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# The Duplicity of Choice and Empowerment: Disability Rights Diluted in Australia's Policies on Assistive Technology

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**Abstract:** The combination of choice as a contested concept and its increasing adoption as a policy principle necessitates a critical analysis of its interpretation within Australia's reforms to disability services. While choice may appear to be an abstract and flexible principle in policy, its operationalization in practice tends to come with conditions. This paper investigates the interpretation of choice in the National Disability Insurance Scheme (NDIS), via an interpretive policy analysis of assistive technology (AT) provision. Analysis of policy artefacts reveals a diminishing influence of disability rights in favor of an economic discourse, and contradictory assumptions about choice in the implementation of legislation. The language of choice and empowerment masks the relegation of the presumption of capacity to instead perpetuate professional power in determining access to resources by people with disability.

**Keywords:** assistive technology; choice; capacity; national disability insurance scheme; interpretive policy analysis

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## 1. Introduction

Reforms to Australia's disability policies represent a cultural and ideological shift in thinking about the rights of people with disability, emphasizing personalization in the provision of services through the National Disability Insurance Scheme's (NDIS) mantra of "choice and control". Different interpretations of policy affect practices and outcomes, which may not be consistent with policy objectives. Interpretations and outcomes from policies adopting choice as a principle have been discussed extensively in international health and social care literature, providing valuable insight into the various interpretations of choice in policy, and outcomes in practice [1–5]. The context in which policies are interpreted places conditions on the possibilities available and the resources required for the act of choosing.

This research explores choice in the context of assistive technology (AT) provision at a time when two different discourses are intersecting in the reforms to Australia's disability policies. The first is the disability rights movement that emphasizes respect for the autonomy and dignity of people with disability, and their right to participation, including making choices pertaining to their own lives [6]. The second discourse is the neoliberal discourse on choice in public policy, and its association with individualized funding and market mechanisms that attempt to produce economic efficiencies [7]. Little consideration has been given to the perhaps irreconcilable incongruities of these two discourses in relation to AT provision; it is possible that privileging one may undermine the other. Theoretical and empirical investigation is required to understand the implications of this policy reform context for AT provision policy and practice and the realization of disability rights.

This paper addresses the research question, “How is choice interpreted in policy related to AT provision?” It is part of a larger research study that used interpretive policy analysis methods to explore the relationship between the macro context of Australia’s policies and experiences at the micro level of AT provision [8]. This paper focuses on the NDIS, examining the legislation and its interpretation in policy documents. The findings show how different interpretations of choice affect policies and practices, responding to calls for “critical engagement with the dominant interpretations” of choice in order to prevent its reduction to a vehicle for “unchecked marketization of social policy” [7] (p. 307). This research contributes to social policy more generally by advancing our understanding of the challenges of integrating different (and competing) perspectives in the complex process of implementing human rights principles.

## 2. Background

‘Choice’ has been adopted as a principle in international disability rights and in social policy by liberal democratic governments. It is defined both as the act of choosing between two or more possibilities, and as the possibilities from which one or more may be chosen [9]. Choice is also defined as the power, right, or faculty of choosing, and is a feature of human autonomy and self-determination, deemed necessary for full participation and inclusion in society [10]. Depending on its interpretation, choice may be translated into policy and practice in different ways, affecting the mechanisms by which it is offered or delivered, and outcomes for individuals and society.

The adoption of choice in social policy has been written about extensively by disability scholars [11–13], but with greater attention to welfare systems and human supports for people with disability in Australia [14,15]. Australian research has found contradictory propositions made about the “choice agenda” in reforms to the disability housing sector [16] but has yet to examine its interpretation in AT provision.

Assistive technology (AT) comprises assistive products and services used to mediate individuals’ environments and optimize performance and participation. Access to AT is recognized as critical for the inclusion of people with disability in societies, along with access to healthcare services and other supports [6]. To date, AT policies in Australia have failed to deliver equitable access to, and optimal outcomes for, people with disability [17].

