Financial Accountability & Management, 25(4), November 2009, 0267-4424

ACCOUNTING FOR (A) PUBLIC GOOD: PUBLIC HEALTHCARE IN ENGLAND

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INTRODUCTION

Since the UK National Health Service (NHS) was founded in 1948, providing healthcare 'free at the point of use' accountants have been accounting for a public service (good) and the public interest (good) therein. Nevertheless NHS accounting has, in recent decades, moved to treating public healthcare on a similar basis to that used for private goods (goods subject to individual market transactions). The 'modernisation' of the public sector which introduced a more market approach is termed New Public Management (Hood, 1995) and the commercial accounting technologies that followed New Public Financial Management (Olson et al., 1998). But NPFM is not clearly identified and does not have a reasoned theoretical foundation. This paper attempts to review the developments in NHS accounting in recent decades with a view to identifying deficiencies and mismatches in accounting technologies and public service reform. The review is based around a series of research studies in the West Midlands. The NHS has repeatedly introduced market initiatives with interrelated accounting technologies. The NHS in England is currently establishing independent public benefit organisations (Foundation Trusts) to provide hospital services and engage with their local communities (Department of Health 2002a, 2002b and 2007). On achieving the new status, the accounting regime moves closer still to that of commercial companies (Monitor, 2009). There has been little research of the implications of the context for accounting technologies as opposed to the interaction of accounting and context (Broadbent and Guthrie, 2008). The context of a public benefit entity, providing a public service and engaged with its local community has implications for the accounting technologies. This overview of accounting technologies in the NHS seeks to identify these implications and add to the limited literature on technically contextual accounting.

Traditionally, the term public good is attributed in economics to a good that is non rivalled and non excludable (Samuelson, 1954).[1] Thus its consumption

*The author is from the University of Bristol. This paper, based on an inaugural lecture, benefited from helpful comments received at the European Accounting Conference 2009, a seminar at Southampton University and those of two anonymous referees.

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by one individual does not reduce availability of the good for consumption by others and no one can be effectively excluded from using the good, very few goods meet this definition.[2] Private goods, on the other hand can be 'parcelled out among different individuals' through market transactions. Hutton (2006) defined a public good or service as 'one that is available to the universe of the population and one that has to be provided equitably'. Broadbent and Guthrie (2008) adopt Hutton's definition in their analysis of 20 years of public service research rather than a definition of public good or service based on public funding, ownership or operation. The term is used here to cover public goods that meet Hutton's definition, often these 'public goods' could be delivered as private goods but they are usually delivered, funded or regulated by the government on the grounds of universal access and equity because of the public benefits they bestow. However, markets and competition are seen as fostering efficiency, hence modern public services are seen in terms of a 'Third Way'[3] combining social justice with economic efficiency. The classification of a good or service as a public good/service is not fixed from country to country, 'activities that comprise the public sector are bound by their context and things that are seen as public services in one nation may not be judged as such in others' (Broadbent and Guthrie, 2008).

The second aspect or meaning of the term public good used in the title is accounting for public interest. The traditional claims of the accounting profession are to protect the public interest (Neu and Graham, 2005). The accounting for private goods is underpinned by neoclassical microeconomic theory; accounting is seen as aiding social welfare maximisation through transparent, reliable information to investors. This is an aspect of accounting that is extremely topical at present with much debate as to whether accounting, with its increasing use of 'fair value', and focus on shareholder wealth and the requirements of the markets has encouraged the current financial crisis. The UK Sustainable Development Commission report argues that for people to truly flourish we need to think in terms of prosperity (wealth creation) measured in different terms (Jackson, 2009). Accounting for social, public goods is an obvious area where a different form of account could be considered more appropriate even without the current crisis in the commercial sector, accounting for public benefit would generally be considered to address a wider public interest necessitated both by the nature of the goods and the objective of reporting for public expenditure in a democratic society (Chan, 2003). When tax payer's money is put into commercial banks, the public are concerned as to what that money is used for not just whether a profit is made. The public is keen to see that funds do not disappear in pay-offs and bonuses; they want to see it used for the 'right' purposes such as stimulating loans again to businesses, resurrecting a prudent banking system with appropriate mortgage lending (Eaglesham et al., 2008). Within the NHS in England, a hospital pursuing financial aims to the detriment of patient welfare has led to public outcry (Lister, 2009). Thus public interest could be served by a different form of account, one that does not see wealth creation as the prime objective,

when accounting for public goods/services. Public funding brings different requirements:

> Parliament rightly expects that public funds, whether raised through taxation or public sector charges, will be used properly (HM Treasury 2007, p. 5).

