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A discourse analysis of the representation of nursing in the National Disability Insurance Scheme pricing guide and eligibility criteria

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ABSTRACT

Background: The Australian National Disability Insurance Scheme (NDIS) is conceptually grounded in the social model of disability, which focuses on removing disabling structures of society to allow people with disabilities full participation and improved quality of life. The social model rests on a dichotomous relationship against a medical model and its focus on treating impairments, and incorrectly places nursing within this paradigm.
Aim: To undertake a discourse analysis of nursing as represented in the NDIS pricing guide and eligibility criteria, and to understand how the profession is conceptualised and valued within the scheme.
Methods: Informed by Lauclau and Mouffe's poststructuralist theory, a discourse analysis of the floating signifier of nursing against the dominant nodal point of the social model of disability was undertaken through a close reading of the NDIS pricing guide and eligibility criteria.
Findings: The nursing scope of practice is confined to physical/medicalised supports for people with disabilities. Nursing is excluded from offering therapeutic and behaviour supports and is structured and fiscally valued differently to other professions.
Discussion: Despite its base in holistic and person-centred care, due to its conceptualisation within the medical model, the full scope of nursing practice is restrictive within the NDIS. This misarticulation of nursing excludes key aspects of adaptive, therapeutic, and holistic practice which can improve health outcomes for people with disabilities.
Conclusion: The NDIS in its conceptual construction based on the social model of disability has upheld a vision of nursing inconsistent with practice relevant to caring for people with disabilities.

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Summary of relevance

Problem or Issue
As the largest healthcare workforce, it is pivotal to understand how nursing practice is represented within the NDIS and this has not been previously analysed.
What is already known
The NDIS is based on the social model of disability, which as a theoretical paradigm conceptualises nursing within a medicalised approach to disability as addressing impairments.
What this paper adds
An understanding of how grouping under the medical model restricts the scope of nursing practice relevant to caring for people with disabilities. Additionally, this paper demonstrates a methodological approach to analyse nursing in diverse disability policy.

1. Introduction

The Australian NDIS is a policy with a conceptual grounding in the social model of disability (Bigby, 2020). The NDIS was enacted in 2013 and offers individualised funding to all qualifying Australians with a disability. The aim of the funding model is to promote community integration and improve the quality of life for people living with disabilities. The social model of disability focuses on the disabling structures of society that impede people with disabilities obtaining full rights, access, and citizenship rather than physical impairments (Oliver, 2009). This model has gained hegemony in contemporary disability discourse, research, and legislation in Australia and internationally. Given the dominance of the social model of disability, it is timely to analyse how a health profession with a substantial workforce such as nursing is impacted within this legislative paradigm that favours the social model of disability. Arguably, the degree of possible expression of the scope of practice, the legitimisation of nursing practice, and the value placed on nursing can be impacted by how it is represented in legislation and policy. Through a discourse analysis, this paper aims to analyse how nursing is represented and valued within key NDIS documentation.

The social model of disability arose from the activities of physically disabled activists and academics in the UK in the 1970s, during a post-war climate of institutionalisation and marginalisation of disabled people, who experienced poverty, and exclusion from full participation in society (Oliver, 2009). Proponents called for the focus to change from the individual's impairments to the problems caused by "disabling environments, barriers and cultures" (Oliver, 2009, p. 45). The central argument of the social model is that disability is imposed on top of individual impairments, by the way society unnecessarily isolates and excludes full participation through the way it is organised.

Increased disability activism in the United States also emerged as growing numbers of disabled Vietnam War veterans returned home in the 1970s, and development of the Independent Living Movement, which assisted people with acquired disabilities to live autonomously in the community (Barnes, 2012). Internationally, growing interest in disability led to the World Health Organisation defining disability, and the United Nations' International Year of Disabled People in 1981, declaring that "national governments are responsible for securing equal rights for disabled people" (Barnes, 2012, p. 16).

Growing academic interest resulted in Oliver's description of the social model of disability in the early 1980s, with the key principles being described by Barnes (2012) as: (1) maintaining the importance of appropriate individually based interventions but also drawing attention to their limitations for further empowering disabled people, (2) shifting attention from the functional limitations of individual impairments onto the problems caused by disabling environments, barriers and cultures, and (3) as a tool to analyse the disabling features of society and generate policy and practice.