The NDIS is a significant social reform in Australia and introduces a new way of funding and providing support for people with disability. Based on the premise that investing in people with disability early will improve their outcomes later in life, the NDIS takes an insurance-based approach toward support [18]. It operates as a social insurance scheme that provides individualized support for eligible individuals with permanent and significant impairment, their families and carers. The most significant change is that the funding is allocated to individual participants, rather than to services or organizations, and participants are encouraged to choose their supports in accordance with their individual goals and plan.

Policies espousing individual choice tend not to differentiate one’s ability to choose from one’s capacity to realize choices [19], and often still grant discretionary power to health professionals or administrators. Reviews of policies promoting choice in the UK’s National Health Service showed that fewer than half the patients eligible to choose a hospital for elective surgery were offered a choice [20], and though policy stated that patients could choose to register with any general practice, the practices did not have to accept registrations [21]. The existence of a right to choose or policy of choice does not guarantee that choices will be offered or realized in practice.

## 3. Methods

The research question was answered through interpretive policy analysis based on a relativist ontological stance and using qualitative methods. Interpretive research acknowledges that the perspectives of individuals directly involved in the studied phenomena are crucial to understanding

their actions and interactions [22]. Qualitative research methods support a depth of understanding rather than a breadth, attempting to explain social phenomena by extracting meaning from data [23].

This paper reports findings from a category analysis that was used to examine the interpretations of choice in the NDIS as they relate to AT provision. This involved careful consideration of language to identify the meanings communicated in public documents by different interpretive communities involved (in this paper, policymakers and policy implementers) and explore the underlying perspectives and assumptions reflected in words [24]. Summaries of each artefact from the two interpretive communities are presented in the following section, followed by a discussion that illuminates the connections and divergences between the artefacts, and implications of policy implementation.

#### 4. Findings

The NDIS commenced operation in July 2013, with activities in eight trial sites, followed by progressive rollout across Australian states between 2016 and 2019. It is administered by the National Disability Insurance Agency (NDIA), an Australian Government agency and a Corporate Commonwealth Entity under the *Public Governance, Performance and Accountability Act 2013 (Cth)* (PGPA Act). The *NDIS Act 2013 (Cth)* was identified as an artefact from the policymakers' community. The Operational Guidelines published by the NDIA represent the NDIA's interpretation of the NDIS Act; they are not legislative instruments.

##### 4.1. The NDIS Act 2013

The NDIS Act is the legislation which establishes the NDIS and the NDIS Launch Transition Agency (now called the NDIA). It sets out the objects and principles for the operation of the NDIS, and the governance arrangements for the NDIA and its Board and Chief Executive Officer (CEO), and an Independent Advisory Council. The Act also sets out how a person can become a participant and have an individual plan prepared, approved and reviewed. These provisions are principles-based rather than prescriptive, for example, stating that participants are provided "reasonable and necessary supports" and outlining broad criteria for determining this (Part 2, Division 2, Section 34) rather than prescribing the types of supports included or excluded.

The objects and principles of the NDIS Act refer to Australia's obligations under the United Nations' (UN) Convention on the Rights of Persons with Disabilities (CRPD) and seek to give effect to some of these obligations. In doing so, the Act clarifies and narrows the scope of participation supported by the NDIS, stating in Section 3(1) the object is to "support the independence and social and economic participation of people with disability." Similarly, Section 3(1)(h) states that an object of the NDIS Act is to "raise community awareness of the issues that affect the social and economic participation of people with disability, and facilitate greater community inclusion of people with disability." The focus on support for social and economic participation overshadows other domains of participation explicitly promoted in the CRPD, namely political (Article 29) and cultural (Article 30) participation.

The legislative framework for the NDIS is based on the presumption that people with disability have the capacity to make decisions which affect their own lives. This is explicated in the first of the Principles relating to the participation of people with disability, Section 17A (1), which states, "People with disability are assumed, so far as is reasonable in the circumstances, to have capacity to determine their own best interests and make decisions that affect their own lives". Support for decision-making is part of the Act's objects and principles, including:

Section 3(1)(e) states that an object of the NDIS Act is to, "enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports".

