that it was cognitively demanding to manage the extensive structural and administrative changes prompted by the NDIS funding and reporting requirements and ensure that offered services were cost effective. They often reported simultaneously navigating service and funding changes within their organization, whilst delivering quality, tailored services in accordance with NDIS requirements, and providing intermediary interpretation of NDIS information for recipients to assist their understanding of new systems and individual funding arrangements.

Our results can be delineated into two categories related to the perceived impact service changes had on participation opportunities for NDIS recipients. Some changes reported to result from the scheme were superficial service adjustments with limited impact for NDIS recipients—we conceptualise these changes as “surface level changes.” Other changes associated with the scheme implementation and evolution, however, were considered to involve service and sector design changes that would likely substantially influence participation opportunities for NDIS recipients—we conceptualise these changes as “deep changes.” “Surface level changes” included features like reporting and administrative requirements or the reshaping of service availability; while “deep changes” included structural service adaptations to accommodate financial drivers, conflicts around best practice and cultural

change or clinical governance. We rely on these distinctions throughout the discussion section to critique how ongoing NDIS implementation could ensure that “deep” and “surface” changes exert positive impact on NDIS recipient outcomes.

Discussion

Our themes describe how allied health services for NDIS recipients are being enacted during a period of transition to the scheme. The NDIS is based on similar logic to other international policies, including those originating in Europe, the United Kingdom and New Zealand [1,4,6–8]; predicated on enhancing participation outcomes for people with disability. Findings from our research provide useful context for future and ongoing policy implementation, through illuminating the nature of the transition to the new funding model and its perceived impacts on participation opportunities for recipients of individualised funding.

Our themes were considered in reference to the ICF, to illuminate how the NDIS may be enabling or promoting participation opportunities for NDIS recipients. Themes in the environmental domain included the nature of transition to the NDIS, the changes taking place in service design and the attitudes of service providers and professionals during the transition to the scheme. In the activity and participation domain key issues were the nature of particular funding items, cross-sector collaboration, and plan uptake and management. Regarding the personal domain, salient features included perceived capacity for self-managed funding and being from a culturally and linguistically diverse or of Aboriginal or Torres Strait Islander background. The ICF was useful to elucidate features of the transition to individualised funding from a government-controlled funding model and how these act as opportunities or barriers for the participation outcomes of NDIS recipients. In our discussion, we aim to critically reflect on the “deep” and “surface” changes identified in our results and how these have influenced participation opportunities (drawing on the ICF analysis). In this way, we link our analysis of the potential participatory impacts resulting from the transition to the NDIS—both good and bad—to a future-facing exploration of how the individualised funding model can optimise NDIS recipient participation.

Deep changes to service structures that responded to the NDIS model were depicted to have substantial impacts on participation opportunities for NDIS recipients. Cross-sector work that facilitated practitioners to collaborate within or between organisations to achieve the recipient’s goals; services that could be delivered outside geographical or organizational boundaries, or in the natural environments in which recipients enacted activities were examples of deep level service constraints that were reported as consequential to the individualised funding or the specified nature of NDIS funded items. These service drivers that responded to the funding model are contrary to the philosophy underpinning the NDIS model and in conflict with known effective community-based approaches that foster wellness [28–30]. Stakeholders viewed these structural changes to reduce opportunities to develop quality and diverse services within their organisations during the NDIS transition. This was viewed to narrow the range of available services, which potentially increased participation barriers for NDIS recipients.

Stakeholders identified concerns about how funding limitations within the NDIS model could enable equitable, quality services for particular populations considered to require additional resources in order to access or use those services. Specific funding constraints were observed to impact how several groups participated

in the NDIS, including those may benefit from support to navigate or develop capacity to manage complex activities associated with coordinating their services; those requiring interpreter or translation services; those who live in rural or remote areas with limited service availability and poor access to technologies required for teleservice delivery; and Aboriginal and Torres Strait Islander populations who may require time to develop individual, family and community relationships that are critical foundations for culturally responsive services [31–33]. Perceived risk that this would negatively impact participation was amplified for stakeholders who felt that NDIS implementation had eroded pre-existing organisational governance structures that ensured equitable service access. These equity concerns are critically important to stakeholders involved in allied health service provision to NDIS recipients as they relate to access and participation barriers for the vulnerable populations who were espoused to benefit from the scheme. Our data suggest that these concerns have resulted in some practitioners developing negative perceptions about the NDIS. These could be usefully responded to in the context of the scheme implementation through enhanced transparency around equity considerations and structures.

