

# Mixed accountability within new public governance: The case of a personalized welfare scheme in early implementation

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## Abstract

We explore personalized funding schemes and associated changes for accountability within new welfare governance reforms. Using the case of the Australian National Disability Insurance Scheme as hybrid institution, requiring mixed accountability arrangements, we examine the implications for broader discussions of accountability in personalized welfare arrangements. Methods used were semistructured interviews with government actors and disability service providers in Australia. In describing how accountability structures emerge, we argue that the way that layers fit together during implementation are often imperfect because of the conditions under which they arise. As a result, critical gaps can emerge in layered systems, which can put end users at risk. We demonstrate that theories on accountability in new public governance welfare reforms must also be informed by context and history informed qualitative analysis of case studies.

## KEYWORDS

accountability, hybrid accountability, participatory accountability, personalized funding

## 1 | INTRODUCTION

Personalized funding arrangements, also known as individualized funding or individualized budgets, are a shift in the way that funding for welfare supports is allocated; rather than allocating funding to a service organization via a commissioning relationship, amounts of public money is allocated to service end users, and used to pay for services directly (Dickinson & Glasby, 2010; LeGrand, 2007). As a result, personalization schemes have been said to create new forms of participatory accountability systems, giving greater control and accountability to end users who chose

how to spend their funds, but none the less still involving government in oversight of the scheme (Bracci, 2014; Dickinson, Needham, & Sullivan, 2014). Personalization schemes are also said to produce mixed or layered accountability systems, whereby a plurality of rationalities are at play within the scheme and the institutions/organizations involved in administration (Malbon, Carey, & Dickinson, 2016). In order to further explore both mixed accountability and new forms of participatory accountability within new public governance (NPG) reforms, we use the case study of the National Disability Insurance Scheme (NDIS), a new reform introducing personalized arrangements for disability care in Australia in 2013. The NDIS is a new form of welfare governance, born of the personalization agenda found within NPG approaches, that has a mixed accountability regime (Malbon et al., 2016).

Mulgan (2000) describes accountability as a “complex” and “chameleon like” term; however, they also identify a “core” definition of accountability as the process of being called to account for one’s actions to another authority, within democratic nations core accountability relationships include citizens, elected politicians, and bureaucrats. This aligns with Romez and Dubnick’s definition that is commonly used in public administration literature; that accountability exists in the social contract between public institutions and citizens, and particularly in the way that the “diverse expectations” of citizens are managed by employees of public institutions (Romzek & Dubnick, 1987). Mulgan (2000) argues that there are multiple iterations of the accountability concept that stem from this “core” definition, such as participatory or democratic accountability (particularly within personalized schemes). Although the list does not include concepts of mixed or layered accountability, with the growing complexity of governance arrangements, these concepts need become more integral to the accountability lexicon. As a version of accountability, mixed or layered accountability occurs as institutions add or “layer” policies, reforms, and legislation atop previous policies which create accountability structures that are not necessarily coherent (Mahoney & Thelan, 2010; Ranson, 2003). Moreover, we show that the participatory accountability that is said to arise in personalized schemes (Bracci, 2014) does not necessarily occur when there are structural complexities and institutional incoherence at play. In this paper, we further develop knowledge of how accountability structures emerge and their associated challenges through an empirical investigation of the emerging accountability structure of the NDIS. We argue that the way that layers fit together in real life implementation are often imperfect because of the conditions under which they arise. As a result, critical gaps can emerge in hybrid systems which put participants at risk.

## 2 | ACCOUNTABILITY IN NEW PUBLIC GOVERNANCE

Christensen and Lægveid (2017: 31) describe the evolution of accountability alongside new public management (NPM) and NPG regime changes as characterized between “the balance between organizational autonomy and traditional forms of democratic accountability.” In liberal democracies throughout the 1980s and early 1990s, there were identifiable efforts to reinvent welfare provision to address perceived inefficiencies and lack of financial sustainability of welfare states. These “inefficiencies” were part caused by institutional layering of one program or reform on top of another, creating both institutional “red tape” and gaps or cracks in accountability structures (Christensen & Lægveid, 2017). Addressing these problems lead to “new public management” reforms characterized by increased marketization, contracts, commissioning, and privatization of public services (Hood & Dixon, 2015; Osborne, 2006). As a result of this reorientation to user and consumer decision-making under NPM, accountability became focussed on “managerial” accountability as opposed to other forms of accountability such as “participatory” or “political” accountability (Christensen & Lægveid, 2017).