The Treasury first published *Government Accounting* in 1915, its successor *Managing Public Money* is seen as a modern restatement. 'The duty to safeguard public funds is invariant. But how it is carried out will change over time' (ibid). Citizen engagement may replace direct parliamentary control (Department of Communities and Local Government, 2008; and NHS Confederation, 2008) in modern public services with consequent implications for the form of account.

The NHS accounting context has changed markedly over the last 30 years (see Table 1). The public sector was large, over 50% of the economy in 1978; services were directly provided and financial management was crude and simplistic. Thus there was (and still is?), scope to improve financial management; management accounting and financial reporting for public good. Improved resource allocation decisions could achieve a better mix of services, reduced inefficiencies could enable more to be provided; reporting could enable accountability and responsiveness to public concerns and so on. This is the context of NPFM. In the public sector the financing, management accounting and financial reporting are intertwined. As the financing environment changes from top down allocations and in house provision to service commissioning then service costing and pricing becomes inevitable. In the NHS where an unregulated market price is neither feasible nor desirable (Donaldson and Gerard, 2004), price is generally based on cost and cost depends on how items are recognised, measured and reported in annual financial statements. This paper therefore focuses on the two main (interrelated) branches of accounting: management accounting and financial reporting.

Table 1 provides an interpretation of differences in the context of accounting for private and public goods such as the NHS and the change or trend over recent decades. Accounting has been transformed throughout the NHS but perhaps not always taking due account of the nature of the health care service or the public interest. The environment remains political being integral with public policy but we have seen the separation of purchaser and provider roles with much less direct State provision. The purchaser role enables a range of providers (including the private and independent sector) and within the public sector transfer pricing regimes operate. Major capital investment in the last 10 years is often through Private Finance Initiatives or Public Private Partnerships. The objectives specified are much more vague and altruistic than we see in relation to commercial companies, but in recent years specific targets including financial targets have been set. Economic appraisal would include social costs and benefits but generally there has been a decline in strategic planning and much more (business) case by case approach in the planning of new investment such as hospitals. The output of public services is more difficult to identify (as

Table 1

The Context of Accounting for Private and Public Goods

	Private	*Public Goods e.g., NHS*	*Change/Trend*
ENVIRONMENT	Market	Political/Quasi-market	State as purchaser with less direct provision
FINANCE	Funds from: Owners /Equity (shares) Borrowing (loans)	Funds from: Central Government (taxation) Local sources Borrowing Private Finance Initiative	Plethora of providers: public sector, private and independent sector. Transfer pricing within the NHS
OBJECTIVES	Profit maximisation Shareholder value Survival	Vague and altruistic e.g., maintain and improve health and welfare of the community	Defined targets including financial
OUTPUT	Tangible & measurable - products sold - turnover	Intangible/ immeasurable - units of service - quality of provision	Identifying activities/ resource groups
ECONOMIC APPRAISAL	Private costs/benefits	Social costs and benefits included	Demise of national strategic planning and evaluation
PERFORMANCE MEASUREMENT	Profit yardstick ROCE Balanced Scorecard	Quasi ROCE[1] Value for Money (VFM) Targets/ Star ratings Balanced Scorecard	Mixing of commercial and public performance regimes. Credit ratings used by Foundation Trusts

Note:
[1]ROCE Return on Capital Employed is a primary business ratio that was first introduced into the NHS when self governing trusts were established in 1991 with the requirement to provide a 6% return on the current cost of assets. In 2008 NHS trusts are required to produce a current cost absorption rate of 3.5% and make quarterly dividend payments to the Department of Health.

they have not traditionally been subject to market transactions) and measure; performance measurement is complex and recently has focused on commercial techniques (those used for 'private goods') such as return on capital. Management accounting has employed costing and budgeting techniques associated with commercial (manufactured) goods. The financial accounting has been transformed and often gives the appearance of commercial company reporting. This context is in line with NPFM reforms identified by Guthrie et al. (1999).[4]