Section 4(4) states that a guiding principle of the NDIS Act is, "people with disability should be supported to exercise choice, including in relation to taking reasonable risks, in the pursuit of their goals and the planning and delivery of their supports".

Section 4(8) states that a guiding principle of the NDIS Act is, "people with disability have the same right as other members of Australian society to be able to determine their own best interests, including the right

to exercise choice and control, and to engage as equal partners in decisions that will affect their lives, to the full extent of their capacity”.

Section 4(9) states that a guiding principle of the NDIS Act is, “people with disability should be supported in all their dealings and communications with the Agency so that their capacity to exercise choice and control is maximised in a way that is appropriate to their circumstances and cultural needs”.

Despite this support for legal capacity, there are limited provisions for supported decision-making in the Act to build on and regulate these objects and principles.

#### 4.2. Assistive Technology in the NDIS

While not mentioned explicitly in the NDIS Act, AT is an important support for many NDIS participants. AT was included in 39% of all participants’ plans in NDIS trial sites, and in the plans of more than 50% of participants aged over 45 years and under 18 years [25]. The NDIA has released several strategic and operational documents related to AT since commencing the NDIS, and the terminology and emphasis have shifted over time. These documents were identified as artefacts from the policy implementers’ community for the interpretive policy analysis, because of the NDIA’s role in interpreting the Act to operate the NDIS.

#### 4.3. Operational Guideline—Planning and Assessment—Supports in the Plan—Assistive Technology, 2014

The NDIA develops Operational Guidelines based on the NDIS Act and relevant Rules made under the NDIS Act. The first operational guideline for AT provision in the NDIS was published on 16 January 2014 [26]. It refers to Sections 4, 33 and 34 of the NDIS Act and the Supports for Participants Rules for guidance on how a participant’s goals are included in planning and what supports are considered reasonable and necessary to fund.

The Guideline emphasizes the purpose of AT to enable independence or prevent impairment, and reduce the need for assistance, or make assistance safe. This is a narrow interpretation of the purpose of the NDIS, failing to mention the contribution that AT might make to inclusion and participation by optimizing performance. In contrast, a rights-based approach might refer to the Objects of the NDIS Act (Section 3) or the General Principles of the CRPD and emphasize the purpose of AT to promote equality of opportunity and enable full and effective participation and inclusion in society (Article 3). Despite the clinical discourse, the Guideline avoids slipping into a medical discourse, by referring to, “helping a participant select assistive technology” (p. 2) instead of adopting the term “prescription” that is still widely used by practitioners in Australia.

The document gives guidance on a range of AT services that may be funded as part of participants’ approved plans. These include, “expert assessment, assistance with selection, fitting, configuring and training where these services are not otherwise available as part of the purchase price or part of the standard service offering” (p. 4). The Guideline states that, “expert assessment and assistance is to be provided by a person with appropriate qualifications and experience in that particular type of assistive technology”. It is unclear how the NDIA operationalizes this expectation given the lack of a national qualification or credential to recognize specific AT knowledge, skills or experience in Australia [27].

The NDIA reviews and updates operational guidelines, and this first version has been superseded to become part of a suite of Operational Guidelines under the heading, “Including Specific Types of Supports in Plans” [28]. The definitions and inclusions from the first version of the AT Guideline are the same, but now also include a link to separate Guidelines on requesting further information or reports to inform a participant’s plan.

#### 4.4. Assistive Technology Discussion Paper, 2014

The NDIA released the discussion paper, “Towards Solutions for Assistive Technology” in December 2014, with the aim, “To deliver an empowering, sustainable and nationally consistent approach to ensuring NDIS participants have ready access to the quality assistive technology they

require to fully participate in their communities” [29] (p. 1). It is focused on purchasing and procurement, as well as individual selection of assistive products.

Premised on a commitment to participant choice and empowerment, a significant part of the AT Discussion Paper is devoted to assessing the capacity of participants to choose their own AT. The process and criteria for assessing participants’ capacity are set out in what is termed the, “participant capacity building framework” (pp. 25–30), which places participants into three categories: novice, developing, and expert. Consistent with the Preamble (o) of the CRPD, it promotes opportunities for participants to be involved in decision-making. However, it makes no mention of the presumption of capacity of participants from Section 17A (1) of the NDIS Act.

