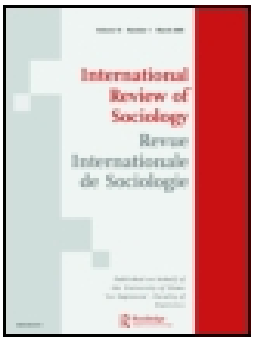

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The personalisation agenda: the case of the Australian National Disability Insurance Scheme

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ABSTRACT
As part of the international trend towards personalisation, in 2013 Australia launched a major disability scheme aiming to give participants greater choice and control over services. The scheme aims to cover a wide diversity of disabilities, services and significant geographical area – resulting in a highly complex system of local overlapping markets. At four years into implementation a range of challenges have emerged. In this paper we firstly describe the Australian National Disability Insurance Scheme, then explore a range of implementation challenges it currently faces as a large-scale personalisation scheme. Based on these experiences we pose a range of questions for similar schemes internationally.

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Personalisation; individualisation; quasi-markets; human service markets

Introduction

Over the last 30 years governments have sought to give citizens greater choice and control of the public services they use (LeGrand, 2007). As a result, we have seen the creation of various forms of public sector markets, including through contracting and tendering processes and, more recently, by utilising individualised or 'personalised' care budgets (Hood, 2005; Klijn & Koppenjan, 2000). Under the latter, individuals are given money to purchase services that meet their needs (LeGrand, 2007; Needham & Glasby, 2015; Williams & Dickinson, 2016). The trend towards personalisation has occurred in the UK, Germany, Scandinavia and the Netherlands to name a few (Anttonen et al., 2012). The aim of the personalisation agenda is to move away from a 'one size fits all' service model, to a situation where citizens can choose services that best meet their needs.

The Australian National Disability Scheme (NDIS) is Australia's first serious venture into personalised funding. It also represents a further extension of the principles of personalisation; while personalisation of care services has been implemented in a number of countries the geographic scale, quantum of funding and complexity of the resulting care market structure under the NDIS could be argued to be unprecedented (Carey & Nevile 2017; Needham & Dickinson, 2017). This, coupled with the diversity of support needs met by the NDIS, distinguishes it from other public service markets. As an illustrative example, consider the market stewardship guidelines for public service markets from

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the Institute for Government (2014) which describe a process of contracting for just one or two providers within a local area (e.g. one bus company in a transport market). Such guidelines would be inadequate for the NDIS, as the equivalent in the NDIS is multiple transport services competing for passengers across multiple routes. The NDIS is not a single market but rather many overlapping markets, with the potential for tens of thousands of providers across a wide range of service types servicing people with a broad variety of disabilities and personal circumstances (Australian Productivity Commission, 2011). In this paper we firstly describe the personalisation agenda for disability care in Australia through the NDIS, and then explore a range of implementation challenges it currently faces as a large-scale personalisation scheme. Through this discussion we pose a range of questions for similar schemes internationally.

Background

Individual budgets (provided under personalisation approaches to policy) in the disability policy area first emerged in the United Kingdom in adult social care, inspired by earlier social movements in the US (Williams & Dickinson, 2016). This was part of both a fight for redistribution and recognition of rights by disability advocates (Riddell et al., 1999). The personalisation agenda has also emerged from broader financial pressures on welfare states. Faced with a range of fiscal and social pressures, we have seen shifts in many industrialised countries away from collective social welfare provision in favour of markets and 'self-directed care' (Giaimo & Manow, 1999). However whether these approaches lead to improvements in people's lives is still a matter of debate (Gadsby, 2013; Gash et al., 2014).

The NDIS was passed in legislation in 2013 with broad public and political support (Thill, 2015). The shift was preceded by a strategic and coordinated public campaign involving people living with disability and their families and carers calling for reform of the old 'broken' service system (Thill, 2015). Under the NDIS, an AU$22billion scheme, approximately 460,000 individuals who have a significant and permanent disability will receive personalised funding budgets (Australian Productivity Commission, 2011; Collings, Dew, & Dowse, 2016). Compared to other personalisation schemes which develop over much longer periods of time the Australian scheme is being implemented at a rapid and almost unprecedented rate. This, we argue, amplifies implementation challenges.