Although there are extremely few 'pure' public goods in the conventional economic sense of the term, many fall within the definition used by Hutton (2006) which characterises Broadbent and Guthrie's 'public services'. Healthcare is characterised by extensive government intervention in most developed countries (see Table 2), it is not left to the traditional market mechanism. The basic reasoning underlying extensive government intervention in healthcare is that

Table 2

Government Intervention in Healthcare[1]

	1990	*1995*	*2006*
Australia	67.1	66.7	67.0*
Austria	73.5	69.3	76.2
Canada	74.5	71.4	70.4
Czech Republic	97.4	90.9	87.9
Finland	80.9	75.6	76.0
France	76.6	76.3	79.7
Germany	76.2	80.5	76.9
Greece	53.7	52.0	61.6
Hungary	89.1	84.0	70.9
Iceland	86.6	83.9	82.0
Ireland	71.9	71.6	78.3
Italy	79.1	71.9	77.2
Japan	77.6	83.0	82.7*
Korea	38.5	35.3	55.1
Luxembourg	93.1	92.4	90.9
Mexico	40.4	42.1	44.2
New Zealand	82.4	77.2	77.8
Norway	82.8	84.2	83.6
Poland	91.7	72.9	69.9
Portugal	65.5	62.6	70.6
Spain	78.7	72.2	71.2
Sweden	89.9	86.6	81.7
Switzerland	52.4	53.8	60.3
United Kingdom	83.6	83.9	87.3
United States	39.7	45.3	45.8

Notes:
[1]% of total healthcare expenditure financed by government.
*2005 data as 2006 unavailable.
Source: OECD Health Data 2008 (Version June 2008).

none of the ideal assumptions of perfectly competitive markets work in the case of healthcare (Donaldson and Gerard, 2004). Market failure in the allocation of healthcare is so complete that extensive government intervention is more likely to result in the achievement of societal objectives than market forces supplemented by minimal government intervention. Most western governments provide healthcare largely from the public purse – the USA being the exception but even there 46% of healthcare (over 7% of GDP) is provided from public funds through schemes such as Medicare and Medicaid.

In the UK, private provision and charges made by the NHS account for less than 13% of health care expenditure (Table 2). The government has remained committed to public funding of health care but has instigated reforms to introduce competition and allow NHS Trusts greater autonomy (Department of Health, 2000; and HM Treasury, 2002 and 2004). Thus, whilst UK public healthcare remains a public good/service according to the definition used by Hutton (2006) and Broadbent and Guthrie (2008), it embodies many NPM and NPFM reforms. Though country specific, it provides an excellent context to investigate accounting technologies – a public service, fully funded from the public purse but with commissioners and a range of providers with implications for stakeholder engagement and reduced democratic accountability.

The next two sections review accounting developments in the NHS in England centred around a series of research studies in the West Midlands on cost-based pricing, GP fundholding and NHS trust financial reporting (Ellwood, 1996, 1997 and 2008).

MANAGEMENT ACCOUNTING FOR HEALTHCARE IN ENGLAND

Within the NHS, costing in the early years was crude merely dividing the total cost of the hospital by the number of patients and then looking at the cost across broad groups of hospitals[5] (Robson, 2007).

$$\text{Total hospital cost} / \text{Number of patients} = \text{cost per patient}$$

Even that simple calculation overstates its sophistication, total cost ignored any costs for equipment and buildings (no depreciation was included). The number of patients was derived from health service statistics 'Discharges & Deaths' with no distinction as to whether patients left hospital dead or alive – very important in performance assessment but still a missing distinction in health service costing. Professor Magee's pilot work in the 1970s started the examination of costs by specialty (orthopaedics, ophthalmology, gynaecology and so on) but it was not until 1987, following the Korner Report in 1984 (DHSS, 1984) that specialty costing became an obligatory requirement and then only in relation to 'direct patient care'.

