Research and Evaluation

Accountability in Public Service Quasi-markets: The Case of the Australian National Disability Insurance Scheme

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Australia's National Disability Insurance Scheme (NDIS) represents the latest in a world-wide shift towards individualised funding models for the delivery of care services. However, market-based models for care deliveries bring new considerations and dilemmas for accountability. Drawing on previous work by Dickinson et al. (2014), we examine a range of accountability dilemmas developing within the early implementation of the NDIS. These relate to accountability for the following: care outcomes, the spending of public money, care workers, and advocacy and market function. Examining these accountability dilemmas reveals differences in underpinning assumptions within the design and on-going implementation of the NDIS, suggesting a plurality of logics within the scheme, which are in tension with one another. The contribution of this paper is to set out the accountability dilemmas, analyse them according to their underpinning logics, and present the NDIS as having potential to be a hybrid institution (Skelcher and Smith 2015). How these dilemmas will be settled is crucial to the implementation and ultimate operation of the scheme.

Key words: *accountability*, *care provision*, *disability*, *individualised funding*, *market*

Over the past few decades we have seen a shift towards individualised funding for self-directed care in Western Europe, North America, and other OECD countries (Needham 2013). Australia has joined this trend at the national level with the introduction of the National Disability Insurance Scheme (NDIS). Moving to a system of individualised funding for disability services, it is argued, will radically change the structure of care provision, emphasising individual choice in a way that 'block contracting' arrangements have traditionally struggled to achieve. Moreover, doing so in the context of a market (or more accurately a quasi-market) is seen as a way to deliver more efficient, responsible, and innovative services than is achievable within large public bureaucracies (Considine et al. 2011; LeGrand

and Bartlett 1993). Dickinson et al. (2014) argued that these changes have significant implications for lines of accountability of care services. Drawing on evidence from international experiences of individual funding systems, Dickinson et al. (2014) set out a number of potential accountability dilemmas that might arise in the shift to the NDIS model of care.

In this paper, we build on Dickinson et al.'s (2014) work to examine how discussions of accountability are evolving during the implementation of the NDIS. Through interviews with policymakers in the months prior to the full scheme roll out, we sought to identify the kinds of accountability dilemmas they face in the design and implementation of the NDIS. We found early descriptions of problems relating to the three accountability dilemmas identified by Dickinson et al. (2014), in addition to two further dilemmas. We consider how problems

may develop into dilemmas (or potentially be resolved before progressing to dilemmas) during implementation, and the degree to which they are consistent with the logics of choice and care identified by Mol (2008). Mol's (2008) work conceptualises the relationships between government and public service provision and the processes for accountability that exist. Mol (2008) explicitly identified two dominant logics: logic of choice and the logic of care. At this stage in implementation, we found that there is a stronger logic of care at play than an ethos of choice, which runs counter to the original design of the scheme (see Australian Productivity Commission 2011). Hence, pre-existing accountability logics may be causing implementation disruption, or at the very least creating tensions during implementation, which creates uncertainty for service recipients.

The Australian National Disability Scheme Context

The NDIS was passed in 2013 after a concerted and highly effective community-led campaign (Thill 2015). Approximately 460000 individuals are expected to be participants in the scheme as of 2019, located across Australia (Australian Productivity Commission 2011; Collings et al. 2016). Based on an insurance model, the NDIS will provide no-fault insurance cover for Australians who are born with or acquire a disability, and more recently, includes people experiencing forms of mental illness (Australian Productivity Commission 2011; Collings et al. 2016; NDIS 2014). The insurance approach is a highly unique dimension to the NDIS and, in theory, means that the Australian Government covers the lifetime costs of disability-related care for eligible individuals (Walsh and Johnson 2013).

The NDIS began with seven trial sites in 2013 and, as of July 2016, has moved into national roll out (ANZSOG 2016; Collings et al. 2016; NDIS 2014). Under the NDIS, eligible individuals will be encouraged and supported to exercise choice and control over a needs-based funding envelope to purchase supports that most effectively meet their needs (Bonyhady 2014; KPMG 2014; NDIS 2014). The NDIS represents a shift from block-funded disability services, to a personalised model whereby individuals are given 'funding packages' determined by their level of need and self-defined goals (Australian Productivity Commission 2011; Collings et al. 2016). It is worth noting that the NDIS is very much in development, described as a 'plane being built during flight' (Whalan et al. 2014). Whalan et al. (2014) presents this as caused by distinctions between the vision of the NDIS presented in the Australian Productivity Commission report and the vision of the NDIS argued for by people with disability and their advocates. This means that issues, such as accountability, have and are likely to continue to shift over time.