Stakeholders perceived that surface-level changes to service design both benefited and limited recipients’ participation outcomes. Some changes, including modifications to service access or availability and the nature, frequency or location of services often responded to the increased demand generated by NDIS recipients. Each highlights the facilitation of participation for people with disability through market-driven approaches to service provision, intended by the NDIS scheme to increase the choice and control of recipients. However, stakeholders often described the service adjustments that were made to respond to the demand created in the market in negative terms, as they perceived that they “scampered” to make the changes that were therefore poorly executed. Many stakeholders also suggested that service models which pre-existed NDIS implementation would better optimise participation opportunities for NDIS recipients. It is unclear from the data how these stakeholder perspectives were aligned with the philosophical ambition of the scheme: that NDIS recipients can enact “choice and control” in order to live a life they deem meaningful. It is possible that there are a range of cultural values about the dominance of expert and professional knowledge that are at odds with a system of care predicated on and driven by the expert knowledge of NDIS recipients themselves. A recent study found that new skills and competencies that achieve genuine person-centred care are required in this new environment [34]. It is also possible that stakeholders do not yet trust the integrity of “marketising forces” that function in individualised funding models, elsewhere positioned as creating an “Uber-style wild west” [35].

Both the deep and surface changes identified in this research could be usefully considered through the concept of “paradigm shift” drawn from Kuhn’s observations of the intellectual change required to understand and enact changes that markedly depart from known norms and processes [36]. Kuhn was interested in how paradigms—which he defined as shared intellectual frameworks—cope with rupture and reshape in light of new ideas and evidence. In reflecting on our data, stakeholders’ negative reporting about how services are evolving vis a vis the objectives of the scheme may arise from knowledge of the previous paradigm where recipients received quality services that were founded according to the priorities of policy makers and practitioner experts. Whilst service providers and practitioners were central to the prior intellectual framework-mediated by

government-controlled funding—in the new consumer-led framework, NDIS recipients dictate the agenda. It is this redirection of decision-making power that presents the new paradigm, where through market logic consumer choice should result in optimal participation outcomes for NDIS recipients. The tension reported by service providers, then, can perhaps be interpreted as evidence of a shift to the new scheme. The integration of individualised support and funding practice into a new paradigm of disability and community has been identified critical to achieving authentic participation and capacity building [37].

Kuhn [36] suggests that the new paradigm will be more readily accepted when it shows itself as useful for influencing thinking and practice. We suggest that elucidating this will be critical to building trust in the market logic of individualised funding models, through proof that consumer-controlled funding can promote optimal participation outcomes across diverse contexts. A challenge, however, is that many service providers have worked with people who have disabilities for many years and over that time have developed knowledge and practice shaped by the structures of the previous paradigm. To the extent that there are concerns about the potential for NDIS recipients to achieve good participation outcomes, it is necessary to explore how this expertise is acknowledged, but also shared with NDIS recipients so that their capacity for optimal participation outcomes is realised through the new paradigm. This is one of several avenues for future research that would yield fruitful enquiry. Generally, there is limited knowledge around to what extent individualised funding models do impact participation outcomes for people with disability [6,17]. More knowledge is required in order to advance this important and nuanced branch of implementation science amidst the disability sector.

Limitations

This research included the perspectives of service providers, policy makers and practitioners, but did not include the perspectives of the NDIS recipients themselves, as we were unable to successfully recruit NDIS recipients to the project despite several and varied attempts. These perspectives are important to fully conceptualise how individualised funding within the disability sector facilitates participatory outcomes for recipients. Therefore, whilst the findings represent a range of perspectives that are important in the context of the policy reform, they cannot represent the experiences of NDIS recipients themselves and further research is required to explore the views of these integral stakeholders. Themes identified in our analysis were most prominently related to the environmental domain of the ICF, as a result of the research focus to explore perspectives of stakeholders who were involved in service provision. Whilst themes that related to the ICF domains of “Activity and Participation” and “Personal factors” were also identified, research that specifically explores the experiences of NDIS recipients is needed to further examine how these “person-related” domains are influenced by the NDIS funding model. Our data were gathered exclusively in South Australia. This may influence the extent to which generalisations can be drawn about the implications for other areas of Australia or international contexts.