The scheme will be fully implemented across Australia by 2020, including in urban, rural and remote localities (i.e. in remote Indigenous communities) and across a diverse range of disability types and ages (Australian Productivity Commission, 2011; Collings et al., 2016). Under the new 'personalised' model individuals are given funding packages, determined by their level of need and self-defined goals, with which to purchase services (Australian Productivity Commission, 2011). These funding packages are determined on the basis of need by a newly established agency – the National Disability Insurance Agency (see Carey et al., 2017; Walsh & Johnson, 2013). The average package is between $10,000 and $30,000, but can range into the hundreds of thousands of dollars (National Disability Insurance Agency, 2017).

The NDIS is said to replace a piecemeal and inequitable system which has negatively impacted those living with a disability (Australian Productivity Commission, 2011). Before the introduction of the NDIS, disability care services were funded according to a commissioning model in which community based service providers competed for one- to five-year blocks of funding from which they ran a variety of services (Productivity Commission, 2011). Advocacy for a move to the NDIS focused on changing the balance of power in decision-making about the lives of people with disability, ostensibly to create a more equal disability care system (Australian Productivity Commission, 2011; Thill, 2015). Here, advocates were drawing on debates in social policy which demonstrate that when benefits and supports are generic (i.e. one size fits all) they produce unequal experiences and outcomes for users because they fail to take account of differences in need (Carey, Crammond, & De Leeuw, 2015; Carey & Crammond, 2017; Thompson & Hoggett, 1996).

While personalised budgets have been used in other countries, as noted above, the Australian experience is unprecedented in several important ways. Firstly, the geographical spread outstrips that of other countries, for example Australia is 30 times larger than the UK, and this has implications for access to care for people living in remote and rural areas. Secondly, in the UK individuals have the choice to opt into personalised schemes, while in Australia the scheme is compulsory for eligible individuals (Needham & Dickinson, 2017). The NDIS has unique challenges compared with international counterparts (such as the National Health Service in England which has utilised personalised approaches in aged care and disability, and Brukerstyrt Personlig Assistanse in Norway, and similar programmes in Scandinavia and Denmark Askheim, 1999; Askheim, Bengtsson, & Richter, 2014; Brennan, Rice, Traustadóttir, & Anderberg, 2017), offering important insights for international counterparts.

The NDIS is expected to meet the needs of very diverse service users, encompassing a broad range of physical, cognitive and psychosocial disabilities, personal circumstances, histories, locations, access to information and support for decision-making, and engagement with disability services and mainstream services. These factors present challenges for the NDIS in meeting the expectations of service users, service providers and citizens; safeguarding vulnerable people from being exploited or neglected by service providers; delivering effective and efficient services; and meeting timelines set for implementation. While personalisation in the UK was introduced over the course of several decades (Needham & Glasby, 2015), the Australian NDIS has seen a rapid implementation of an essentially transformative policy change (three years from scheme initiation to national roll out) (Carey et al., 2017). Not surprisingly, it has encountered a range of implementation challenges as a result. Below we explore some of the major challenges encountered thus far.

Implementation challenges

Drawing on current research into the implementation of the NDIS we explore four major implementation issues: policy and regulatory coherence, market stewardship, inequities in choice and control and challenges of accountability. Each of these implementation challenges raises questions for the implementation of personalisation schemes internationally.

1. Policy and regulation coherence

The implementation of the NDIS has involved multiple actors working to elaborate the initial vision for the scheme into a range of distinct policy instruments and regimes.

This poses questions about the extent to which they reflect an integrated regulatory framework.