Accountability Dilemmas and Logics of Choice and Care

In this paper, we explore perspectives of policy-makers charged with implementing the NDIS to examine the degree to which different aspects of the NDIS are underpinned by logics of care and/or choice and the implications of this for considerations of accountabilities. Dickinson et al. (2014) argue that the introduction of the NDIS has the potential to introduce a series of accountability dilemmas into disability services. In this paper, we draw on the established academic literature on accountability, defining it as 'the principle of holding people responsible for having participated in, contributed to, or effected an occurrence' (Sullivan 2009: 3). Accountability occurs in a range of different spaces including the relationship between government and citizens, through reporting (media and otherwise), meetings, and external scrutiny by expert peers (Dickinson et al. 2014: 419). Thus, accountability is the normative process through which the media, advocacy groups, independent organisations, unions, citizens, and so on hold others (especially government) responsible for their actions, rather than a strict legal responsibility (though legal responsibility may occur within this broader definition of accountability). Based on the accountability dilemmas put

forward in Dickinson et al.'s (2014) assessment, an accountability problem becomes a dilemma when those concerned (i.e. citizens, service users, policymakers, service providers, advocates, and other members of the community) cannot agree about where accountability should lie, or, where agreement does occur, it is persistently difficult to implement and regulate through formal and informal systems.

The dilemmas identified by Dickinson et al. (2014) include issues relating to the following: who is accountable for care outcomes, how can we ensure the accountable use of public money, and who is accountable for the welfare of care workers (see below for further discussion)? They go on to draw on the work of Annemarie Mol to develop a more comprehensive framework of accountability dilemmas. Mol's (2008) work can be used to conceptualise the relationship of government and public service provision to various publics, such as service users, service providers, and community, and the processes for accountability between. The application of Mol's insights can be used to develop a relational understanding of accountability, in which it is conceptualised as being shared between all participating institutions (mediated by power dynamics).

Mol's (2008) work presents a duality of ideal-type logics of care provision; the logic of choice and the logic of care. She argues that these logics hold different assumptions about actors and their roles within care systems. Operating within a 'logic-of-choice' framework views individuals as autonomous actors who exercise personal judgements over a market of service providers, with professionals playing advisory roles and the market making new options and innovations available. In contrast, the 'logic of care' idealises a process-based relationship between individuals and professionals providing care, in which there is strong mutual communication and adaptation to ensure that the individual receives the best care. Mol (2008) argues that a logic of choice has traditionally underpinned public service delivery, but this is a flawed approach and working from a logic of care would develop a more effective and truly consumer-centred way of approaching care services. She develops the argument that

we should move from a choice logic through to one of care logic, largely treating these as binary analytical categories (although she notes that the logic of care is not superior in all cases).

Dickinson et al. (2014) draw on Mol's (2008) logic-of-care approach to consider individual funding systems in terms of how we conceive of and practice issues of accountability. As an illustration of the implication of underpinning such a system via a different logic, Dickinson et al. (2014) describe that when considering the question of 'who is responsible for care outcomes?' a logic of choice would consider accountability to rest with the individual budget holder, taking advice from professional advisors but with freedom to determine priorities and activities. Approaching this from a logic-of-care perspective would conceive of accountability for care outcomes in a more relational fashion. Dickinson et al. (2014) describe this as follows, 'Government, professional advisers and individual budget holders share accountability. Outcomes determined and activities jointly led by wishes of Budget holder. Government maintains responsibility for providing commissioning and regulatory frameworks that reflects public priorities for care quality.' (Dickinson et al. 2014: 432). Such an approach recognises individual budget holders as being in a relationship with some manifestation of the 'public' through government. This does not allow for the easy separation of individual and public accountabilities as they are intertwined.

Methods

Data were collected as part of a longitudinal study into the implementation of the NDIS (Ethics clearance from the University of New South Wales, Canberra, No. HC16396). In this study, we concentrate on the institutional decisions and logics that impact, or ultimately transform, the structure of the NDIS through implementation, with a particular focus on decisions that constrain or enable learning in this complex reform. The case study approach allows us to capture the nuances of the implementation in context (Yin 2014).

Semi-structured interviews were conducted with all senior policymakers from the implementation team within the Commonwealth government as of March–April 2016. Twenty-six interviews were completed in total, conducted face to face, and transcribed verbatim. The research is undertaken with the support of the Commonwealth Government and interviews were organised by the head of the NDIS implementation group.

Issues covered in interviews included the following: decisions regarding the governance structure of the NDIS, implementation challenges relating to the development of the scheme, the markets, and national roll out. Data were analysed using a thematic approach (Blaikie 2010). 'Like' data were grouped together to form categories and subcategories. These categories were developed into more substantive themes, by linking and drawing connections between initial categories and hypothesising about consequences and likely explanations for the appearance of certain phenomena (Strauss 1987). This was done through discussion between G. Carey and E. Malbon. In the refining of themes, selective coding was carried out by E. Malbon, whereby transcripts were revisited with the explicit intent of finding further linkages and connections between the central issue being explored and other themes.