Under NPM approaches, reforms characterized by contracts and strict financial and efficiency requirements gained prominence. Since this, we see the rise of “new public governance” approaches. Importantly, in proposing NPG as the post-NPM regime, Osborne (2006) refers collectively to diverse policy created and implemented in the wake of NPM. Osborne raises NPG as a question rather than as certainty or a unified set of reforms, in contrast to NPM that was relatively clearly defined (Osborne, 2006). Whereas NPM is concerned with performance of public programs and tackling “wicked” problems, a major focus of NPG welfare reforms is enhanced accountability through

relationships and collaboration. Yet Christensen and Læg Reid (2017) present both NPM and NPG reforms as creating additional complexity in welfare provision, and consequently adding to confusion and conflicts in accountability processes: Whereas NPM outlined quite clear (though also limited) lines of accountability, the layering of NPG reforms has both extended and confused these, creating situations of mixed accountability.

Questions of who should be held accountable for what, and to whom, and to what consequence, are hardly ever clear-cut. Christensen and Læg Reid (2017, p. 1) contend that reforms under NPG have created increasingly complex processes for accountability:

*The underlying idea behind many welfare state reforms, often ideologically driven, was to enhance accountability and at the same time performance and legitimacy of welfare arrangements. But in practice, these reforms in many areas have created complexity, conflicts and confusion over who is accountable to whom for what and with what effects.*

The emergence of NPG has altered political and administrative leadership, and the types of clear levers of control regarding influence and information that perhaps existed previously (Christensen & Læg Reid, 2007). Such increased complexity of accountability systems is seen within personalized funding arrangements for welfare reforms (Dickinson & Glasby, 2010), often resulting in hybridized forms of accountability arrangements (Bracci, 2014; Malbon et al., 2016; Whitaker, 2015). In public administration, hybridity has largely been used as a way of exploring structures of organizations, and as Malbon et al. (2016) note, less attention has been given to the idea of hybridity in cultural, social values, or logics. Skelcher and Smith's (2015) work has begun to explore these alternate forms of hybridity, employing the concept of institutional logics to clarify mixed institutional values to contend that hybridity in this context emerges from a plurality of rationalities at play within institutions (Skelcher & Smith, 2015).

### 3 | ACCOUNTABILITY IN THE AUSTRALIAN NDIS

The Australian NDIS, introduced in 2013, aims to increase choice and control for approximately 420,000 people with disability in Australia through a shift to personalized funding arrangements. The personalized funding approach of the NDIS is similar to other personalized funding of care and welfare payments worldwide including the United Kingdom's National Health Service and the Norwegian Brukerstyrt Personlig Assistanse. Services that were previously block funded or delivered through commissioning relationships are now funded according to individual arrangements (Australian Productivity Commission, 2011). The shift to personalized funding changes the "rules of the game" for the disability care sector in Australia, creating a public service funded market or a "quasi-market" (LeGrand, 2007). The transition to the NDIS is primarily a transition to personalized funding whereby eligible people choose the services that they need to help them to live well, and funds are then allocated according to a "personal budget" to be used to pay for services under normal business arrangements (Malbon et al., 2016). These changes are designed to support greater choice and control for eligible people living with disability, and there are associated changes in the structure of accountability systems for the scheme.

The NDIS reform has the potential to significantly improve the lives of some people with lifelong disabilities by empowering them to make independent decisions about their care (Mavromaras, Moskos, Mahuteau, & Isherwood, 2018); however, the success of the new NDIS market is crucial to enabling this choice and control (Carey, Malbon, Reeders, Kavanagh, & Llewellyn, 2017). Specifically, the NDIS is arranged so that participants define their own goals for their care, such as developing skills for communication and self-expression or joining community programs that are meaningful to them. These are presented in a meeting with a planner, and a "Care Package" of government funding to pay for care services is established (Australian Productivity Commission, 2011). There are a number of ways in which participants can use their Care Package to pay for services, but for the majority of transitions, this occurs through a government run payment portal.

Unlike personalized schemes in other countries, the Australian NDIS is attempting to be fully functional in just 5 years. This is in contrast to the 25-year implementation of the NHS in the United Kingdom and similar time frames in Norway (Askheim, Bengtsson, & Richter Bjelke, 2014; Needham, 2013).

From an accountability perspective, the new structures created within the NDIS introduce new types of accountability, which are layered onto existing managerial types, and these create a set of hybrid accountability arrangements in the NDIS (Malbon et al., 2016). Early conceptual work on accountability in the NDIS sets out a range of potential accountability dilemmas that must be faced and resolved; accountability for care outcomes (the spending of public money and the welfare of care workers; Dickinson, 2014) and accountability for systemic advocacy and for market function (Malbon et al.). These sit along a spectrum of accountability logics, and Malbon et al. contend that within complex individualized schemes such as the NDIS “accountabilities [need] to be shared and that better accountability results from clear and communal systems for resolving dilemmas” (2016:13).