Conclusion

This study explored how allied health services for NDIS recipients are being enacted during a period of transition to the scheme, and used the ICF to consider how service providers perceived the transition to impact participation opportunities or barriers for

NDIS recipients. Stakeholders who participated in this research identified extensive changes within the disability sector, resulting in administrative burden for service providers that was perceived to impact on provision of best practice services. They also reported changes resulting from individualised funding that fostered participation outcomes for NDIS recipients, but were often framed negatively. Service providers may experience a tension with the new system of care that is predicated on the expert knowledge of NDIS recipients. This warrants further exploration as there is risk of continued lack of trust by service providers in the integrity of market-driven approaches which are inherent to individualised funding schemes.

Acknowledgements

The authors would like to acknowledge the participants in this research, and the full project team including Dr Angela Lawless, Lillienne Coles, Nicole Baldwin, and Kendal Stone.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research was funded by a grant awarded by the Department of Industry and Skills, South Australia.

ORCID

Kristen Foley  <http://orcid.org/0000-0002-8169-8652>
 Stacie Attrill  <http://orcid.org/0000-0001-6194-8987>
 Sue McAllister  <http://orcid.org/0000-0003-1597-0563>
 Chris Brebner  <http://orcid.org/0000-0002-8571-6061>

Data availability

Please contact the corresponding author, Kristen Foley, regarding access to the data used in this study.

References

- [1] Needham C, Dickinson H. Any one of us could be among that number': comparing the policy narratives for individualized disability funding in Australia and England – Needham. *Social Policy Admin*. Wiley Online Library. 2017; 52(3):731–749.
- [2] Rummery K. Disabled citizens and social exclusion: the role of direct payments. *Policy Politics*. 2006;34(4):633–650.
- [3] Purcal C, Fisher K, Laragy C. Analysing choice in Australian individual funding disability policies – purcal – 2014. *Australian J Public Admin – Wiley Online Library*. 2014; 73(1):88–102.
- [4] Glasby J, Littlechild R. *Direct payments and personal budgets* (3 ed.). Great Britain: The Policy Press; 2016.
- [5] Commission P. *Disability care and support: productivity commission inquiry report/Australian Government, Productivity Commission*. Australia: National Library of Australia; 2011.