From this, we identified the kinds of accountability dilemmas faced by policymakers and through this better understood the values and logics inherent within the system. Here, an accountability 'dilemma' refers a situation in which 'the perceived failings of governance are in conflict with people's existing beliefs, [and] such failures pose dilemmas' (Bevir and Rhodes 2006). These data were initially analysed according to emergent themes, including general accountability dilemmas, ambiguities around market management, and processes to support advocacy. This was further analysed according to Dickinson et al.'s (2014) accountability dilemmas; the spending of public money, care outcomes, and care workers. An additional two categories of accountability dilemmas emerged; advocacy and market function. The five categories of accountability dilemmas were identified and analysed

according Dickinson et al.'s criteria for the logic of care and the logic of choice, originally drawn from Mol (2008).

Findings

We present findings here according to the five accountability dilemmas identified through the data analysis process. In addition to the three dilemmas that Dickinson et al. (2014) identified, we found two further dilemmas for consideration: accountability for advocacy and accountability for market function. We set out an account of each these dilemmas in turn, illustrated by quotes from interviewees and summarise briefly what these tensions indicate in terms of underlying assumptions. In the discussion section, we build on these brief summaries and explore the tensions between these logics with regard to different aspects of accountability within the NDIS.

Accountability for Care Outcomes

Dickinson et al. (2014) suggest there is potential for an accountability dilemma to emerge in relation to responsibility for care outcomes. In doing so, they point to evidence from UK social care reforms. In this case, legal responsibilities remained the same (i.e. government is accountable for care outcomes), but some degree of confusion existed regarding the degree to which responsibility was being shifted to individuals with a disability. In our research, those charged with implementing the NDIS were also concerned with issues relating to accountability for care outcomes, demonstrating a degree of path dependency for the logic of the previous model of accountability.

Many interviewees explained that originally they believed the NDIS was to be underpinned by a push to make individuals more responsible for their care outcomes. However, as the implementation process has unfolded, interviewees reported becoming aware of the need for government to hold some accountability. In part, this stems from perceived risks about 'dodgy' providers and a current ambiguity about responsibility for detecting rogue providers.

Individual care package holders, and those who act as their spokespersons, have been pushing for the Commonwealth government to accept some accountability for potentially poor service outcomes and manage the risk that clients will enrol with service providers who are 'dodgy' or 'scammers'. Study participants within the Commonwealth acknowledge the tension between allowing for choice and managing the risk of vulnerability to poor service provision:

> The risk management side, there's also the tension around if you're trying to encourage people to have more options and to have more responsibility for their lives, then you also have to balance that with the risk. And I don't think that anyone had come to any conclusion, and I'm not sure that there is a risk because there'll always be that balance between responsibility and risk and vulnerability as well. And that will vary so much with individuals as it does in life, anyway, and different views amongst participants, too. So some participants who have often expressed a lot of concern that how will they know that someone coming to provide service is qualified and can they really rely on people? (Participant 1)

Both Commonwealth government representatives and service providers reported a tension in allowing freedom for decision making for people with care packages and managing the risk of service providers that do not deliver on promised care. Currently, some individual care package holders and their advocates are asking the Commonwealth to carry more of the accountability than originally outlined in the inception of the Scheme. This problem highlights the potential dilemma of ensuring quality care outcomes in a quasi-market system when markets are new or not fully formed and when the monitoring of quality service provision occurs primarily at the client level.

While initial conceptualisations of the scheme suggested that individuals would be free to choose services from providers, as the scheme is being rolled out the reality appears to be that individuals do not have quite this level of choice. As one interviewee notes, 'people have the choice to pick up and go from this provider to that provider. People just don't do it ... ' (Participant 13). Some within the Common-

wealth expressed a concern about the ability for market mechanisms to mitigate risks associated with care outcomes:

> So one of the things we're all very conscious of is the risks of lack of supply, the risk of lack of quality and that's where it then leads into safeguards obviously, exploitation, it could be a lot of focus from enquiries on abuse and neglect of people, but also the scammers that are out there waiting. When there's money around they come out of the woodwork. So there's a whole kind of spectrum of risks like that that we're conscious of in designing quality and safeguards and how that gets implemented. (Participant 16)

One of the major challenges facing implementers of the NDIS is the idea that many of the disability markets are 'immature'. As one interviewee described, ... talking about the market in terms of the participants as well as the providers, until all that matures, you know these are people that have never really had much choice and control let alone handling money for example. And that's the good thing about the NDIS, that we want to work with participants so that they're the drivers of the market, not the providers, which it kind of has been. (Participant 16). Given that the NDIS disability market is yet to develop in a significant way, policy makers argued that structures for dealing with accountability for care outcomes would need to be shared among government, service providers, and individuals:

> We'll make that kind of careful development – it always takes time because people are involved, it just may make that difficult at first. What you might find is not so much market failure but just a really slow market, including a key market factor when – just that – and honestly you see it in all kinds of other markets too is; people have the choice to pick up and go from this provider to that provider. People just don't do it because it – I mean we don't do it with our banks or our telephones or whatever it is. (Participant 13)

In order to deal with the diverse needs of people within the scheme and to match them with their chosen care, the Commonwealth has set up a number of 'streams' through which the individuals' chose their service providers. The majority of individuals will work directly with

a Local Area Coordinator (LAC, an outsourced position) to develop their care package. LACs will then gain sign off with a 'planner' based in the National Disability Insurance Agency (NDIA). However, the most vulnerable people will work directly with an NDIA planner to develop their care package (i.e. no LAC). Two further streams exist with varying degrees of advice offered depending on the type and severity of the disability. Critically, the LACs and planners are the conduits through which accountability is shared between government and individuals.

> [For] The majority of people, you'll be assigned a LAC . . . [to] set up some appointments, here are a range of providers in this area, any preferences about who you might go to? . . . And the LAC will stay in touch with [the client]. The most vulnerable [clients] coming out of it will get what's called a support coordinator . . . almost a case manager [with the NDIA] . . . . Then the third group, the most vulnerable group and might be something like 20 percent maybe, what you'll get is an NDIA planner who will actually meet with you, plan with you and talk with you who will then build your plan and sign it off. (Participant 15)

Ensuring Accountability for Spend of Public Money

Dickinson et al. (2014) identified a potential accountability dilemma relating to the possibility of individuals spending money on the 'wrong' kinds of things. Within the NDIS, the shift from 'block funding' of disability service providers to individual-based funding significantly changes the processes for accountability in the spending of public money. The NDIS is funded conjointly by the Commonwealth and State governments, with a view to be fully funded by Commonwealth at full scheme. Public money will be allocated to eligible individuals through 'Care Packages', which can then be spent on care with registered NDIS care service providers. Accountability for the spending of public money will also occur in the first instance with the individual's choice of care provider. However, this choice is mediated by a number of factors including the following:

organisations that are or are not registered as care providers in the NDIS and, the availability of care providers in situ (a restriction most relevant to individuals in remote and regional communities).

The NDIS is therefore more restrictive in terms of individuals being able to spend their care budgets on things of their choosing than, for example direct payments in the United Kingdom. Although individuals are able to direct their care, a menu of NDIA-registered service providers mediates their choice. Restrictions in the form of price setting by the NDIA (which involved the development of 600+ items that can be claimed through the NDIS) also further curtail individual choice and mean that accountability is shared among the individual, state, and commonwealth governments (NDIS 2015a). It is argued that this arrangement is better placed than individuals having free choice over services, as it will help ensure that the scheme's budget does not 'blowout'. Interviewees suggested that should NDIS participants have too much choice then they may select services that fall outside of the parameters of the scheme:

> If we started to see some wonky decisions from the A[dministrative] A[ppeals] T[ribunal] that we thought had the potential to see the NDIS start covering costs that should be outside the Scheme, then there could be potential for that - or for there to be a blowout or start seeing a blowout of the additional costs, at which case we might need to take action to reign that in and say no, we're going to be more specific and say this is not within the remit of the NDIS. (Participant 12)

If an over spend on the NDIS occurs, the Commonwealth will have to readdress the service providers and/or services that are included in the scheme to avoid '. . . covering costs that should be outside the Scheme'. It remains to be seen what services will be considered in or outside of the scheme over time; however, it is apparent that the Commonwealth is taking on responsibility for the regulation of the boundaries of the scheme. According to some interviewees, this is a task that policymakers are keeping a keen watch on, 'They're worried sick about the cost, they're worried sick about

the cost and that they don't have control of the imports.' (Participant 6).

Accountability for Care Workers

Dickinson et al. (2014) identified a dilemma in terms of accountability for care workers, arguing that individual funding systems have the potential to bring with them profound changes in conditions for care workers. With the rise in employment of personal assistants (e.g. in the UK), there is the potential for better and more flexible services for people with disabilities, but this might come at a cost of the loss of employment protections for care workers. Moreover, there is some evidence to suggest that those most at risk are women and recent migrants (Dickinson et al. 2014; IIF 2008; Needham and Glasby 2015). Many of these fears will not be realised in the same way in the NDIS as providers need to register with government in order to receive funds under the scheme. Technically, this gives government a line of accountability to the care workforce. However it was not framed as such by our interviewees.