While framed as an empowerment strategy, the participant capacity building framework appears to be a risk management approach for the NDIA to retain control of AT decision-making and funding. This is illustrated in Table 3 (pp. 29–30), which attempts to combine the categories of assistive products (grouped by complexity, based on purchase price) with the categories of participant capacity in order to produce a recommended “level of professional support” offered by allied health professionals and/or suppliers. The framework assesses capacity, which should not be a necessary qualification given the presumption of capacity stated in the Act. It assesses capacity in relation to the individual and their circumstances, rather than in relation to a specific decision, and fails to recognize that multiple decisions are made over an extended period of time in AT provision. Moreover, it assumes that capacity can be attained through the provision of information, rather than recognizing the differing nature of decisions and value of dialogue and relationships in supporting decision-making. In seeking to assess participants’ capacity prior to AT provision, the NDIA does not provide opportunities for participants to demonstrate or develop capacity (CRPD Article (e)) by first having access to appropriate AT (e.g., communication devices) as an enabler.

The other significant part of the AT Discussion Paper is focused on procurement and management of assistive products as a means of lowering costs. There is mention of the involvement of people with disability in collective decisions, in the form of representatives on a sourcing and procurement team. While this may constitute choice and political participation according the CRPD, the Discussion Paper does not discuss the constraints of collective decision-making on the choices of individual participants. In addition to bulk procurement, the AT Discussion Paper advocates direct purchase of assistive products by participants to increase choice and control. It acknowledges the need for “specialist professional and technical advice” (p. 11) but does not address how service providers will collaborate with participants, instead referring to “knowledgeable consumers” (pp. 3, 8, 10) and emphasizing the role of information in guiding AT decisions. There is no mention of a strategy to develop service quality or workforce competence, apart from reference to existing (unspecified) Competency Frameworks and Codes of Practice and the NDIA’s proposed “Quality and Safeguards” project.

#### *4.5. Assistive Technology Strategy, 2015*

The NDIA released its Assistive Technology Strategy on 26 October 2015, setting out its vision (revised from the AT Discussion Paper) to, “build an empowering, sustainable and consistent approach to ensuring National Disability Insurance Scheme participants have choice in, and access to, individualised assistive technology solutions that enable and enhance their economic and community participation” [25] (p. 3).

The AT Strategy is an ambitious but somewhat contradictory document. The section on “strategic framework and initiatives” attempts to combine two objectives: “to transform the selection, sourcing and supply of technological solutions for people with disability, and to leverage technology to revolutionise disability service delivery and outcomes” (p. 4). The first of these aims can be linked back to the Objects of the NDIS, including Section 3(1)(d) to, “provide reasonable and necessary supports, including early intervention supports, for participants in the National Disability Insurance Scheme launch”. The imperative to, “revolutionise disability service delivery” may come from, “the Technology Authority Strategy”, mentioned in a section justifying the use of AT in “value creation” for the NDIA

(p. 7). These two, potentially competing, objectives force the AT Strategy to focus on participants and the Objects of the NDIS Act, while also prioritizing cost-saving applications of technology in service delivery. This is exemplified in a small section about rural and remote areas that states, “Technology solutions will be valuable in addressing some market supply gaps, particularly in rural and remote areas. For example, telehealth functionality could be used to supply some services and supports from allied health professionals” (p. 8). This statement, and the AT Strategy in general, ignore widely acknowledged inequalities in internet access, literacy and affordability that affect Australians living in rural and remote areas [30].