Malbon et al.'s (2016) findings regarding the hybridity of institutional logics in the NDIS and the flow on effect for hybrid or mixed accountability systems links to other work on accountability in individualized arrangements. For example, Benish and Maron (2016) have traced the patterns of competing and sometimes conflicting institutional logics (in their case, between lawyers and economists) about ideal governance arrangements for privatized welfare. Ranson (2003: 472) suggests that mixed or hybrid forms of accountability are both inevitable and necessary 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.” Determining what these hybrid forms of accountability are and how they can best function is a major challenge in NPG reforms.

A discussion about accountability in the NDIS must be positioned within the broader context of Australia's legislated accountability structures. In 2014, a set of reforms to accountability structures in Australia were legislated under the Public Governance, Performance and Accountability Act (PGPA, 2013). Under the PGPA Act, the agency responsible for implementing the NDIS, the National Disability Insurance Agency (NDIA) holds final legal and financial accountability for the spend of public money and for the success of the NDIS in terms of safe and quality care outcomes. This aligns with Ranson's (2003: 472) normative claim that the “Ultimate accountability for the delivery of a public service should always rest with the commissioner of the service – the public body.” However, this relatively straightforward arrangement is more complex in practice; while accountability rests with the NDIA, the Commonwealth government holds oversight over the NDIA (in conjunction with NDIS Actuaries which set pricing based on long term modeling) and the control of all aspects of spend and care rests with the people receiving their individualized budgets to pay for care (Australian Productivity Commission, 2011). Moreover, some the quality and safeguarding systems remain with state and territory governments. Hence, control is shared/divided between layers of government (i.e., federal and state government), participants, and service providers creating a mixed or layered accountability structure.

Further to this, the NDIS Act (2013), the legislative foundation of the NDIS, has omissions that mean that transparency is difficult to enforce. Based on analysis by Carey Dickinson, Fletcher, & Reeders, (2018), these include (a) no rules for transparency about how rules that govern the market are set and (b) no rules to authorize the collection and publication of information enabling civil society to assess whether the scheme is effectively meeting its policy goals. These omissions reduce the ways in which the NDIA and the NDIS actuarial teams can be held accountable about their decisions on market stewardship and the handling of complaints about unsafe care practices or other crises.

Finally, the integrity of the NDIS, as in all personalization schemes, relies upon a well-functioning disability care market that offers a range of services that provide choice, control, and participatory accountability to participants. Without market stewardship and successful market function, the NDIS will not distribute quality care equitably between participants or offer opportunities for participants to exercise participatory accountability for their care (Carey, Dickinson, Malbon, & Reeders, 2017; Carey et al., 2017). This is a crucial concern for both the welfare of people with disability in Australia and for accountability within personalization schemes worldwide.

The accountability dilemmas found in personalization schemes in general (Gash et al., 2014; Needham, 2013) and in the Australian NDIS in particular (Dickinson, 2014; Malbon et al., 2016) are not likely to be solved by using new public managerialism approaches to accountability that emphasize outcomes such as performance reporting, outcome statements, program deliverables, and key performance indicators (Mattei, 2009). Such performance indicators and monitoring may show red flags, but do not in themselves constitute ameliorative action. These approaches have not been found to be an effective way to maintain accountability for quality in program implementation worldwide:

*It is easy to agree that performance reporting is most effective in informing the government, the parliament and the public when based on clearly expressed outcome statements, programme objectives, deliverables and meaningful KPIs. We do not seem to have achieved that goal yet but nor does it appear that any other country has either .... (Barrett, 2014: 63)*

Hence, performance reporting has proven to be an ineffective accountability mechanism within more standard social service contracting arrangements, let alone under personalized approaches where accountability is necessarily more diffuse. Arguably, what is needed is an accountability culture. Here, accountability is not “broken” into clear boxes of responsibility but rather designed as a policy that encourages accountability at all levels of design and implementation. Here, we can recall Osborne and Gaebler’s (1992) metaphor of governance as “steering” and government as “rowing.” A government (rowing) approach might allocate specific resources and responsibilities to specific people, organizations, or agencies to carry out accountability work, whereas a governance (steering) approach might authorize all participants in a system to raise accountability issues. Fostering a culture of democratic accountability that encourages mixed accountability at all levels of design and implementation is one of the ways that a regulatory actor can try to “steer” the workings of the broader system (including government, citizens, private sectors, and civil sectors). In other words, accountability as responsiveness (Mulgan, 2000).