One of the key fears in relation to the workforce is that there will be insufficient numbers of care workers in the system. One interviewee explained, 'we're probably going to have a shortage of workers who deliver in home services and care and some of that … there's shortages of allied health now … it's really hard - it's very hard to be predictive.' (Participant 2). As this quote illustrates, one of the major concerns is the ability to easily predict where gaps may lie in terms of numbers and capacities of workforce:

> The challenges mostly arise in workforce capacity. That goes to issues around making sure that there are enough people to provide direct services to participants and that there is this new function, particularly around local area coordination and support and planning. So making sure that there's an adequate balance in where the workforce will be at different times, and I think it's going to be a big challenge. (Participant 3)

As the comments of interviewees set out above indicate, the focus of discussions around the workforce to date seems to be more concerned with ensuring there are adequate numbers of workers rather than the wellbeing or job quality of those workers. Accountability for the wellbeing of workers appears to sit with the organisations that employ them at present (in addition to standard industrial relations protections). This raises some accountability dilemmas for workers in precarious working conditions, such as women, immigrants, and people on working visas. The use of low skilled worker visas was mentioned by one interviewee as a way to manage care workforce shortfalls. However, the working conditions for immigrant workers on these visas are known to be poor (Wright and Constantine 2015). The new market for disability care provision offers no significant changes to this. Thus far, we have examined the accountability dilemmas identified by Dickinson et al. (2014). Below, we consider a further two accountability dilemmas we uncovered through our research.

Accountability for Advocacy

The first of our new accountability dilemmas revolves around accountability for advocacy. Advocacy bodies play a key role in maintaining the welfare of people with disability. Within individualised funding models, it is important to retain advocacy bodies are financially accessible to all and provide collective voice and uniting requests for change (Collings et al. 2011; Thill 2015). Australia has a long, albeit tense, history of government funding of advocacy bodies (Casey and Dalton 2006; Lyons 2003). Within our research, interview participants indicated that on-going support for advocacy bodies will sit outside the NDIS and remain predominantly block funded: 'Disability advocacy, systemic and individual advocacy will sit outside of the NDIS and we will maintain a program and a budget for disability advocacy' (Participant P05). Included in the block funding is the External Merits Review Program though which people with disability can access support for appealing any decisions that the NDIA has made. Some policymakers we interviewed working in the disability space more broadly than the NDIS noted that they

had taken responsibility for advocacy groups to communicate problems with NDIA processes:

> Sometimes we do facilitate discussions between our peaks and the NDIA. So recently we facilitated a discussion between Carers Australia and the NDIA because there were some issues that Carers Australia wanted to engage with the NDIA with, and we said that we were interested and we were happy to facilitate that. (Participant P10)

However, the parameters of government responsibility and accountability for advocacy are not entirely clear. As one interviewee explained:

> . . . if they've [individual's have] got a need for advocacy support, that will be met within the NDIA scheme, but if it's other advocacy it sits outside. The obvious reason for that decision is that of the 4.7 million people with disabilities in Australia, 460 will end up having a plan and a package. There's a lot of people who will still need disability advocacy outside of the scheme. (Participant 4)

The quote above suggests that some individual care package holders will be able to include payments for advocacy services as part of their NDIS package. This could include, for example, advocacy support to make decisions about the make up of the care package, or advocacy support to lobby the NDIA about an individual problem; however, this has not eventuated and individual advocacy remains only available through block-funded institutions. Some support to review care package is available through the 'Support Co-ordination' line item; however, this does not cover the broad range of issues that an individual may require advocacy support for. The proposal for the NDIS Quality and Safeguards framework (NDIS 2015b) puts emphasis on the need for individuals to conduct their own advocacy and be active in personal advocacy networks:

> It will therefore be critical to develop and build the capacity of participants for self direction and self-advocacy, to focus on building personal support networks and help people connect with mainstream and community-based supports, particularly people who may be isolated and have no natural supports. (NDIS 2015b: 15)

The decision to maintain block-funded advocacy bodies appears to have occurred because the advocacy bodies represent all people with disability, and not just the people who qualify for the NDIS. Moving these advocacy bodies into individual funding could lead to their collapse. The implication of this for people with disability is that there is less availability for choice of advocacy bodies than in care service provision. Instead, the responsibility for allowing choice and agency lies in the relationship between the advocacy bodies and the people with disability. The responsiveness of the advocacy bodies to the varied advocacy needs of people with disability is not ensured by the NDIS itself, but by other accountability processes. Finally, while interviewees were adamant that government would continue to have accountability for advocacy, which part of government was unclear:

> The States and Territories fund advocacy services at the moment, but they're pulling back from that at various times, based on what their bilateral agreement says. And so those providers, some of whom aren't currently funded by the Commonwealth, are looking to the Commonwealth as the place that they can get their funding [for advocacy]. (Participant P10)

While accountability for advocacy currently remains block funded, a review of this funding is scheduled (Department of Social Services 2016) and much remains undecided in this space.