- [6] Da Roit B, Le Bihan B. Similar and yet so different: cash-for-care in six European countries' long-term care policies. *Milbank Q.* 2010;88(3):286–309.
- [7] Fleming P, McGilloway S, Barry S. The successes and challenges of implementing individualised funding and supports for disabled people: an Irish perspective. *Disab Society.* 2016;31(1):1369–1384.
- [8] Wiley A. At a cultural crossroads: Lessons on culture and policy from the New Zealand. *Disab Strategy.* 2009;31(14):1205–1214.
- [9] Agency NDI. Overview of the NDIS Operational Guideline – About the NDIS | NDIS. 2019 [cited 2020 Feb 3]. Available from: <https://www.ndis.gov.au/about-us/operational-guidelines/overview-ndis-operational-guideline/overview-ndis-operational-guideline-about-ndis>
- [10] Wilberforce M, Glendinning C, Challis D, et al. Implementing consumer choice in long-term care: the impact of individual budgets on social care providers in England – Wilberforce. *Social Policy Admin.* Wiley Online Library. 2011;45(5):593–612.
- [11] Hirschman A. Exit, voice, and loyalty. Cambridge: Harvard University Press; 1970.
- [12] Leadbeater C. Personalisation through participation. London: DEMOS; 2004.
- [13] Williams I, Dickinson H. Going it alone or playing to the crowd? a critique of individual budgets and the personalisation of health care in the English National Health Service. *Aust J Public Admin.* 2016;75(2):149–158.
- [14] Poll C. Co-production in supported housing. In: Hunter S, Ritchie P, editors. *Co-production and personalisation in social care: changing relationships in the provision of social care.* Vol. 49. UK: Leeds Beckett University; 2007.
- [15] Hatton C, Waters J, Duffy S, et al. A report on in Control's Second Phase. Evaluation and Learning 2005–2007. London (UK): Control Publication; 2008.
- [16] Needham C. Personalization: from story-line to practice – Needham. *Social Policy Admin.* Wiley Online Library. 2011; 45:54–68.
- [17] Carey G, Dickinson H. A longitudinal study of the implementation experiences of the Australian National Disability Insurance Scheme: investigating transformative policy change. *BMC Health Serv Res.* 2017;17(1):570.
- [18] Bickenbach JE, Bickenbach JE. Disability, culture and the U.N. convention. *Disabil Rehabil.* 2009;31(14):1111–1124.
- [19] WHO. How to use the ICF: a practical manual for using the International Classification of Disability and Health (ICF). Geneva: World Health Organization; 2013.
- [20] Ustun TB, Chatterji S, Bickenbach J. The international classification of functioning, disability and health: a new tool for understanding disability and health. *Disabil Rehabil.* 2003; 25(11–12):565–571.
- [21] Oliver M. *Social work with disabled people.* London: Macmillan; 1983.
- [22] Glasby J. Whose risk is it anyway? Risk and regulation in an era of personalisation. *J Care Services Management.* 2013; 5(4):173–183.
- [23] WHO. *International classification of functioning.* Geneva: Disability and Health; 2001.
- [24] Baum F, MacDougall C, Smith D. Participatory action research. *J Epidemiol Commun H.* 2006;60(10):854–857.
- [25] Simons L, Lathlean J, Squire C. Shifting the focus: sequential methods of analysis with qualitative data. *Qual Health Res.* 2008;18(1):120–132.
- [26] Meyer S, Ward P. How to use social theory within and throughout qualitative research in healthcare contexts. *Sociology Compass.* 2014;8(5):525–539.
- [27] Meyer SB, Lunnay B. The application of abductive and retroductive inference for the design and analysis of theory-driven sociological research. *SRO.* 2012;18(1):12.
- [28] Breen L, Wildy H, Siggers S. Challenges in implementing wellness approaches in childhood disability services: views from the field. *Int J Disab Dev Educ.* 2011;58(2):137–153.
- [29] Breen LJ, Wildy H, Siggers S, et al. In search of wellness: allied health professionals' understandings of wellness in childhood disability services. *Disabil Rehabil.* 2011;33(10): 862–871.
- [30] Breen LJ, Green MJ, Roarty L, et al. Toward embedding wellness approaches to health and disability in the policies and practices of allied health providers. *Fall.* 2008;37(3): 173–179.
- [31] Stephens A, Cullen J, Massey L, et al. Will the national disability insurance scheme improve the lives of those most in need? Effective service delivery for people with acquired brain injury and other disabilities in remote aboriginal and Torres Strait Islander communities – Stephens. *Australian J Public Admin.* Wiley Online Library. 2014;73(2):260–270.
- [32] Do PL. How well does the national disability insurance scheme respond to the issues challenging indigenous people with disability? *Health Worker J.* 2017;18(3):29–34. Available from: <https://anzswjournal.nz/anzsw/article/view/281>
- [33] Gilroy J, Sydney TUo, Donnelly M, et al. Twelve factors that can influence the participation of Aboriginal people in disability services. *Australian Indigenous Health Bulletin.* 2016. Available from: <http://healthbulletin.org.au/articles/twelve-factors-that-can-influence-the-participation-of-aboriginal-people-in-disability-services>.
- [34] Moskos M, Isherwood L. Individualised funding and its implications for the skills and competencies required by disability support workers in Australia. *Labour Industry.* 2019;29(1):34–51.
- [35] David C, West R. NDIS Self-management approaches: opportunities for choice and control or an uber-style wild west? – David. *Australian J Socl Issues.* Wiley Online Library. 2017;52(4):331–346.
- [36] Kuhn T. *The structure of scientific revolutions.* Chicago: The University of Chicago Press; 1966.
- [37] Lord J, Hutchison P. Individualised support and funding: building blocks for capacity building and inclusion. *Disab Society.* 2003;18(1):71–86.