## 4 | METHODS

Data were collected as part of a longitudinal study into the implementation of the NDIS that interviewed scheme architects, implementation staff, and service providers (see Carey & Dickinson, 2017). Fifty-seven participants were interviewed across government and in the disability service sector. Participants were recruited using criterion-based purposive sampling (Blaikie, 2010) to target larger service providers with more complex organizational structures (as opposed to single employee organizations such as independent occupational therapists) and to target individuals based on their current or past roles in Commonwealth administration comprising the Department of Social Services and the Department of Prime Minister and Cabinet (Carey & Dickinson, 2017). Service provider participants were drawn from two case areas, Canberra and Melbourne, Australia. Canberra was chosen because it was a trial site for the NDIS, beginning implementation in 2015. Melbourne was chosen to be a contrasting site as it is a larger metropolitan area that was not a trial site for the NDIS, implementation began in Melbourne in July 2017, along with the national implementation.

In the results, the government participants are referred to as “GP” followed by an individual number, and the service provider participants are referred to as “SP” followed by an individual number. Recruitment followed purposive snowball sampling (Blaikie, 2010) and proceeded until saturation was reached ( $n = 57$ ). By speaking to both government actors and service providers, we are able to get a broader set of perspectives about the way that accountability plays out in the NDIS during implementation.

We conducted semistructured interviews in person or over the phone and generally with individuals (though one interview with government actors combined three government actors, this was not by arrangement). We found no meaningful differences between in person and over the phone interviews. The aim of the interviews was to understand the implementation of the NDIS and accountability dilemmas from people working in different positions in relation to the NDIS. Government actors were asked about the design and implementation of the NDIS and the

five accountability dilemmas identified in Malbon et al. (2016). Service providers were asked about their organization's transition to the NDIS and their understanding of accountability systems for the five accountability dilemmas. Importantly, we asked about accountability for both "positive" and "negative" care outcomes, but we left the definition of these positive and negative outcomes open to participants. Interviews were recorded and transcribed verbatim using an external transcription service. Transcripts were coded by all authors using a thematic approach (Blaikie, 2010).

## 5 | FINDINGS

### 5.1 | The state of the NDIS accountability dilemmas

Previous work (Dickinson et al., 2014; Malbon et al., 2016) identified the five potential dilemmas for accountability in the NDIS; care outcomes, care workers and workforce, advocacy, public money, and market stewardship. There is not space to do justice to all of these accountability dilemmas in this paper. Instead, we will focus on two accountability dilemmas of particular relevance to personalized schemes: care outcomes and market stewardship. These were also the most prominent through thematic analysis (Blaikie, 2010). It is important to note that according to NDIS nomenclature, the scheme is still in "transition" (i.e., different regions are shifting from the old scheme into the NDIS). As a result, the individual States and Territory governments are currently accountable for quality and safeguards under their own quality and safeguarding systems.

### 5.2 | Accountability for care outcomes

Our findings identified two areas of concern discussed within care outcomes; (a) accountability for "negative" care outcomes such as a loss of safety or reduction in care quality for people in the Scheme and (b) accountability for overall "positive" care outcomes which refers to an overall positive effect on the lives on people in the NDIS. Accountability for positive care outcomes might be about ensuring that care meets the aspirations that a person with disability has for their lives, whereas accountability for negative care outcomes might be about ensuring that care never falls below minimum standards (quality and safeguarding). We find a discrepancy between those considered accountable for these "negative" and "positive" care outcomes. This indicates a perception that government has responsibility to provide safeguards to avoid negative care outcomes rather than for assuring positive care outcomes, which are instead considered a success of the relationships between service providers and people with disability. Specifically, the layered nature of the accountability structures in relation to care outcomes mean that there is likely to be ambiguity or "buck passing" if a care service goes wrong and there are negative (i.e., dangerous or abusive) outcomes to care services. Who would and could be held accountable in such a situation? The participant for their choice of provider, the provider themselves, the NDIA for allowing such a provider to have registrations, or the Commonwealth for creating a marketized structure of care delivery that shifts quality monitoring onto the patient and service provider?

During the transition phase of the NDIS, the State and Territory governments each implement their own quality and safeguards frameworks and carry legal responsibility for negative care outcomes, causing the need for coordination by the Federal government (Department of Social Services, 2016). At the time interviews were conducted, participants in the federal Department of Social Services indicated that for negative care outcomes, "The bulk of the accountability would sit with the state/territory government ... because they've got the quality and safeguards responsibilities" (GP20). This is coupled with the acknowledgement that the NDIA, the agency tasked with administering the NDIS, would have some oversight in pressing State and Territory governments to make an appropriate response: "The agency would have some ... but they would probably press most of the response back onto the state or territory government" (GP20). This arrangement, in which States and Territories carry responsibility for quality of care outcomes is temporary, and national standards will eventually be set by the new Quality and Safeguards Commission.