We provide a brief history of the translation of the NDIS design into legislation and regulatory rules. The initial design of the NDIS (Australian Productivity Commission, 2011) was translated into legislation (NDIS Act 2013). The NDIS Act authorises the newly established implementation agency – The National Disability Insurance Agency (NDIA) – to create policies in line with the rules of that Act. The NDIA developed subsidiary regimes (i.e. making policies under the rules that are provided for under the NDIS Act) for pricing services (NDIS, 2015) and for quality and safety (Commonwealth Department of Family and Community Services, 2017). Policymakers charged with implementation have described this process as 'building the plane while flying it' because the development of the pricing rules and quality and safeguards rules occurred as the NDIS began implementation (Whalan et al., 2014). As a result of this 'build while implement' approach, substantive policy instruments were developed and introduced at different times (e.g. complaints process, quality and safeguards frameworks and processes for the regulation of providers), posing challenges to the creation of an integrated and coherent policy framework for the scheme as a whole.

As noted above, the NDIS Act (2013) creates the National Disability Insurance Agency (NDIA) as an independent statutory agency (NDIS Act 2013). An important innovation in the Act is a policy instrument that enables regulation of the scheme via rules set by the NDIA with sign-off by the overseeing Minister. This allows greater flexibility for responsive market stewardship than a scheme governed by contracts or mandatory best practice guidelines (Considine, Lewis and O'Sullivan, 2011; Dearnaley, 2013). However, the Act has two significant omissions which have implications for the policy and regulatory coherence of the scheme.

Firstly, the Act does not explicitly authorise the setting of prices for services by the NDIA or commonwealth government. This is significant because price-setting is the most important lever available to the NDIA or the commonwealth government for market stewardship and an essential tool for 'steering' the emergence of markets to provide choice and control. Importantly, the NDIA is not authorised to set prices in response to market issues. Rather the power to set prices in outlined indirectly by a section in the Act requiring individual plans to 'represent value for money' and the 'long term sustainability of the scheme' (NDIS Act 2013, s.34). This means that prices can only be changed in response to the sustainability of the scheme not the needs of users or issues emerging in the market.

Secondly the Act outlines actuarial oversight of scheme expenditures; however, it does not authorise monitoring and evaluation of how well the scheme is meeting its goals of ensuring choice, control and better outcomes for individuals. Other stakeholders called for a requirement on government to report on whether the NDIS roll-out and its policy goals are in alignment (Earnst and Young Consulting, 2015, pp. 26–27). Arguably, the Act displays the 'democracy deficit' identified by Flyvbjerg et al. (2003) because it does not require transparency about rule-setting, nor does it authorise the collection and publication of information enabling civil society to assess whether the scheme is effective. This means it is difficult to hold the scheme accountable if information about its functions and effects is not available (as discussed in section 4 below, 'Challenges for accountability').

We know that similar market-based schemes for social care in the United Kingdom have been beset by repeated public scandal over a series of crises in quality and safety

(Transforming Care and Commissioning Steering Group, 2014). In the case of the NDIS there are multiple regulators of care quality, market entry, and practitioner conduct across multiple levels of government. The complexity of the quality and safety regime means complaints and early warning signals could be missed, limiting the government's ability to avert serious crises. The key policy instrument for protecting against this is the Quality and Safeguarding Framework (Commonwealth Department of Family and Community Services, 2017). The Quality and Safeguards framework specifies developmental, preventative and corrective actions across the three domains of individuals, providers, and workforce (Commonwealth Department of Family and Community Services, 2017). It does not specify any process or pathway via which *systemic* causes of risk to participants could be identified and addressed – in other words, causes arising from the configuration of the NDIS or NDIA policy and procedures. As Windholz (2014) identifies, risks can emerge from the interaction between omissions or deficits in scheme design. These risks can pose a threat to the legitimacy of the scheme as a whole.

Turning the vision of the NDIS into an over-arching regulatory framework is an ongoing process (Candel & Biesbroek, 2016; Productivity Commission, 2017a). As the scheme develops, it has become clear that mechanisms are needed that allow deliberation about risk and accountability for decision-making, along with a 'clear framework of principles and evidence to support devolved and flexible decision-making' (Flyvbjerg et al., 2003, p. 6). In their absence, difficulties in learning about local market conditions and gaps in the regulation of quality and safety pose hidden but substantial risks to public support for the scheme.

The NDIS highlights the need for clear design of early legislation as well as regulatory coherence. The implementation experience so far raises questions about whether this is best done up-front or if such coherence can indeed be secured by staged development (or building the plane while flying it)? Moreover, how can the vision of such a complex scheme be communicated to diverse stakeholders?