Undoubtedly, the social model has been integral in influencing disability rights, citizenship, and understanding of inequality. A substantial shift arose out of the view that disability was attributable, not to a specific aetiology or impairment, but to the response of society to those impacted (Oliver, 2013) . Proponents of the model have influenced substantial gains in disability policy in the United Kingdom and United States, and internationally with the adoption of the UN's Convention on the Rights of Persons with Disabilities (2006), and the development of the International Classification of Functioning in 2001 (Barnes, 2012). A key element of this change in Australia was addressing the exclusion of people with disability from mainstream society through a process of de-segregation and inclusion in employment, education, and society. However, critics have noted that by homogenising understandings of disability in societal and structural barriers away from the individual experience, complexities of "the personal dimension of living with an impairment" become neglected (Shakespeare, 2018, p.19). That is, inherent and personal disadvantage, such as having a severe intellectual impairment, are individual issues that are present and cannot be ignored or changed.

In an analysis of the evolution of disability research, Winance (2016) identified that one of the major contributions of the social model of disability has been to identify societal dimensions which influence disability inequality and the way this can be related to the organisation of society. This is particularly pertinent in the Australian context where a recent audit of disability research highlighted the dominance of research that described barriers and inequality, but very little research that sought to solve the issues underpinning such disadvantage (Centre for Disability Research and Policy, 2017). The social model is upheld by the political demand that people with disabilities should have the same rights as the able bodied, who live independently and autonomously (Winance, 2016). Critics indicate limitations with Western assumptions of valuing individual choice and autonomy, over other important ways of experiencing disability where relationships, caring and interconnectedness are important (Winance, 2016). Additionally, the social model arose from activists with physical disabilities (Oliver, 2009) and the model assumes the person with the disability is able to make their own choices autonomously, and wants to live autonomously, which is often unattainable for the most severely disabled or those with cognitive disabilities such as intellectual disability and/or autism (Winance, 2016).

An integral component of the social model of disability is its hegemonic structure against the dichotomous binary of the medical model. The medical model was used as the contrast of the social model of disability to elucidate the concept of the model. It became an exemplar to differentiate the facets of what the social model is not: with its focus on the personal and individual impairment, disease, illness, or process with a defined aetiology that could be understood, and for which there was a cure, treatment, or preventative strategy (Oliver, 2009). The construction of the medical model has also influenced the way in which certain fields are represented. In this discursive struggle nursing has been grouped with medicine and cast, quite inappropriately and incorrectly, in an assistive role to it. The medical model places the nursing profession's attitude and approach to provision of health-related supports to people with disability in the context in which such care was administered to some people with a disability in the past: that of institutions. The view of the practice of nursing as represented, however misses all dimensions of nursing practice other than physical care. The traditional role of nurses in habilitation,

behavioural support, and mental health care, even though undertaken in the institutions, has not been an acknowledged aspect of practice.

Despite its grouping under the medical model within the confines of the discursive struggle against the social model, nursing has a biopsychosocial and spiritual history. In the development of nursing both holism, and recently, person-centred care has been a focus. Nursing care has long been acknowledged as encompassing the individual, family, and community levels or using Goffman's terms the mirco, meso and macro layers of focus (Hancock, 2011). Diers (2004) argued that "the tradition of nursing care is lodged in an explicit value; that is it is our job to help others do what they would do for themselves if they had the skill, energy or will. And, when recovery is impossible to assist others in the ultimate act of dying, dignifying the individual with all his (sic) personal history, idiosyncrasies, needs, values and desires" (p.143). The focus of nursing care is not just at the physical level, and supports of daily living, but is equally therapeutic. Nurses have a role in capacity building at the individual and community levels. As a holistic endeavour, nurses care for both physical, social, and mental health. Nurses have an awareness of and incorporate notions of both abilities and disabilities into practice and have traditionally had education in the domain of behavioural and social sciences, and in the contemporary context this includes positive behaviour support. The current Nursing and Midwifery Board of Australia (NMBA) Standards for Practice incorporate these understandings and represents the scope of Registered Nurse practice in Australia (Cashin et al., 2017). Likewise, the NMBA Nurse Practitioner Standards for Practice are founded on such concepts (Cashin et al., 2015)