Although there is a clear understanding that State and Territory governments currently have responsibility for negative care outcomes and are required to look into the quality and safeguarding systems of problematic service providers, one participant observed that “there is a perception that the Minister [of the Commonwealth Department of Social Services] has overarching responsibility” (GP25). This participant described the attention that negative care outcomes can and do get in the media and the way in which the public can hold a Federal government minister to account through these channels. The participant refers to a specific Australian current affairs program and its depiction of problems in the NDIS as a failure of “government” in general terms rather than in specific terms: “... when it's a car wreck happening, everyone's accountable and yet nobody is. I think that's one of those blurred lines at the moment” (GP25). Although State and Territory governments still hold the responsibility to uphold quality and safeguards in the NDIS in their respective jurisdictions, the NDIS is still seen as a Federal government program by the public and a “scandal” level problem is likely to impact heavily on the legitimacy of the NDIS and the Federal government itself.

Conversely, the State and Territory governments get little credit for the successful delivery of positive care outcomes, as described by one Federal government participant: “The good outcomes, again it's diffused and it's an interesting thing because when you reverse it you get a different kind of answer. So, it's not so much the state-territory government in that sense” (GP15). It became clear that accountability for delivering positive care outcomes is primarily envisioned to occur in the social contract between people with disability and the service providers:

*We're moving from a contracting environment to an environment where there is consumers commissioning, and a level of government regulation ... But the most interesting thing, I think, will be about who is accountable, participants can actually hold their service deliverers accountable. (GP30)*

*Essentially responsibility for outcomes needs to be ultimately held by people, by the person [with a disability]. As it always should have been, but sadly has not. (GP31)*

Greater accountability, and greater choice and control, is an aspect of the NDIS that garners popular support from people with disability, advocates of the scheme and service providers alike (Thill, 2015). Many service providers consider a focus on shared accountability for overall positive life impacts to be welcome:

*If we're dropping somebody off at home after spending the day with them and they've had a really great day and they've achieved and they're feeling great and mum and dad are saying thank you to us and saying 'You've done a great job. We've noticed a change.' And in that position, they're engaged; they've got purpose in life – well that's accountability at its best. (SP23)*

*Participants can actually hold their service deliverers accountable. (GP30)*

The perception that there is a shift in accountability “toward” people with disability aligns with Bracci's (2014) claims that personalized care schemes can achieve participatory accountability for participants. However, there are a number of other social factors that affect whether a person with disability is fully empowered to take on the task of holding their service provider to account. For example, Carey et al. (2017) explored the social determinants that influence equity in the NDIS and found that differences in disability types, the robustness of the local disability market, geographical proximity to services, strong kinship ties, and knowledge of how to navigate bureaucracy will affect how equitably the NDIS impacts lives. Based on our data, we would also add the possibility that people with disability have been “institutionalized” under the previous scheme to withhold complaints about poor care or poor service providers for fear of losing their access to services, which has serious implications for their ability to exercise the types of “participatory accountability” expounded by Bracci (2014):

*If they send you three people who don't have the skills to do the job then you can actually ring up and go “Uh-uh, not anymore.” Whereas in the old world [it was] “Shut up, because you're going to lose*

your service." And that's a big risk to take if you've been - I mean - people are institutionalised into that environment to be grateful for what they've got, because there's a lot of people who didn't get anything. (GP30)

For people that are empowered through advocacy support, kinship, wealth, or other social determinants, the sort of participatory accountability that is described by Bracci (2014) may be possible. However, participants who are vulnerable to any or multiple social determinants, and potentially institutionalized toward passive consumption of care services, may not be as empowered to exercise accountability for their care and achieve the sort of participatory accountability that proponents of personalization schemes espouse (see Bracci, 2014; Bracci & Chow, 2016; Whitaker, 2015). As noted by Carey et al. (2017), particular groups within the scheme (i.e., those living in remote communities such as indigenous people, people with poor social networks, or less common forms of disability) are unlikely to experience the same benefits from the scheme or be able to exercise true choice and control. It is known that groups who experience psychosocial disability, complex needs, or have cultural barriers to participation fare worse under personalized schemes (Australian Productivity Commission, 2011).