2. Stewardship of personalisation markets

The rise of markets and personalisation is based on the assumption that these approaches are more efficient and effective than state provided services and will lead to an increase in citizen's welfare through greater choice and control (LeGrand, 2007; Ostrom & Ostrom, 1971; Spicker, 1994). However, research into public sector markets has highlighted uncertainty and ambiguity with regard to the role(s) governments should adopt to personalisation markets (Carey et al., 2017; Gash et al., 2014; Malbon, Carey, & Dickinson, 2016). Gash et al. (2014, p. 5) found 'repeated uncertainty about whose job it was to perform important market stewardship functions'. Despite being four years into the implementation of a national market-based scheme and having commenced full roll out, issues of market stewardship remain undecided and unclear in the Australian NDIS – in part due to the policy and regulatory incoherence outlined above (Carey et al., 2017).

Uncertainty around market stewardship has significant implications for practice, as it is unclear who will be responsible for identifying and addressing emerging market issues such as thin markets or market failure. Research suggests that vulnerable citizens are less likely to reap the benefits of market-based service reforms (Anttonen et al., 2012; Booltink, van Genugten, & Lako, 2015; Botti & Iyengar, 2006; Dan & Andrews, 2015; Jilke, 2015). Jilke (2015), for example, found that socioeconomic position is a significant determinant of the quality of services citizens will receive and their ability to switch from unsatisfactory providers. This suggests that if governments' aim to prevent a rise in inequity, stewardship roles (as opposed to just regulatory roles) are crucial. As Needham (2010) suggests, at the core of government intervention in markets sits the question of the state/citizen contract. If this contract is to ensure the welfare of citizens and protect against rising inequality, governments must ensure high quality services and proper choice and control for all citizens – requiring a more hands-on approach to (or stewardship of) public sector markets.

Markets have been positioned as the most effective way to breakdown the power and public sector monopolies, while enabling the expression and diversity of individual choice (Anttonen, Sipila et al., 2012; LeGrand, 2007; Spicker, 1994). But, as others have noted, this raises questions regarding choice for whom and on what basis? Research has shown that vulnerable people can still end up in tutelage relationships with the state within market approaches – limited in their ability to exercise choice and control (Booltink et al., 2015; Carey & Crammond, 2017; Jilke, 2015; Williams, 1992). At present the market stewardship roles for the NDIS remain unclear and spread across multiple entities, including different levels of government and the NDIA (Australian National Audit Office, 2016; Productivity Commission, 2017a). As noted in a recent report by the Australian Productivity Commission (a premier policy advice body):

> To date, market stewards have not given market supply issues sufficient and timely attention. This may be partly due to ambiguity about who is responsible for market development, what market stewardship entails, why it is needed, and lack of capacity or impartiality of governments to undertake market stewardship functions. As such, 'the system for identifying and addressing emerging issues is currently informal and unfixed in the NDIS implementation'. (Productivity Commission, 2017b, p. 394)

This creates challenges for ensuring markets work effectively and the NDIS fulfils the social contract between government and citizens (Carey et al., 2017). That is, can personalisation schemes also ensure equity?

3. Inequities in choice and control

As noted above, the use of markets (particularly in the absence of clear market stewardship roles) raises the questions of equity. While the principles of empowerment, choice and control are important to citizen wellbeing, we need to recognise differences in people's abilities to exercise this choice and control. While the evidence regarding personalisation is in its infancy (Williams & Dickinson, 2016), currently it indicates that in some contexts personalisation can lead to greater satisfaction and continuity of care and a more effective use of public resources (Bornat & Leece, 2006; Glasby & Littlechild, 2009) – thereby redressing inequities between people with and without a disability. However, in the UK, take up of opt-in personalisation schemes for managing individual budgets and care has been relatively low (Williams & Dickinson, 2016). Williams and Dickinson (2016) argue that this cannot be put down to a lack of interest, but rather reflects the capacity of individuals to engage in personalised care and of professionals to support people to engage. Importantly, Williams and Dickinson (2016, p. 5) have found differential take up and outcomes between amongst those accessing such supports.