## 5. Discussion

### 5.1. *The Economics and Politics of Choice in Public Policy*

The policy documents analyzed illustrate competing ideals that drive policy, and multiple interpretations from different interpretive communities. The multiple meanings of choice provide flexibility for policymakers, but present contradictory propositions [16]. The dominance of economic discourses in policymaking has the potential to overshadow the disability rights agenda on choice, which is ostensibly the primary driver of reforms to Australia’s disability sector. While the NDIS Act is consistent with a rights-based reform agenda, its interpretation in the NDIA’s documents related to AT provision demonstrates a shift in focus toward prioritizing economic efficiency. The tension between the economic imperatives of cost-containment and the disability rights agenda is evident in the only statement in the AT Strategy that discusses dignity of risk:

The design of full scheme operations and AT guidelines will need to balance the need for participants to be afforded the dignity of risk-taking and decision-making autonomy with policies, processes and systems that protect Scheme sustainability in a rapidly evolving technology market. (p. 16)

The influence of economic discourses on the interpretation of choice in the NDIA’s documents is inconsistent with the disability rights paradigm expressed in the NDIS Act and has potentially significant implications for NDIS participants.

### 5.2. *Loss of the Assumption of Capacity*

The emphasis on assessing participants’ capacity to choose in the AT Discussion Paper and AT Strategy is particularly notable in light of the recommendations from the Australian Law Reform Commission (ALRC) report published in 2014 [31]. The ALRC inquiry considered how to promote the rights and dignity of people with disability in Commonwealth laws and legal frameworks, with regard to the principles of the CRPD. It addressed the shift from substitute decision-making to supported decision-making that is central to Article 12 of the CRPD [32], and the implications of this for legislation and policy affecting people with disability.

The ALRC report acknowledges that the NDIS Act is already largely consistent with the CRPD in its provision for supported decision-making. It recommends explicit reference to supported decision making, and provision of any support necessary for people to make, communicate and participate in decisions that affect their lives. The ALRC also comments on the presumption of capacity in the NDIS Act, and the binary classification that this tends to imply (into people who have legal capacity, and people who do not) because it may be rebutted. The report proposes amendments that would help clarify the shift in mindset of the NDIS from a focus on whether people with disability have legal capacity, to what supports enable people with disability to exercise their right to make decisions. The amendments would align the NDIS Act more closely with the CRPD, but the Australian Government has not yet responded to the ALRC report, and legislative amendments to implement its recommendations are not anticipated in the short term. Instead of emphasizing categories of participant capacity, the NDIA could focus on providing decision-making support for participants with

regard to the selection, acquisition and use of AT [33]. The AT Strategy ignores the Act's presumption of participants' capacity in the first of its strategic principles, "Participants can be empowered by building their capacity to make decisions about their AT needs" (p. 10). The AT Strategy emphasizes information and the number of assistive products as facilitators of individual choice in its second and third principles:

- (1) Participants have access to all the information they require to identify AT options and explore the 'fit-for-purpose', relevance and utility of potential technology solutions;
- (2) The range of AT options to explore and choose from is broad enough to offer real choice and ensure quality, informed by direct engagement with, and input from, people with disability; (p. 10)

The AT Strategy's "Participant capacity-building framework" (also called a, "participant empowerment framework") claims to, "provide guidelines for increasing participants' capacity to make informed choices on AT selection, access and use" with the intention to, "reduce, where appropriate, participants' reliance on therapists to 'prescribe' AT on their behalf" (p. 15). The framework categorizes participants' capacity as novice, developing or expert based on their prior experience using AT and self-directing their supports, and their access to information and trial equipment. While the description says that, "The participant could do this independently or they could be supported to evaluate their expertise in each area" (p. 27), the proposed initiatives imply that the assessment of capacity is intended to be conducted by practitioners: "NDIA will refine and finalise the participant capacity-building framework into an accessible format for NDIA planners and Local Area Coordinators, as well as Allied Health Professionals" (p. 16).

Ignoring the presumption of participants' capacity and placing the power to assess capacity with practitioners is inconsistent with the Objects of the NDIS Act. The emphasis on participants' capacity also contrasts with research on AT provision that suggests that high rates of non-use of AT are linked to policies and processes, the skills of practitioners, and their relationships with consumers [34,35]. Moreover, the emphasis on assessing a participant's capacity prior to AT provision ignores the notion that AT is an enabler, and that often people with disability require AT (and time and support to optimize their use of assistive products) to develop and demonstrate capacity [35]. As an alternative, the NDIA could adopt the recommendation that the CRPD Committee made to Australian governments to work with Disabled Persons' Organizations (DPOs) in providing training on supported decision-making for public servants and others involved in interpreting or implementing the CRPD [36].