Concern for barriers to achieving positive care outcomes can be found across providers and government:

*[Small organisations] just won't have the skills, the governance, the capacity to go from what they do now to meeting the needs into the future. That results in a few different things, one is that you just get people's plans not being fully resourced so they might be eligible for more assistance, but they don't get it because the organisation can't get the workforce or can't provide that assistance. The agency [NDIA] then needs to think about whether that's catastrophic for an individual, or certain individuals. (GP18)*

*In the Northern Territory you've got to come up with bespoke answers when talking about remote communities, that's how they deliver health and disability services now, in a way that doesn't happen around the rest of the country. It's very likely that the way that the NDIS gets rolled out in the Northern Territory, and possibly other parts of the country where there are practically non-existent markets just will have to be different ... How much choice do people get if they are not happy? Probably not a lot. (GP18)*

The NDIS personalized scheme sees accountability for positive care outcomes shift to the contract between people with disability and service providers. This means that the power that a person has to exercise accountability for their care, such as moving to a new service provider, is mediated by their situation and by the robustness of the market that determines whether an alternative service provider is available (Carey, Malbon, Nevile, Llywellyn, & Reeders, 2017). This NDIS has a mixed accountability regime, whereby accountability for negative care outcomes (i.e., ensuring care never falls below minimum standards) is split between State and Territory government and service provider quality and safeguard processes, and positive care outcomes are primarily situated in the contract between people receiving welfare and service providers. The consequences of this change in accountability regimes, consistent with a shift to NPG approaches, mean that participatory accountability may be achieved for people with other forms of social stability and wealth but is not as likely to be achieved by people with a complexity of social vulnerabilities, especially without effective market stewardship.

### 5.3 | Accountability for market stewardship

There is recognition that market stewardship is crucial to the success of the NDIS, and currently the structures of accountability for market health are shared between the NDIA, the Department of Social Services, and a new commission soon to be established in 2018, creating a situation of mixed accountability (Department of Social Services, 2016). When markets are used to deliver social services, as in personalization arrangements, market stewardship is seen as going beyond ensuring minimum protections for citizens, to ensuring that public good and

public value are delivered to citizens (Carey, Dickinson, et al., 2017; Gash et al., 2014). This includes guarding against thin markets through intervention or preventing against the development of market gaps. Here, the role of government is expanded to guard against inequities, including inequities in the ability of citizens to exercise choice and control in market arrangements. Market stewardship is essential to ensure the social contract between government and its citizens is maintained within personalized arrangements (Needham, 2010).

At present, the role of market stewardship is split between the federal government and the main operational body the NDIA. Internal Commonwealth documents supplied to the researchers indicate that there is a great deal of layering between the NDIA and the commonwealth Department of Social Services in terms of responsibility for market oversight. For example, the Department of Social Services holds overall responsibility for the functioning of the market (i.e., a market stewardship role), but the NDIA plays important roles in identifying market gaps or working to close them through the provision of information about “best practice” strategies (Carey, Dickinson, et al., 2017), and finally, the NDIS actuaries hold responsibility for setting prices which is the main lever that government holds for stewarding the NDIS market. Arguably, this mixed structure creates risks for accountability of market stewardship. For instance, there is a high chance that a “tick box” approach typical of NPM could be taken to manage accountability reporting across these organizations, as seen in other market based reforms such as employment services (Considine, 2002). For example, early discussions between the research team and the Commonwealth government indicate that financial reporting is under consideration as a mechanism through which the Commonwealth government tracks providers and market health. Such a measure is a classic NPM approach and is being discussed despite well documented evidence of market failures occurring even under strict financial reporting and scrutiny (Considine, 1999; Sumsion, 2012). However, it is important to note that particular mechanisms for tracking market robustness are not yet finalized.

The layered accountability for market stewardship between the commonwealth and the NDIA is of particular concern given the known capacity limitations of the NDIA. In late 2016 and early 2017, the NDIA experienced a major collapse of IT systems pertaining to implementation pressure and a lack of capacity, triggering a national audit (Australian National Audit Office, 2016). The Commonwealth audit office noted that a lack of clarity and transparency exists around accountability for market stewardship across the different entities involved, which has continued into 2017:

*It would be useful for the Department of Social Services and the National Disability Insurance Agency [NDIA] to publish statements defining their ‘market oversight’ and ‘market stewardship’ roles, respectively, to improve transparency and accountability. (Australian National Audit Office, 2016, p17)*

Concerns about the capacity of the NDIA during the roll out of the scheme were reiterated by service providers within our study:

*It's like nobody knows who's in charge, so decisions are being made, sent down from on high, there's very little communication from NDIA to providers about what's happening, there's very little communication to families. It's like the whole ... the management chain or the system of decision-making and communication is in chaos. (SP10)*

*There's an understanding by the NDIA there are issues with pricing, there are issues with transport, there are issues with a range of different things but there has been no ... there's been a bit of a commitment to try and resolve them. They haven't been resolved. They're still tabled but they're not moving anywhere ... (SP12)*

Hence, although it may be tempting for the Commonwealth government to assign market stewardship largely to the NDIA, there are significant capacity issues associated with this body. Further, they do not have control over price settings, a key lever in market stewardship, which sits with the NDIS actuarial team who are not held accountable to commonwealth or the NDIA under the NDIS legislation (NDIS Act, 2013).