It is possible that inequities between disability types will begin to emerge in the Australian NDIS. Evidence from the UK has shown that individuals with physical disabilities are able to take better advantage of these opportunities than those with intellectual impairments. In the latter, good outcomes appear to depend upon strong advocacy or brokerage support (Needham, 2013; Riddell et al., 1999; Williams & Dickinson, 2016). In the UK, Riddell et al. (1999) found that the top users of individualised funding and management are people with physical and sensory impairments, with people with mental health problems the least likely to opt in. This is consistent with the literature on health service usage, whereby those who are more disadvantaged are less likely to access services or support and receive less benefit when they do (Hart, 1975; McLean, Sutton, & Guthrie, 2006). Similar findings exist with regard to the Australian accident and injury compensation schemes (upon which the NDIS is based); higher take-up is found amongst those with physical disabilities rather than neurological impairments such as acquired brain injury (Piccenna et al., 2013). This suggests that personalisation and individual budgets – or choice and control models – can widen inequities between people with different types of disabilities.

A critical difference between the UK and Australian context is that in Australia personalisation for those deemed eligible is not a choice – all eligible individuals will be participants in the NDIS. Around 70% of eligible participants have an intellectual disability or autism and related disorder (NDIA, 2015). This enforced participation has the potential to be favourable in terms of equity, as the extra effort required to opt into a scheme is lessened. Yet participation between different types of disability does not guarantee equitable outcomes.

The extent to which the benefits of personalised funding are realised depends upon the advocacy and support networks individuals have access to (Needham, 2013; Williams & Dickinson, 2016). Under the NDIS, individuals must have the ability to negotiate and define goals and plans, and where this is not possible an advocate negotiates on their behalf. For some individuals, Williamson and Dickinson (2015) have found that they neither want nor expect to have to direct their own care. Being able to maximise the gains of personalised care budgets requires skills in managing them as well as navigating new systems. This poses challenges to young people in particular who make up a large proportion of participants (NDIS, 2016).

The UK evidence demonstrates that individuals with significant supports in place prior to personalisation (i.e. financial and interpersonal) are more likely to experience benefits than those who do not (Needham, 2013). This suggests that those who are already marginalised or of low socioeconomic status may benefit least from the NDIS. Needham's (2013) work in disability has shown that there is little supporting evidence that personalisation efforts have a positive effect on social inclusion or income. She argues that 'evidence highlights the dangers of inequity between those with financial and social resources to supplement their use of budgets and those without' (Needham, 2013; Riddell et al., 1999). That is, those who have more resources are more likely to reap the benefits of personalisation than those without.

Currently, the implications of personalised funding and individualised budgets for equity under the NDIS are uncertain, based on the differential ability of individuals to engage in exercising the choice and control (Health Foundation, 2011; Needham, 2013; Williams & Dickinson, 2016). Again, this is exacerbated by a lack of coherent policy instruments and clarity regarding market stewardship to guard against the emergence of inequities. Currently, inequities are likely to emerge on the basis of education, lack of supported learning, or a lack of a market from which to choose. For example individuals with intellectual disabilities – who are already more marginalised – appear to fare worse under such arrangements unless they have advocates or strong support networks (Needham, 2013; Riddell et al., 1999). Moreover, socially isolated people or those without strong support networks and resources to supplement personal budgets also do not reap the same benefits as those who do have strong supports. In this instance, the NDIS risks significantly extending inequities between these individuals and other groups accessing personalised care budgets (and the rest of the population) without more attention to market stewardship. For the NDIS, and other personalised schemes, these issues point to serious concerns about equity. Hence, personalised schemes may assist some but do they do so at the expense of retrenching or expanding inequalities across populations (Carey et al., Online First)?