Accountability for Market Function

The final accountability dilemma we reflect on is in relation to market function. Inherent in many of the background documents to the NDIS (Australian Productivity Commission 2011) is the idea that, in time, markets self-manage and regulate. The implication is that there is little need for individuals or organisations to be accountable for the effective functioning of the market. Yet research has established that quasi-markets such as the NDIS are difficult to create and even more difficult to manage (Considine et al. 2011; Knuth 2014; LeGrand and Bartlett 1993) and that

management is in fact essential (Considine 2003; Considine et al. 2011). Policymakers discussed issues of market management and stewardship extensively, indicating that while the vision of the NDIS is of a fully deregulated market (Australian Productivity Commission 2011), there is awareness that government regulation, or commissioned regulation, of the market will persist into the foreseeable future. Government will therefore retain a degree of accountability for the market.

At present the precise role of government in the function of the new disability service market remains unclear, though much discussed. As one interviewee described,

> We've all got responsibilities for the development of the market along those sorts of different governance – It's interesting because you can't do nothing, but you can't do everything so how do you collectively – how do get the best intelligence about where the best place to intervene is? How do you not do it too late? That kind of thing. (Participant 13)

Many participants expressed concern about the idea that poor market function could have significant implications for the ability of individuals to express choice and control over care services: 'We keep talking about the structural change for the market being 10 or 15 years ... how long does it take to have an informed and capable participant community ... Because at the end of the day we need the market to be there, I mean there's no choice in control for participants, if there's no services being delivered in a particular area, and the whole fundamental underpinning is ... let's improve choice and control.' (Participant 2)

Policymakers see the market as requiring some degree of stewardship, though the form of stewardship (and for how long) remains unclear. The on-going normative discussion about who should take greater accountability for market function commonly swings between Commonwealth and the service sector: 'There is also plenty of rhetoric around the individual business's "responsibility to be market ready", but also the acknowledgement that Commonwealth and NDIA have responsibility to aid

businesses to become market ready.' (Participant 13)

Policymakers positioned the Commonwealth as accountable for the development of market function, while simultaneously maintaining that it is not 'their' (the government's) market and that the Commonwealth should be careful about being overly interventionist:

> How do think about something as slippery as the market? Because it's not our market, how do you think about it? [Governments] don't tend to want to be terribly interventionist in markets. (Participant 13)

While the Commonwealth has accepted some responsibility for market readiness, some policymakers seem to remain uncomfortable about this and uncertain about how long such supports should be maintained. In order to prepare the disability service sector for the shift to individualised funding, and simultaneously maintain the financial sustainability of the NDIS, the Commonwealth has provided a small number of transition supports and regulations. These include (i) the sharing of information regarding market gaps, (ii) price setting, and (iii) the registering/deregistering of providers. However, in terms of the supports previously given to the disability service sector (pre-NDIS), these are markedly light.

Discussion

In this paper we have sought to identify a range of accountability dilemmas that exist within the NDIS. We examined the three accountability dilemmas identified by Dickinson et al. (2014; care, public money, and care workers), in addition to identifying two new accountability dilemmas – advocacy and market accountability. We extend Dickinson's et al.'s (2014) work by aligning it with empirical data and by considering the logics through policy implementation (rather than on scheme design alone). This is made possible by the progression of the Scheme into implementation. We now move on to consider where these dilemmas sit in terms of Mol's logics of choice and care (Mol 2008).

By examining the accountability dilemmas within the NDIS, we can see at least two institutional logics at play – the logic of choice and the logic of care. Overall, we find that these two logics (care and choice) both exist at present, and are often in tension with one another. Path dependency processes appear to be giving the logic of care (as a normative frame) a degree of dominance over the logic of choice approach through the implementation of the NDIS. These normative frames are driving policymakers to adopt processes and structures that push the NDIS towards more traditional institutional arrangements. Logics give meaning to actors, and many of our interviewees were deeply concerned about the welfare of individuals living with a disability – promoting an ethos of care according to Mol's (2008) conceptualisation of a relational responsibility between individuals and professionals providing care, in which there is strong mutual communication and adaptation.

In many of the NDIS design documents (Australian Productivity Commission 2006; NDIS 2016), accountability is expressed in terms of the logic of choice, where accountability rests with individual clients who act on their own judgements, at times taking advice from others. This is not surprising, as the NDIS is based on personalisation of care principles and public sector markets, which pivot on the concept of choice (Needham and Glasby 2015). What is of note is how this logic has shifted more towards once of care during implementation. This suggests that there may be path-dependency-related forces at play in the implementation of the NDIS (Howlett and Rayner 2006; Kay 2006).