The nursing scope of practice is not delegated from medicine, as Registered Nurses are autonomous health professionals. Nursing does have an intimate entanglement of co-practice with medicine as both professions intervene and support people in all domains of health and ill-health and across many contexts. Practice includes nursing people with lifelong disabilities, such as intellectual disability and/or autism, who, in addition to being the largest user group of the NDIS (Australian Bureau of Statistics 2020), experience greater chronicity and earlier morbidity when compared to the general population (Wilson, Charnock and Chang, 2017). Nurses who specialise in working with people with intellectual disability and/or autism work closely with individuals, families, and groups in a person-centred manner that is focussed on facilitating equitable and timely access to healthcare as well as directly improving the health and wellbeing for individuals across a range of contexts (Kernohan, 2019). Nursing practice in intellectual disability and/or autism includes specialised assessment and intervention in the domains of physical health, mental health, behavioural support, adaptive behaviour skill development, support for sexuality and identity, and spiritual support (Wilson et al., 2020). Furthermore, this nursing practice includes the direct and indirect oversight, delegation, supervision, and training of disability support workers in health-related tasks. Nursing practice is holistic and person-centred in nature, and well-equipped to provide support for people with disabilities. However, what remains unclear is how nursing practice is represented within the NDIS which is deeply rooted in the social model of disability.

Under the NDIS the dedifferentiation of all people with disabilities is a central tenet of the shift from funding based on diagnosis, toward funding being based on function, via an assessment of reasonable and necessary supports (Bigby, 2020). Dedifferentiated policies are aligned with the principles of the social model of disability, and privilege self-determination over one's support needs where capacity, competence and independence are prerequisites to participation as a consumer of funded supports. For people with more severe disability/ies that directly impact capacity, competence, and independence – such as intellectual disability and/or autism – it has been argued that they are at a distinct disadvantage in dedifferentiated systems as the emphasis is on ability, rather than disability (King, 2020). In fact, King (2020) argued that the NDIS – and indeed the social model of disability – has flawed assumptions that all barriers to participation and inclusion can be removed with the right kind of funding, assistance and supports. It can also be argued that regardless of assistive technology and other funded supports, the exacerbation of underlying disability-related health problems can act as an absolute barrier to social participation and inclusion (King, 2020). Indeed, there is a growing body of research about the roles of highly skilled nurses who provide both oversight and day-to-day direct and indirect nursing care and support that helps keep people with intellectual disability and/or autism healthy enough to participate (Wilson et al., 2019; Wilson, Reeve, Lin, and Lewis, 2021). Yet, the highly skilled care and supports nurses can provide are not only defunded by the NDIS, but we argue are also misunderstood by its policy in relation to incorrect advice at the creation stage and/or a perceived ideological mismatch between the social model of disability and what underpins the holistic profession and practise of nursing. The very representation of the medical model and by default nursing as represented by proponents of the social model of disability may explain in what role nurses are considered as eligible providers under the NDIS. This paper seeks to draw out this critical debate by conducting a discourse analysis of the NDIS pricing guide and eligibility criteria to understand how nursing is represented.

2. Aim

Through a discourse analysis of the representation of nursing embedded in the Australian NDIS pricing guide and eligibility criteria, this paper aims to understand how the profession of nursing, and nursing practice, is conceptualised and valued in the funding scheme.

3. Methods

A discourse analysis of the NDIS pricing guide and eligibility criteria was undertaken to understand the way nursing is conceptualised and positioned within the scheme. This analysis was informed by the Foucauldian notion of discourse, and Laclau and Mouffe's development of the theory.Foucault, (1979))wrote of rediscoveries in language as process that allowed the perception of the forgotten figures or those that had become obscured. This differs from re-activation in which discourse is inserted into new domains or levels of generalisation, transformations, and practice. In *Nietzsche, Genealogy, History,* Foucault (1977) laid out a vision of the history of humanity as a repeated chain of dominations. These events are, "not a decision, a treaty a reign or a battle, but the reversal of a relationship of forces, the usurpation of power, the appropriation of a vocabulary turned against those who had once you used it, a feeble domination that positions itself as it grows lax, the entry of a masked other" (p.154).