### *5.3. Collectivism for Economic Efficiency Rather Than Self-Determination*

In Australia, procurement of assistive products has traditionally been coordinated by government agencies [37,38], but with the individualization of disability services this strategy now has to be justified.

The fundamental principle applied in determining the appropriate role for NDIA in sourcing and procurement was that it should deliver outcomes that are as good, or better than, what could be achieved otherwise, and also deliver net financial benefits for the scheme (and ultimately taxpayers). (p. 17)

Thus, although the AT Strategy claims to be, "anchored in participant choice and control" (p. 18), these rights are clearly contingent on economic analyses. The criteria for determining which assistive products will be sourced by the NDIA in bulk rather than being selected by individual participants is clarified, "The guiding principle for that selection is to maximise value for participants and economic returns for the scheme" (p. 18). The central sourcing will result in a smaller selection of assistive products from which participants will be able to choose. This is similar to the Competitive Enablement approach [39] and is justified in the Strategy as being positive for participants.

First, for all centrally sourced AT parcels, the recommended approach will enhance participants' ability to choose products that meet their needs by offering an appropriate range

of pre-tested products from a tender or panel, based on merit (superior quality, competitive price). (p. 20)

Collective choice is not in itself counter to human rights principles, particularly self-determination, which is often considered a collective process [10,40]. However, to be consistent with the General Obligations (Article 4, paragraph 3) and Article 12 of the CRPD, the process must still ensure the active participation of people with disability in decision-making. The AT Strategy addresses this, if somewhat superficially, with the comment, "... if central sourcing is selected as the best solution for some types of AT, NDIA will include participants at each stage to inform the end-to-end procurement process" (p. 10).

A detailed explanation is provided for the selection of assistive products collectively chosen by the NDIA, to justify the relegation of individual participant choice. Other than mention of, "participant interviews and other engagement methods" (p. 18), there is no indication that this process was led by, or actively involved, people with disability or representative groups in decision-making. The Strategy states that, "participants may choose to opt in or out of sourcing their AT through NDIA" (p. 19), without any explanation of how this would be balanced against the principle of "economic returns for the scheme" or potential negative repercussions for participants if their choice was deemed not to "maximise value". Given the NDIA's emphasis on capacity, a participant's choice to opt out of central sourcing would likely be considered "unwise" and could trigger a classification of "novice" capacity and the requirement to have AT "prescribed". Health professionals and institutions have a history of risk-aversion and paternalism, imposing restrictions on the decision-making of people with disability that do not apply equally to people without disability [41,42]. A lack of legislated protection for unwise decisions in Australia has made it easy to conflate legal capacity with mental capacity, and difficult to shift to a culture of presumed capacity and supported decision-making [33].

#### 5.4. Devolved Responsibility for Policy Implementation

It has long been observed that well-intentioned policies can get lost in implementation. High-level legislation and policies are necessary but not sufficient to realize disability rights, as they are reinterpreted, distorted or even subverted when applied at a local level, or across different sectors of government [43,44]. The responsibility for implementing the ambiguous concept of choice is a critical policy design issue that affects the conditions in which choice exists for NDIS participants. The allocation of public resources to support legitimate individual needs and preferences tends not to be specified at the policy level, but instead devolved to organizations and their administrators [19]. This is evident in the AT Strategy, where participants' access to resources may be dependent on relational strategies such as negotiation with administrators and health professionals.

Although choice has multiple meanings and associated policy mechanisms, political and popular rhetoric about individual choice has dominated the disability policy discourse and made it difficult to express concerns or propose alternative policy visions and mechanisms. An alternative approach is evident in the National Standards for Disability Services (NSDS) which, unlike the AT Strategy, promote partnering with service providers and active engagement with family, friends or other supporters in the planning and delivery of supports [10]. The NSDS incorporate notions of "citizen-consumerism" that allow people with disability greater input into the "co-production" of public services at an individual or collective level [4].