Costing healthcare is not like costing goods in a manufacturing setting. In healthcare it is difficult to even define the cost object (the item to be costed). For

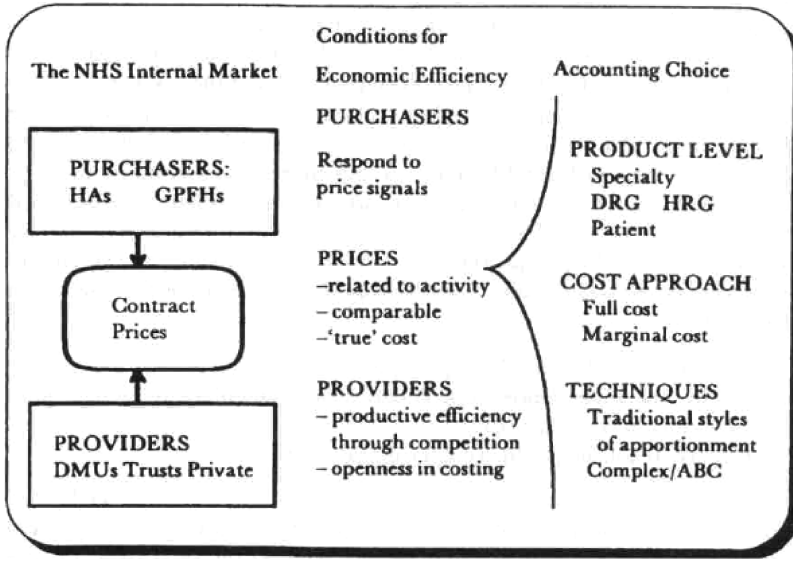
private goods there is an identifiable product that is sold, in public healthcare it is much less straight forward. In healthcare, a costing dilemma arises: to define a cost object that is more meaningful to clinicians gives rise to more subjectivity about the cost. Costs at the level of the hospital can be determined reasonably accurately; specialty costs also encompass a large level of direct costs (the consultants and their teams; single specialty wards), but as we move to more meaningful 'product' categories i.e. ones that have greater homogeneity and do not encompass wide variety, we have fewer and fewer direct costs – virtually every cost is a cost that has to be shared (necessitating detailed activity cost systems and the exercise of judgement as to how costs are attributed).

The introduction of the NHS internal market (splitting the previously top-down financing and management system into purchasers and providers) in 1991 required healthcare to be costed and priced (Department of Health, 1989). The relationship of accounting choices and economic efficiency is outlined in Figure 1.

Prices were to be based on cost including depreciation and a return on capital. A series of surveys of West Midlands hospitals and case studies in two hospitals concluded that it was difficult to achieve reliable comparative costs because of the nature of healthcare; inadequate activity measurement systems; and unavailability of costly computer systems that 'purchasers' were not prepared

Figure 1

The Internal Market



Source: Ellwood (1996).

to fund.[6] 'True' cost was elusive (Ellwood, 1996). Detailed costing remained a one-off year end exercise, but Healthcare Resource Groups (HRGs) became established as the cost units. Budgets and budgetary control remained the main focus of management accountants.

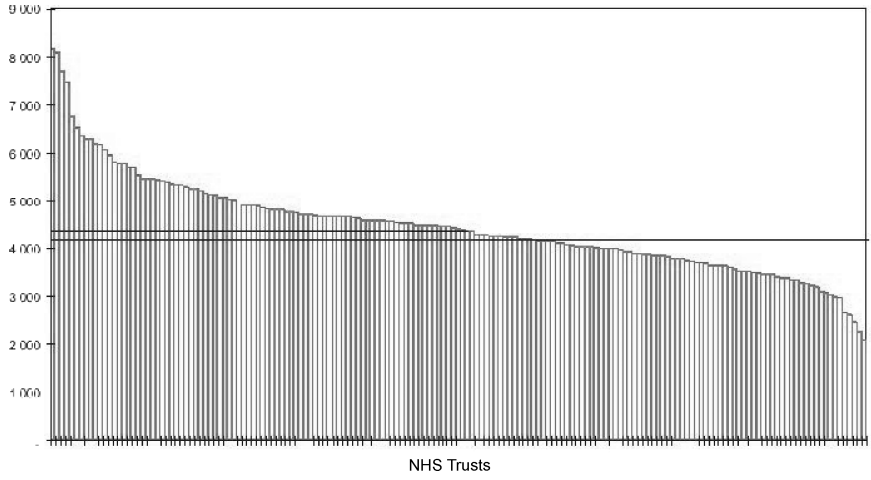
On the other hand, giving budgets to GPs (GP fundholding), did result in considerable savings but also led to a two tier service and limited control over the use of savings. Ellwood (1997) studied GP referral patterns in Hereford & Worcester; Staffordshire; Solihull and Sandwell (matching referrals with distance traveled; prices and waiting times.) The GPs were able to achieve savings in prescribing and improved services for their patients with very little change in referral patterns. They were extremely good at negotiating services for their patients through the threat of transferring patients but rarely did.