The devolution of accountability to the NDIA is consistent with current literature in commissioning, which argues that the commissioning agency should hold ultimate accountability for policy outcomes (Ranson, 2003). However, this is an approach that works in “theory” but may not work in practice as shown in the case of the NDIA. Capacity and appropriate structures of transparency and accountability to different sets of authority need to be in place to ensure these appropriate market stewardship functions occur in the NDIS. However, the NDIA is in fact hampered in its ability to steer the market due to the split of accountability with the commonwealth government and NDIS actuaries who influence scheme pricing on the basis of actuarial modeling. The NDIA is an agency under pressure to produce big results and quickly, the realities of this implementation mean that the NDIA is pouring its resources into getting people registered into the Scheme and in monitoring the long-term financial sustainability of the scheme rather than the diversity of local markets (Australian National Audit Office, 2016). As it currently functions, the NDIA is not likely to have the capacity to achieve the level of market stewardship that is needed for the NDIS to achieve its goals of greater choice, control, and participatory accountability, in an equitable and fair way (Australian National Audit Office, 2016). We judge that the potential capacity limitations of the NDIA presents one of the most significant accountability dilemmas in the NDIS to date.

The NDIA has also been found to be lacking in transparency (Australian National Audit Office, 2016), which limits the ability of other market actors (including other commonwealth agencies and service providers) to access critical information about market performance, market gaps, and so forth. Participants in the commonwealth government identified issues working with the NDIA in their layered accountability roles:

*Where there's a slight gap, sometimes, is you can agree on something at that policy level with the NDIA, but it doesn't necessarily always filter through very smoothly to the operational level. So, you can kind of think you have agreed on what the policy will be, but then there'll still be complaints from providers or participants saying; “hey, this did not happen.” (GP30)*

Our findings reveal important realities of the implementation of personalization schemes. Through the complications, hybridity of accountability systems, and implementation challenges that are within the NDIS, we can see that although the literature may claim that personalized funding schemes offer participatory accountability for scheme participants (Bracci, 2014; Bracci & Chow, 2016; Whitaker, 2015), the reality may not reflect this. In the discussion, we address how the claims regarding hybrid accountability structures made in the literature contrast with the experiences of implementation in the NDIS.

## 6 | DISCUSSION

We examined the political and administrative dynamics of the Australian NDIS as a new form of welfare governance and a personalized funding scheme of international significance. We find that accountability for care outcomes takes a hybridized form due to the different institutional logics (see also Malbon et al., 2016) and the layering of accountability systems such as the quality and safeguarding systems. We suggest that the way that layers fit together, in real life implementation, is often imperfect because of the conditions under which they arise. As a result, critical gaps can emerge in hybrid systems which can put participants at risk and draw schemes away from the ideal of participatory accountability, which are explored below. Based on our analysis, we have derived three (nonexhaustive) principles for preparing and managing for layered accountability.

### 6.1 | Transparency omissions in the NDIS Act, 2013

#### 6.1.1 | Principle 1

A lack of coherence in legislation and initial policy making sets up for layered accountability during implementation.

The NDIS Act has omissions that mean that accountability systems in the NDIS are nondirective: The NDIS Act does not require transparency about rule setting, or authorize the collection and publication of information that could enable civil society and media to assess whether the scheme is effective, creating barriers to democratic accountability processes (Carey, Malbon, Olney, & Reeders, 2018). Although the NDIS Act (2013) provides for actuarial oversight of scheme expenditures, it does not authorize monitoring and evaluation, or market stewardship to ensure that thin markets or market gaps do not arise. In an independent review of the NDIS Act, stakeholders called for a requirement on government to report on the alignment between the NDIS implementation and its policy goals in an ongoing way (Earnest and Young, 2015, pp. 26–27). The omissions in the NDIS Act are, in some instances, being addressed in subsequent policy documents and processes, such as the (soon to be established) NDIS Quality and Safeguards Commission, which will provide oversight of the state and territory safeguard processes. However, the fact of these omissions means that policies and processes to address these have created the conditions for a layered approach, leaving open the possibility of “cracks” in accountability systems through implementation.

## 6.2 | Mixed accountability

### 6.2.1 | Principle 2

Mixed accountability measures can be managed well, but it is important to monitor for possible gaps.