These dominations occur in discourse. As neurotypical thinkers (those without autism) are primarily linguistic processors of information, discourse or language forms the building blocks of the social construction of meaning (Cashin, Gallagher, & Hughes, 2012). Discourse is not however just practiced at an individual level but shaped by the context in which the individuals are embedded or the discourses to which they are subjected to. Rules and norms upon the use of discourse are imposed by institutions and cultures and propagated through pedagogy and andragogy practiced formally and informally (Wexler, 1983).

All discourse including those within legislation, regulation/s, policy, and documentation, in this case the NDIS, is inherently political and values a certain construction of knowledge (Phillips & Jorgensen, 2002). The implicit rules of who gets to say what and when are formed within the hegemonic struggles in discourse. Language, and hence discourse, is never fixed but in a constant state of flux as each discourse comes into contact with other discourses, and language is the field in which hegemonic struggles for the dominant perspective take place. In periods of time one perspective may appear to become dominant and the inherent meaning potentials become naturalised, but they are never fixed and permanent (Heidegger, 1962).

This paper utilises the theory of Laclau and Mouffe which provides a lens to breakdown and understand the elements at play in the hegemonic struggles within discourse as represented in the NDIS documentation analysed (Phillips & Jorgensen, 2002). A discourse analysis is not a prescribed (step-by-step) process, but rather offers a conceptual framework to understand power dynamics between the use and representation of language. This inherent power struggle is not merely aggressive, but also productive as meaning potential is constructed. A discourse forms through a partial meaning fixation around nodal points, which is a privileged sign around which other signs are ordered, the other signs acquire their meaning from their relationship to the nodal point (Phillips & Jorgensen, 2002). These other signs can be identified as floating signifiers. The meaning potential of floating signifiers is conditional upon that which is constructed at the nodal point. Useful points of analysis are identification of the nodal point and the representation of the floating signifiers generated. For this study, the nodal point of the social model of disability has been identified. In this model nursing has been represented as akin to the medical model. This representation creates some meaning potential and excludes others that may be realised through interpretation in relation to other models.

The NDIS is a funding mechanism that claims to be informed by the social model of disability. Its eligibility criteria and pricing guide articulate what types of services and practices are valued under the funding model by the Commonwealth of Australia. An analysis of these documents presents an interesting way to conceptualise the scope of practice of nursing under the NDIS, through analysis of how nursing is conceptualised, the supports nurses can provide, and the monetary value allotted. Supports can be claimed by a participant that meet their individualised plans and must come under three categories: core to help participants complete daily living activities; assistive technologies and modifications; and capacity building supports to aid independence (NDIS, 2021). The National Disability Insurance Agency regulates the maximum pricing of supports under the pricing guide, and fiscally adds value to differing categories of supports and the provision of these supports by practitioners.

Through a close reading of the NDIS eligibility criteria and pricing guide this paper analyses the representation of the floating signifier of nursing, which has not been explicitly articulated, and explores what elements of nursing have been valued as legitimate in having a role as eligible, and hence funded providers of service, as represented within the funding model of the NDIS.

4. Findings

As illustrated in Fig. 1, the discourse analysis approach undertaken involved analysis of the floating signifier of nursing orbiting around the fixed, privileged, nodal point of the social model of disability. The close reading of the NDIS eligibility criteria and pricing guide and analysis of the floating signifier of nursing within them led to the identification of three key themes in how nursing is articulated, legitimised, and what aspects of nursing practice are valued. The first key theme, 'elements of nursing practice' largely reflects the grouping and restriction of nursing within a medical model against the nodal point of the social model of disability. Two other major themes identified 'hierarchies of nursing' and 'what nursing is not', offer insight into how levels of nursing are fiscally valued against each other and coinciding professions, and what areas of practice nursing is excluded from due to its misrepresentation.