4. Challenges of accountability

The changes to funding in personalisation schemes have significant implications for accountability systems and structures (Christensen, 2016; Christensen & Laegreid, 2007). Accountability within such schemes is diffuse and often difficult to manage. In the case of the NDIS this includes: accountability for care outcomes, the spend of public money, the welfare of care workers, for market function and for systemic advocacy (Dickinson, Needham, & Sullivan, 2014; Malbon et al., 2016). Malbon et al. (2016) found a plurality of accountability systems in implementation of the NDIS, revealing a hybrid institutional structure that may lead to highly complex processes for holding government or service providers to account. Malbon et al.'s (2016) conclusions on the hybridity of accountability logics in the NDIS accords with other research into personalisation schemes that concludes that hybrid or mixed forms of accountability are both necessary and predictable for hybrid institutions: 'the traditional polarisation between public (democratic) and private (market) modes of accountability is now inadequate. Hybrid forms of public service organization require hybrid forms of accountability' (Ranson, 2003, p. 472).

When considering accountability for safe and quality care outcomes, a goal of the NDIS was to make people with disability hold a higher level of accountability (alongside support from government) for their services (Australian Productivity Commission, 2011). Implementers of the NDIS understood that the scheme supported individuals to hold primary responsibility for their care outcomes; however, the burden of this accountability is not always feasible or desired by scheme participants (Malbon et al., 2016). The primary way that a scheme participant can exercise choice and control, and accountability for their care, is by moving their service to a new service provider. However, the ability to do this is highly reliant upon the availability of a *better* service provider, which can only occur in a robust market (Carey et al., 2017). Alongside individual responsibility for care outcomes, government does provide quality and safeguard standards that must be met by service providers. As noted earlier, in the NDIS the quality and safeguards processes are currently run by the State and Territory governments of Australia, with a view to moving to a national Quality and Safeguards framework over the next five years (Department of Social Services, 2016). This means that current forms of accountability for care outcomes span individuals, service providers, state and territory government and, eventually, federal government. Negotiating this diffuse accountability, and ensuring individuals or issues do not 'slip through the gaps' is a major challenge for personalised schemes (Malbon et al., 2016).

Personalised funding models have also been shown to increase the casualisation and precariousness of the care workforce, with possible flow on effects for quality of care delivered (Baines, Charlesworth, & Daly, 2016). One NDIS policymaker interviewed in Malbon et al. (2016) highlighted problems for the availability and capacity of the NDIA workforce well: 'The challenges mostly arise in workforce capacity. That goes to issues around making sure that there are enough people to provide direct services to participants.' The notion that robust markets will self-manage and regulate around issues like the care workforce is strong within the background documents for the NDIS (such as Australian Productivity Commission, 2011). Because of this assumption and faith in the market to incentivise increases in workforce capacity and availability, there are little formal accountability measures in place for ensuring that there is a capable and available workforce to provide disability care to Australia's people with lifelong disability.

The accountability dilemmas that arise in the NDIS, and arguably personalisation schemes worldwide, behove us to examine crucial questions around government responsibility, such as: Can the implementation of market-based reforms separate governance from its effects? How can governments continue to be held accountable for matters between individuals and service providers in a market-based system?

Discussion

In this paper we have explored four major implementation challenges facing the NDIS, an important international example of a large-scale scheme based on personalisation principles. We argue that these implementation challenges provide important insights for those seeking to implement similar personalised schemes internationally. In particular we identified that rushed implementation has created a host of implementation challenges, including a lack of coherence in policy and regulatory instruments, which in turn has lead to market stewardship challenges and questions over accountability and whether choice and control can truly exist for all participants. The lack of coherence across these domains raises questions about whether the NDIS is a genuine effort to secure greater choice and control for all people with a disability (Thill, 2015), or a way to disrupt and reform a problematic system using language and ideas which are hard to argue against (i.e. choice and control).

Returning to the roots of the NDIS, the case for development of the scheme was underpinned by evidence that Australian disability services were underfunded, inflexible, fragmented and built around the needs of the service system, rather than those of individuals accessing those services (Australian Productivity Commission, 2011). Proponents argued that people with disabilities had little choice and control over services they could access, which were largely being determined by professionals, what was locally available, or what various levels of governments provided. The funding and organising of disability services was complex and inefficient, with gaps and overlap in state and territory and federal responsibilities (Purcal, Fisher, & Laragy, 2014); and the complexity of the system was compounded by the existence of insurance-based funding of disability services and services funded privately as a result of public liability claims. Flagging inequity of access to services and support, the NDIS promised to ‘support a better life for hundreds of thousands of Australians with a significant and permanent disability’ (National Disability Insurance Agency, 2017).