From our analysis, it is clear that during implementation, accountability for care outcomes in the NDIS has begun to shift from the vision of 'logic of choice' (in which individuals and market mechanisms respond to poor outcomes to remove poor service providers) to a shared logic of care approach. Here, government and individuals, along with service providers, share accountability through strong mutual communication and adaptation to ensure that the individual receives the best care (Mol 2008). Notably, through the process of implementation we

are seeing government take up greater accountability for care outcomes. It should be noted that the current processes for managing risk for poor care outcomes are not final, and that the logics at play within the NDIS are likely to remain in competition as the scheme progresses, the market transition occurs, and further accountability dilemmas arise.

In relation to the accountability dilemma regarding the spending of public money, we found considerable concern for the spend of public money in terms of the potential for scheme costs to 'blow out'; however, we found that less attention was placed specifically on the accountability of the spend. Currently accountability for public money is shared between individuals and government; the Commonwealth will retain accountability for service providers covered within the scheme indicating an ethos of Mol's (2008) logic of care.

Responsibility and accountability for care workers is one of the least developed accountability dilemma within the NDIS at present. Much of the conversation that involved care workers centred on the need to ensure conditions that will attract workers to the disability care sector rather than to other caring roles in eldercare or childcare. The success of the scheme relies on the care worker's willingness to engage with the transitioning market, yet the structure of the scheme means scheme bureaucrats have little recourse to interact directly with care worker wellbeing and job quality. At it is most extreme, a scheme that leaves accountability for care workers to the logic of choice leaves care worker wellbeing at the discretion of the employer (Mol 2008). In instances where care is purchased directly by the individual budget holder, they hold accountability for ensuring that funds are used responsibly. This raises the potential for accountability dilemmas if both the care worker and the person being cared for are members of vulnerable populations, such as recent immigrants and people with intellectual disability. Within the NDIS, accountability for care workers sits towards the logic of choice; however, this is mediated by regular Industrial Relations practices that still exist where a care worker is part of a larger service provider organization or union.

Figure 1. Plurality of Logics within the NDIS
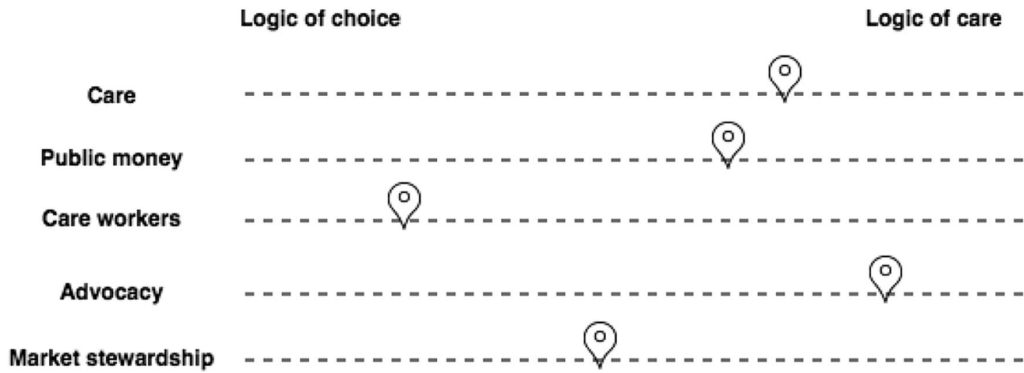
Currently, accountability for advocacy is illustrative of a logic-of-care approach, in which accountability for the funding of advocacy is carried by government and shared between service providers and people with disability. There remain certain ambiguities around the system for advocacy, due to the proposed review into the continued block funding of advocacy services (Department of Social Services 2016), and unclear guidelines for when an individual should move beyond NDIA planners and LACs and seek advocacy support from outside the NDIS system. Despite these ambiguities, the logic of care remains the underlying logic for advocacy in and around the NDIS due to the continued focus on shared accountability among advocacy organisations, government, service providers, and individuals.

Accountability for market function within the NDIS has shifted through implementation from a heavy logic of choice as set out in the original document, to one partially concerned with sharing the burden of the transition by identifying market gaps and attempts to find support for service providers to fill those gaps. Such a shift draws upon the logic-of-care approach. However, while this accountability dilemma represents a strong shift through implementation, this is not the case for all accountability dilemmas identified. While this plurality of logics has emerged, the concrete tools by which the government can manage market function (i.e. 'market levers') are still restrained to sharing information

about market gaps, price setting, and provider deregistration.

What is clear from this analysis is that neither of Mol's logics can be seen to fundamentally underpin the NDIS. Indeed, Mol (2008) acknowledges that in practice these logics will inevitably overlap to produce interesting results. Where this happens, 'the possible interferences are many . . . Only detailed empirical studies of different sites and situations are likely to give insights into the various kinds of interferences. I do not doubt that some of these will prove to be surprisingly creative, and better for living than the "pure" forms I have distilled' (p. 83). Our research has found that not only do these logics co-exist but that the boundaries between these move over time and through implementation. Indeed, it seems that from the process of the conceptualisation of this scheme and the move to making a reality of it there has been an associated shift in logics, ostensibly to safeguard individuals with disabilities and various agencies of government. We have illustrated the current positioning of these dilemmas on a continuum between choice and care in Figure 1. Arguably, the shift towards a logic of choice that the initial plans for the NDIS outlined would also require shifts in actor's frames of reference from the logics that have traditionally underpinned government provision of disability services (Carey and Crammond 2014; Esping-Anderson 1990).