When the Labour government came to power in 1997 GP fundholding was scrapped and the rhetoric changed from the 'divisive' internal market to co-operation and partnership working. However, in England, from 2004 patient choice was trumpeted and funding moved towards a national tariff (Payment by Results). The national tariff is based on the average cost for the HRG (see Figure 2).

The claim was that a national tariff would reward 'efficiency' while allowing 'purchasers to concentrate on quality'. This has increased instability and led to extensive transfers/subsidies between low and high cost hospitals. The funding system bears little relation to cost structure or quality. Hospitals (of all levels

Figure 2

Elective Inpatient Cost NHS Trust-H02-Primary Hip Replacement



Source: Department of Health, PbR presentation 2004.

of cost efficiency) stand to gain significantly if activity increases but vulnerable if activity falls. Even high cost providers would gain if activity rises as the HRG tariff (on average cost) is likely to be higher than marginal cost, but if activity falls hospitals would lose much more than could be saved in the short run.

Foundation trusts (FTs) which received funds under the national tariff (without adjustments or transition arrangements applied to other NHS hospitals) have made huge surpluses. The consolidated accounts for the 89 FTs in England showed a surplus of £400m at 31 March, 2008 (after current cost depreciation and dividends). The cash balances were £1,893m with a further £374m held in investments (Monitor, 2008). There is no assurance that such surpluses are indicative of efficiency – the NHS 'market' is not a competitive market for goods. The money is largely from the taxpayer and voted to provide public healthcare according to need.

The Payments by Results system could more correctly be termed 'payment by activity' as there is still no distinction in the payment mechanism as to whether the patient is discharged dead or alive. The Darzi Report (2008) has unsurprisingly recommended quality measures be included in the payment system. The Department of Health is again supporting the introduction of patient level costing systems (similar to support for resource management systems in the internal market) practice based commissioning has been introduced to provide greater involvement of GPs in commissioning health services. There is a feeling of déjà vu - cost based pricing and GP fundholding with modifications. Employing some of the mechanisms used for private goods within the NHS. The use of accounting techniques originally developed by commercial companies for 'private goods' has become much more common in public services. The latest NHS costing standards (Department of Health, 2009) provide ten recommended standards to be applied in all Patient Level Information and Costing Systems[7] (PLICS). The NHS continues to apply accounting technologies associated with manufactured goods but it is often extremely difficult to apply them meaningfully because of the nature of public services such as acute healthcare. Yet the environment in which public services now operate often requires costs as a basis for pricing and benchmarking comparisons.

Just how far this 'private good' approach has permeated healthcare is shown in the following guidance from the Audit Commission to its in-house NHS auditors when verifying the current asset figure in the balance sheet:

> Auditors may wish to: . . . establish that the Trust has considered the need to account for partially completed patient spells.

The NHS may value part completed patients as a current asset on the balance sheet. The costing of inventories has provided a traditional link between cost accounting and financial reporting, but the introduction of cost-based pricing ensures a strong link between the branches of accounting. The next section examines changes in recent decades in the financial reporting of health service organisations responsible for delivering 'public goods.'