This reform of disability services has been framed as a rights-based issue for people with disability (Thill, 2015) – a position few could reasonably counter. The objects and guiding principles of the NDIS recognise the rights of people with disabilities to be provided with reasonable and necessary supports and to have certainty that they will receive the lifelong care and support they need (Australian Productivity Commission, 2011). However, early evidence suggests that swift and sweeping changes to disability services and funding are not producing the desired effect in all instances. The range of serious implementation issues at play – outlined throughout this paper – raise questions about whether the scheme will really provide all users with the desired choice and control.

One of the major challenges to the scheme has been the readiness and capacity of service users to understand and navigate the changes, as well as the readiness and capacity of service providers to adapt and change in response to new funding arrangements and respond to consumer demand, and in part to the readiness and capacity of the government and NDIA to build and monitor the scheme’s architecture. This has been exacerbated by incoherence in policy and regulatory instruments.

Research into the experiences of participants of the scheme reveal frustration about inconsistent access to services, information and resources to be able to exercise choice and control over their care; disappointment that their knowledge, needs and preferences were overlooked in the care planning process; and concern that boundaries between services they wanted to combine remained pronounced (Warr et al., 2017). While the NDIS promises participants choice and control, their options for support are bounded by cost–benefit analysis of what is reasonable and necessary within a normative frame, and involves discretionary decision-making on the part of care planners. This is exacerbated by policy incoherence and unclear responsibilities for different parts of government regarding accountability and market stewardship.

Arguably, the NDIS has been used as a means by which to undertake a major restructuring of the disability sector under the guise of choice and control. This is not the first time Australia has turned to the market to disrupt entrenched ways of delivering publicly funded services with mixed results. Outsourcing employment assistance for the unemployed in the 1990s was a mechanism to abolish an arguably lax Commonwealth Employment Service that was seen to be deterring the long-term unemployed from adapting to changing labour market conditions (Considine et al., 2015). More recently, reform of Australia’s training system created ‘direct relationships between clients and training organisations’ (The Allen Consulting Group, 2011, p. 7), shifting the incentives and structure of the system away from the needs of providers and agencies to the needs of industry and the economy (Rudd, 2007). In both cases, with minimal political risk and bypassing protracted negotiation with existing service providers by framing the reforms as ‘user choice’, the Australian Government adopted ‘a science of governance, in which those delivering programs and those receiving them each had to be carefully activated through a new regime of exhortations and incentives, honed to achieve an explicit and exemplary change in behaviour’ (Considine & O’Sullivan, 2015, p. 4). Organisations delivering services adapted and changed the way they worked, spurred by machinery of government changes, outcomes based performance management, the entry of contracted community and private sector agencies to the system, administrative reforms and competition for funding (Considine et al., 2011). But over time, most tested the limits of their funding regimes in different ways to achieve their own objectives. Our research suggests that the NDIS has the potential to be used to disrupt the service sector through the same 'science of governance' processes in combination with existing implementation challenges.

Conclusion

Overall, while the aspirations of the NDIS and the Australian personalisation agenda are noble, there are currently a range of pressing implementation issues faced by the scheme. These provide important insights for similar schemes internationally. Rushed implementation has lead to policy and regulatory incoherence, which has implications for market stewardship, choice and control for participants and robust accountability. Together, these issues pose a major challenge to the legitimacy of the scheme and questions over whether the NDIS is truly an effort to secure greater choice and control or a means by which to disrupt and reform a system using language which is hard to counter. Addressing implementation issues that have emerged to date may require a return to first principles and a redesign of the NDIS Act, along with careful attention to market stewardship. For international schemes the NDIS highlights the importance of careful planning, measured implementation and clear design particularly regarding foundational legislation.

Disclosure statement

No potential conflict of interest was reported by the authors.

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