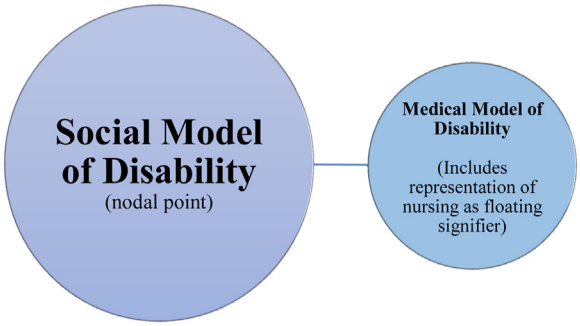

Fig. 1. Discourse analysis approach.

4.1. Elements of nursing practice

The scope of nursing practice under the NDIS pricing guide reflects its group within the medical model of disability against the nodal point of the social model of disability. As a floating signifier, nursing practice as related to NDIS supports was not significantly articulated and is mainly restricted to the category of "disability related health supports" (NDIS, 2021, p.36). These supports are conceptualised as responding to the "disability-related health needs of a participant" under their NDIS plan and are required to be outside of the responsibility of the everyday health system in Australia (NDIS, 2021, p.54). Examples of disability-related health supports are described in addressing ongoing medical conditions related to a participant's disability, such as dysphagia, nutrition, diabetes, continence, wound and pressure care, and support for epilepsy. These conditions are largely described in physical terms and their impact on the body of the person with a disability, for example dysphagia involves people who "have trouble eating, drinking or swallowing" and respiratory care involves "help with… breathing and maintenance of… respiratory health" (NDIS, 2021, p.37). No detail is given to what such supports would look like when caring for people experiencing these conditions. Thus, the scope of practice of nursing under the NDIS is confined to medicalised/physical supports for people with disabilities.

Registered Nurses are allotted the ability to provide another level of disability-related health supports, under the therapeutic services category. These additional therapeutic services reflect their restrained scope of practice under medical model as physical/medical supports. Therapeutic services are ongoing supports designed to aid the physical maintenance of a body part, or to slow the deterioration of a medical condition or body part. Under this category, Registered Nurses are allowed to undergo assessment and provision of care for therapeutic services and delegated nursing involving training and supervising other workers to provide care in the domain of physical care. Additionally, they are allowed to provide community nursing for continence aids provision of care, training, and assessment.

4.2. Hierarchies and value of nursing

The hierarchies of nursing qualifications and role types within Australia are also presented and ranked within the pricing guide.

Nursing roles were described within terms of educational preparation, and registration status in Australia. Whilst the descriptions of advanced levels of nursing are allocated greater detail in terms of practice experience, there is minimal detail under position roles about how nurses provide care that is specific for people with disabilities. In areas of specialisation, only the role of mental health nurse and continence nursing are mentioned in the document. Mental health nurses are only noted as eligible providers in the domain of co-ordination of specialist support, as opposed to providers of therapeutic or specialist support.

The value of nursing delivery of disability related health supports differs depending on the level of nursing qualifications. An enrolled nurse is valued at $86.62 for an hour of care on a weekday during the daytime, a Registered Nurse: $107.25; clinical nurse: $124.05; a clinical nurse consultant: $146.72, and $153.39 for a Nurse Practitioner. The hourly amount goes up by increments depending on the time of day, if the support is offered on the weekend, and remoteness of the location where the service is provided. Registered Nurses providing therapeutic assessment, supports, and continence care are assigned a monetary value of $124.05 an hour, inconsistent with other categories of nursing supports there is no varied rate for time, or day, of delivery. A mental health nurse is only mentioned as an example of a profession (alongside social workers, occupational therapists, and psychologists) eligible to coordinate a specialist support that is valued at $190.54 per hour. These rates compare to values of $193.90 for allied health workers doing therapeutic supports and $214.41 for clinical psychologists.

4.3. What nursing is not

A further way to conceptualise the scope of practice of the floating signifier of nursing is to analyse the areas of practice nursing is excluded from. Whilst some areas of supports do not fit under the scope of nursing practice in Australia, other nurses have been excluded as eligible providers within the NDIS pricing guide for activities that fit within the scope and traditional practice of nursing. Supports that nurses traditionally have provided but are not allocated under the NDIS include mental healthcare and counselling and behaviour support for people with intellectual disabilities and/or autism. Nurses are only funded as having a role related to impairment and not capacity building. Positive behaviour support is confined to the role of support workers with speciality qualifications, categorised under high intensity supports. Whilst specialist behavioural intervention designed as intensive supports to manage behaviours that are harmful or persistent are classified under 'Capacity Building' which is a category of care nurses are not included under as eligible providers.