Mixed accountability is apparent in two main areas of the NDIS; (a) accountability for care outcomes and in (b) accountability for market stewardship. The systems for quality and safeguarding that protect against substandard care practices are born of hybrid relationships between state quality and safeguarding practices, and federal government frameworks, to which will be added the NDIS Quality and Safeguards Commission, as well as the quality and safeguard processes of service providers (Department of Social Services, 2016). This system of accountability for quality and safeguards is acceptable by modern welfare state standards; however, its effectiveness is clouded by limitations regarding transparency in the NDIS Act and the capacity limitations of the NDIA. Due to the omission of market stewardship accountabilities in the NDIS Act (2013), combined with omissions regarding transparency of the NDIA and NDIS Actuaries, there is mixing of responsibility for market stewardship across the Department of Social Services, the NDIA and NDIS Actuaries. According to the NDIS Act (2013), responsibility for setting prices in the NDIS market rests with the NDIS Actuaries; a set of individuals within government but distinct from the NDIA and that sit outside the influence of both. This has prevented both the NDIA and the Commonwealth from influencing the price of services, one of the major levers for market stewardship. What can be seen in NPG style reforms is a bricolage of accountability responsibilities and agents, this is not necessarily a problem, except when participants or situations can fall “between the gaps” in layers of responsibility. In order for mixed or layered accountability to be managed well, it is important for there to be an oversight body to take in the “big picture” and ensure that responsibilities are clear and ensuring all agents have the capacity to carry out their accountability roles.

## 6.3 | NDIA implementation capacity

### 6.3.1 | Principle 3

Accountable institutions must have the capacity and resources to carry out their responsibilities.

Under the PGPA (2013) Act, the main agency accountable for the success of the NDIS is the NDIA; however, the NDIA is facing a major challenge to implement the scheme in a tight timeframe and has recorded capacity limitations (see Australian National Audit Office, 2016). This has added to the complexity to accountability systems in the scheme, as other parts of government “pick up” lines of accountability which would have originally sat with the NDIA (Australian Productivity Commission, 2011). This reaches across many areas of the scheme already discussed, including market stewardship, complaints, and quality and safe guarding practices. Hence, through under resourcing the main implementation agency, inadvertent layered accountability systems have emerged.

## 6.4 | Participatory accountability?

Our findings also have implications for the concept of participatory accountability, which has been raised as a potential benefit of personalized schemes (Bracci, 2014; Bracci & Chow, 2016; Whitaker, 2015). Although it may be possible for many people within the NDIS to achieve this idealized form of participatory accountability mixed with government-based accountability, there are also many structural and institutional barriers that may affect the ability for people with disability to exercise this new form of participatory accountability for their care outcomes. We found the presence of a *narrative* supporting the ability of this personalized funding scheme to achieve choice and control for participants and therefore a new form of participatory accountability mixed with government-led accountability, this is in alignment with similar ideas in the accountability literature (Bracci, 2014; Bracci & Chow, 2016; Whitaker, 2015). However, although it may be possible for many people within the NDIS to achieve this idealized form of participatory accountability mixed with government-based accountability, there are also many structural and institutional barriers that may affect the ability for people with disability to exercise this new form of participatory accountability for their care outcomes. These include complex vulnerabilities such as access to kinship networks, remote geography, wealth, access to advocacy, or education (Carey et al., 2017). Our participants also highlighted the potential that some people with disability have been institutionalized toward a passive consumption of care services by the previous funding arrangements, in line with other literature on institutionalized care systems in Australia (Braithwaite, 2001). Such institutionalization adds psychological barriers to the potential to exercise accountability, choice, and control by switching service providers. When accountability for care outcomes exists in the contract between service providers and participants, as is said to occur in personalized funding structures (Bracci, 2014; Bracci & Chow, 2016), the ability for participants to exercise this new form of participatory accountability relies on the ability for them to (a) negotiate with their existing service provider or (b) change to a new service provider. The ability for a participant to change service providers necessitates a robust market in which a new (and better) service provider is available. However, as we note, who is responsible for market stewardship is unclear and the main body implicated (the NDIA) is experiencing major capacity issues.

## 6.5 | Conclusion

Earlier in this piece, we introduced the idea of an accountability culture that “steers” safe practice and market stewardship by being responsive to citizens, civil society, the care sector, bureaucrats, and politicians as accountability dilemmas are raised and identified (Ayres & Braithwaite, 1994; Mulgan, 2000). Despite some of the challenges that we have highlighted, the Australian NDIS is moving in the right direction for its policy goal to increase choice and control (i.e., participatory accountability) for people with lifelong disability. However, as we highlight, there are mediating factors that affect a person's ability to exercise participatory accountability in personalized schemes, but this reality should not detract from the important goal of aiming to increase participatory accountability processes alongside more government-led accountability processes. Personalization schemes such as the NDIS should extend additional supports to participants with barriers to participatory accountability.

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