Co-production seeks to avoid setting up competitive or adversarial relationships between participants and providers, and support people's capacity to express their needs and preferences. In practice, these approaches recognize that services may be produced and consumed individually or collectively [45] and are constructed over time through multiple interactions. Problems are addressed through continuous quality improvement activities instead of being linked to participants' capacity and constraining their involvement in decision-making. From a policy perspective, however, the concept of co-production lacks specificity with respect to the allocation of responsibilities [46]. It may also not provide sufficient safeguards to prevent the entrenchment of professional power, or undue family influence over individuals [10], or the prioritization of cost-containment.

Devolving responsibility for implementing policies to the organizational or practitioner level risks exacerbating inequalities between individuals, in this case NDIS participants. People skilled in expressing their needs and negotiating, and those who have sufficient financial or social resources to operate independently of public services are at a significant advantage over people requiring social or financial support [47,48]. Choices are thus shaped by the interpretation of policies made by providers interacting directly with participants, as well as the capacities of the participant and their relationships with providers. The realization of choice in practice may, therefore, vary depending on the organizational culture and resources of providers, and so the experience of choice will differ among participants.

## 6. Conclusions

Choice has been adopted as a principle to recognize disability rights in Australia's reforms to disability policies. This paper analyzed its interpretation in NDIS legislation and policy documents related to AT provision, finding a diminishing influence of the disability rights agenda in favor of economic discourses. These issues arise because choice is part of a larger political and ideological movement in liberal democratic countries that has seen the reconstitution of publicly funded disability services as select goods that the discerning consumer can evaluate in terms of utility benefits and thereby achieve their personal goals [45].

The ambiguity of choice as a policy principle allows policymakers to avoid or delay specifying how it will be applied in practice, to gain popular support and pre-empt criticism. Support is gained by arguing that market competition generates choice for individuals and efficiency for taxpayers, compared to the stereotypical view of bureaucratic and paternalistic public service provision. The "Shut Out" report illustrated a failure of mainstream and disability services in Australia to deliver equitable access to, and optimal outcomes from, AT [17]. Choice has become a dominant yet imprecise vision to address these failures but is taken for granted and unchallenged.

The findings from this research contrast with the political rhetoric of "choice and control" and highlight the risks of devolved policy implementation perpetuating inequalities in access to support. Analysis of AT policy documents produced by the NDIA reveals an interpretation of choice driven by neoliberal ideals that are not necessarily complementary to the social liberal intent of the NDIS or the disability rights paradigm. Economic imperatives for cost-containment have been adopted as the primary criteria for assessing individual and collective assistive product procurement decisions, while the persistent problems with the AT workforce capacity and systemic issues of service quality remain unaddressed.

The AT Strategy's "participant empowerment framework" [25] (p. 15) conflates mental capacity with legal capacity and ensures that only those participants deemed by professionals to have sufficient capacity will be able to realize their right to choice in AT provision. The framework and detailed descriptions of participants' levels of capacity deflects attention away from institutional structures that have contributed to the disempowerment of people with disability and poor outcomes from AT provision. Instead, it places responsibility on people with disability to make rational choices, while positioning them as clients, "lacking the capacity to transform their lives without the help of the professional bodies" [49] (p. 266). Adopting the language of empowerment while failing to address a culture of victim-blaming and ignoring structural factors that limit the agency of people with disability is, as Imrie suggested, "duplicitous, a misnomer . . ." [49] (p. 266).

This research shows that people with disability are still dependent on the goodwill of practitioners or administrators to access support [50]. The analysis reveals that, in Australia, AT is still understood as assistive products, with little recognition of the importance of AT services in facilitating their selection, acquisition and use. The interactions between individuals and service providers that occur beneath formal legislation are where inequalities often re-emerge [51], with the potential to perpetuate discrimination on the basis of ethnicity, gender, education and life experiences [19,52]. Even with

legislation to promote disability rights, deeply rooted social structures and power relations may limit the emancipatory effects of policies based on neoliberal notions of choice.

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