5. Discussion

This study utilised a discourse analysis of nursing as represented within the NDIS pricing guide and eligibility criteria to further understand its articulation and the elements of practice that are valued. As a floating signifier, nursing has been constructed against the nodal point of the social model of disability, and consequently the articulation of its scope of practice has been restricted and othered because of this hegemonic structure (Wilson et al., 2020).

Despite its roots in holistic, and person-centred care, nursing practice has been 'othered' under the NDIS pricing guide. As a discipline, nursing is adaptive and therapeutic in nature and incorporates elements of behaviour support when caring for people with disabilities (Professional Association of Nurses in Developmental Disability in Australia, 2020). However, under the pricing guide nursing has largely been restricted to providing primarily physical and medicalised care in terms of disability-related health supports. The terminology of "support" implies to do alongside the person with a disability, rather than the hierarchical nature of "care for/provide care" and is arguably rooted in the social model of disability (Smith, 2013) . Yet, the kinds of supports nurses can offer remain within the conception of the provision of medicalised/physical care. Even when Registered Nurses are viewed as eligible providers of therapeutic supports, these remain confined to biomedical care of the physical body with the aim of: "physical maintenance of a body part, or to slow the deterioration of a medical condition or body part" (NDIS, 2021, p.104).

The 'othered' nature of nursing within the pricing guide is further evident through the articulation of professional hierarchies, and fiscal values. Of the tertiary-educated, health professions who are eligible providers under the NDIS such as psychologists, social workers, exercise physiologists, and occupational therapists, nursing is articulated and fiscally valued in a different way. Although it is plausible that certain levels of nursing should be costed differently due to different levels of education and clinical experience, such as Enrolled Nurses versus Registered Nurses and Nurse Practitioners, the sheer number of pricing lines allotted to nursing implies a misunderstanding of the profession and its function. For example, single rate pricing lines of an adequate, higher value for Enrolled, Registered, and Nurse Practitioners would be more appropriate than differentiation for time of day, and day of the week. As with other providers if the rate is adequate business models can be created to provide care as needed.

Under the level of nursing practice referred to as type of nurse (NDIS, 2021) there is some definitional confusion and conundrums in application. The definitions of Enrolled Nurse, Registered Nurse and Nurse Practitioner are clear discrete levels of nursing practice endorsed by the NMBA. However, Clinical Nurse and Clinical Nurse Consultant are problematic and need further refinement if they are to remain. The definition of Clinical Nurse Consultant is adapted from that of Advanced Practice Nursing definition for the previous iteration of the Nurse Practitioner Standards for Practice (Nursing and Midwifery Board of Australia, 2018). In the price guide it is stated that the Clinical Nurse Consultant is viewed as practicing in the advanced practice role.

> Advanced practice nursing is a qualitatively different level of advanced nursing practice to that of the registered nurse due to the additional legislative functions and the regulatory requirements. The requirements include a prescribed educational level, a specified advanced nursing practice experience, and continuing professional development. Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice…They work within a generalist or specialist context, and they are responsible and accountable in managing people who have complex health care requirements
>
> (NDIS, 2021, p.38).

While the elements are true for Nurse Practitioners, Clinical Nurse Consultants are not a recognised entity in every state and territory and they do not have a legislatively prescribed level of education and are not regulated, and therefore have no regulatory requirements. The Clinical Nurse Consultant role as it exists in Australia does not meet the requirements of this definition. As there are no prescribed levels of education or regulatory requirements, any Registered Nurse could self-assess that they meet the requirements for clinical nurse or nurse consultant and bill at that level. The definition of clinical nurse (a term not in common use in Australia) applied is described as a "more experienced and skilled registered nurse. Duties of a clinical nurse will substantially include, but are not confined to, delivering di-

rect and comprehensive nursing care and individual case management to a specific group of patients or clients in a particular area of nursing practice" (NDIS, 2021, p.38). This is again based on self-assessment, as there is no prescribed education level or regulatory requirement that differentiates this from the Registered Nurse.