In exploring the interaction of these logics, it is perhaps helpful to consider notions of hybridity. Within the public administration

Table 1. Theoretical hybrid types adapted from Skelcher and Smith (2015) and applied to the NDIS

Hybrid Type	Characteristics	Evident in the NDIS
Segmented	Functions oriented to different logics are compartmentalized within the organisation	Yes, evident in NDIS where plurality of logics are compartmentalised within the Scheme
Segregated	Functions oriented to different logics are compartmentalised into separate but associated organisations	Mildly evident within the NDIS; accountability for care workers also sits with industrial relations and is thus compartmentalised
Assimilated	The core logic adopts some of the practise and symbols of a new logic	No discernable core logic in the NDIS as it is being implemented, but a combination of logics of care and choice
Blended	Synergistic incorporation of elements of existing logics into new and contextually specific logic	No synergy of logics within the NDIS as problems and dilemmas continue to arise
Blocked	Organisational dysfunction arising from inability to resolve tensions between competing logics	No evidence that the NDIS is being blocked due to dysfunction between logics as the logics are existing in plurality

literature, hybridity has largely been used as a way of exploring structures of organisations and the resulting functions of hybridity (Borys and Jemison 1989; Grohs 2014). We have seen far less exploration of this concept in relation to cultural, social, or value sets. Skelcher and Smith (2015) provides one exception to this trend; employing the concept of institutional logics to gain greater clarity regarding hybridity. Hybridity emerges, they argue, from a plurality of rationalities at play within institutions or organisations. This approach connects organisational forms, normative frames of meaning, and individual agency. Skelcher and Smith (2015) classify hybrids into five types summarised in Table 1.

The result of the interplay between policymaker's existing frames of reference and the radically new market logics embedded in the NDIS design has formed a hybrid set of institutional arrangements around the NDIS. By this, we mean the NDIA tasked with implementing the NDIS and the Department of Social Services who oversee the Scheme are together taken as the 'institution of the NDIS'. Specifically, the type of hybridity that has emerged is that of segmented hybridity, whereby the logics for dealing with different accountability dilemmas are compartmentalised within the same institution (the NDIS). Though, we would like to note that accountability for care workers falls into normal industrial relations procedures outside of the scheme, and thus the NDIS is also a slightly segregated hybrid. Skelcher and Smith (2015: 441) claim that segmented and segregated hybridity is common 'where an organization has to manage the relationship between two logics'; in the case of the NDIS these are the new market logics of choice and the path-dependent tendency towards logics of care. Existing in a segmented or segregated state of hybridity is not entirely unusual, and while it may not be an optimal state for working, it may be required of some institutions that must cross boundaries of logic such as the NDIS. However, segmented institutions are in danger of shifting into Skelcher and Smith's category of 'blocked' hybridity whereby 'inherent tensions between logics cannot be resolved or managed, leading to organizational dysfunction' (2015). This should be avoided by managing the plurality of logics within an institution through paying attention to dilemmas as they arise, communicating and addressing problems and dilemmas, and being aware that the institution exists in a state of hybridity (Skelcher and Smith 2015).

As described above, hybridity due to a plurality of logics can be managed; however, this requires bringing attention to the dilemmas that arise when logics come into conflict. As much remains undecided regarding the NDIS, it will

be important to track over time how the plurality of logics matures into different types of hybridity in the institution of the NDIS.

Conclusion

In this paper, we have examined the logics of choice and care at play in the implementation of the NDIS along five different accountability dilemmas using Mol's dialectic (Mol 2008). Crucially, Mol (2008) argues that the logic of choice is contrary to the nature of care for people with complex needs. We do not go so far as to argue that choice is counter to good care, but we agree with Mol (2008) that care requires accountabilities to be shared and that better accountability results from clear and communal systems for resolving dilemmas. What emerges from our analysis is a picture of plurality of logics that are pushing the NDIS towards a hybrid scheme. It is not unusual for institutions and programs to function in a plurality of logics; however, dilemmas emerge when logics come into contestation. As implementation progresses, it will important to examine how logics of care and choice progress, change, and challenge one another and what this means for the functioning of the overall Scheme. Moreover, as Skelcher and Smith (2015) suggest, the NDIS provides an opportunity to examine the processes by which competing logics create hybridity in institutional structures and processes and what these means for how institutions serve the public interest.

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