Disability-related nursing supports are costed differently compared to allied health professions with additional lines for weekends and public holidays requiring penalty rates. This suggests nursing is fiscally conceptualised differently to the other professions, as being more hourly task driven than therapeutic in nature. Such conceptualisation of nursing costing could plausibly be attributed to advice regarding nursing secured by the NDIS from sources who are more familiar with workforce organisation in acute hospital settings, rather than diverse areas of practice. Arguably, by costing nursing at a higher rate, at parity with other professional providers under the NDIS, work could still occur at differing hours and days.

The NDIS pricing guide presents a homogenised and limited image of nursing. Despite representation of practice levels, there is lack of articulation of the specialisation of nursing as relevant to caring for people with disabilities. As the only forms of specialisation articulated is in the form of continence care and mental health nurses (and only as care co-ordinators), the varied nursing specialisations that can assist people with disabilities are not represented. Arguably, this lack of specialisation works to reinforce the representation of nursing as a generalist, medicalised profession against the 'social' nature of the allied health professional.

The discursive struggle of the social model against the medical model does a disservice to the scope of practice of the nursing profession. The holistic and person-centred care that nursing offers people with disabilities to improve health outcomes should be acknowledged. Alternative and 'blended' models such as the human rights approach have been constructed and may later gain hegemony to address health inequalities (Degener, 2016). The Convention on the Rights of Persons with Disabilities (CRPD) marked a key turning point to a rights-based approach in disability support, which recognises disability as a key social determinant of health status (Article 25) and fosters re-engagement of health professionals and services. However, the impact of the CRPD on the Australian healthcare landscape for people with disability has been slow, as evidenced by the recent finding by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability of "systemic neglect" of people with cognitive disability by the Australian healthcare system (Sakville, Atkinson, Bennett and Galbally, 2020). In the human rights model, while the focus again turns to inclusiveness of the individual, it is at the level of impairment and prone to the employment of the same representation of medicine, and by default nursing, as exists within the social model.

6. Conclusion

Champions of the social model of disability in the discursive struggle for hegemony offered up a representation of the medical model as the contrast. Nursing was grouped with medicine and in so doing was restricted to a delegated function in the provision of physical care. The representation used to contrast to the social model of disability is not consistent with the current conceptualisation of contemporary nursing. The NDIS in its conceptual construction based on the social model of disability has carried forward a vision of nursing consistent with the inaccurate representation offered up within a discursive struggle where it remains confined to biomedical supports. Nursing is represented differently to other providers, valued at a lower fiscal rate than comparative professions and much of the nursing scope of practice is not enabled as nurses are excluded as eligible providers.

The NDIS has made a large positive difference to the lives of many Australian citizens (National Disability Insurance Agency, 2020) However, health outcomes for people with intellectual disability and/or autism remain the worst of any disability groups and arguably the worst of any Australian citizens (Cashin, 2021). Enabling the full expression of the nursing scope of practice and providing access to professional nursing care would be a positive step toward improving these health outcomes.

While the social model of disability made a valuable conceptual contribution, arguably the representation used to contrast it, originating in the 1970s, and grouping certain professions within the 'medical' model is not accurate at this time. To address the acute issues in terms of health and quality of life outcomes refinement is needed as we move to conceptualise how best to include and support citizens in Australia with intellectual disability and autism.

The findings of this national study have international significance as through analysis of the NDIS the representation of nursing afforded through the social model of disability has been elucidated. Further study is needed to determine the implications internationally in workforce design and funding.

Authorship contribution statement

Amy Pracilio: Conceptualisation, methodology, analysis, writing – original draft. **Nathan Wilson:** Conceptualisation, methodology, analysis, writing – original draft. **Michelle Kersten:** Conceptualisation, writing – review and editing. **Julian Trollor:** Conceptualisation, writing – review and editing. **Andrew Cashin:** Conceptualisation, methodology, analysis, writing – original draft.

Ethical statement

This research was a qualitative discourse analysis and did not involve human subjects or require Ethics approval.

Conflict of interest

None.

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