FINANCIAL REPORTING OF PUBLIC HEALTHCARE

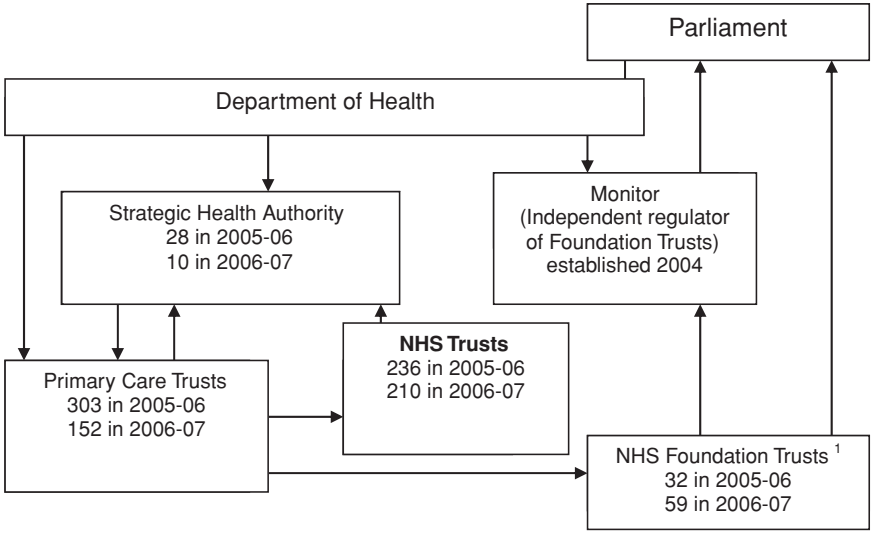
In the early decades of the NHS, external financial reporting was on a modified cash basis[8] i.e. recognising current assets and current liabilities. Fixed assets were excluded with health authorities merely recording how much was spent on capital items each year. The service costing discussed above included no measure of capital consumption prior to 1991. This omission led to inefficient use of capital stock (DHSS, 1983) which was termed a 'free good' and poor comparability of NHS costs (Mellett, 1990). The introduction of the NHS internal market led to major changes, notably the split of the top-down health service funding system into purchasers and providers.

In 1991, the newly established NHS trusts moved to full accruals with fixed assets and depreciation appearing for the first time on NHS balance sheets and the introduction of public dividend capital.

Each Trust has a statutory obligation to achieve break-even on its income and expenditure after payment of a dividend to the Department of Health, thus financial reporting plays a major part in performance assessment. Figure 3 illustrates the funding and accountability relationships in recent years.

Figure 3

The Structure of the National Health Service in England



Notes:
Arrows denote funding and accountability relationships.
[1]Foundation Trusts are new public benefit corporations introduced from April 2004. They are subject to a different financial, performance management and audit regime. There are 120 Foundation Trusts at 1 May, 2009.
Source: Adapted from NAO Achieving financial balance 2007.

The accounting regime adopted after 1991 claimed to follow UK GAAP designed for profit-making entities (Ellwood, 2003). However, an analysis of this claim in reporting entities in the UK health service, local government and a central government department concluded that the accounting regime designed for commercial entities must be modified for public service entities.

> The essential difference between the two sectors must be acknowledged. Public accountability is not well served by financial statements that focus on the interests of investors, and public sector assets frequently do not give rise to future cash inflows. On the other hand, fiscal control and compliance is important in the public sector, but is not in the commercial sector. Furthermore, the adoption of UK GAAP emphasises financial accounting and external reporting to the neglect of budgeting and cost analysis that have traditionally been important aspects of public sector accountability (Ellwood, 2003, p. 119).

More recently a case study of an individual hospital trust has illustrated some of the problems when GAAP is modified both by the Government and the account preparers (Ellwood, 2008). An analysis of the accounting statements of a NHS trust[9] showed every balance sheet item was modified to provide a significantly different figure from that which would have been produced under UK GAAP used by profit making bodies (see Table 3), but the initial impression of the balance sheet and the audit statement is compliance with UK GAAP.

The operating statement uses an uninformative company style layout and provides no insight into the healthcare provided by the Trust – no segmental analysis is provided as many trusts merely regard 'healthcare' as their main segment and provide no further segmental breakdown (Monitor, 2009). It appears that the objective of the trust is to generate a financial surplus (profit)

Table 3

Balance Sheet Distortions from 'GAAP' (Worcestershire Acute Hospitals NHS Trust)

Balance Sheet at 31 March, 2006	£*m*	*Distortion* £*m*
Fixed assets	162	−100 Worcester Royal Hospital (a hospital built under the PFI[1])
Current assets	40	+13 Deferred assets included
Creditors < one year	30	−29 Short term loan excluded
Creditors > one year	0	−100 PFI liability excluded
Provisions for liabilities and charges	3	−11 Clinical negligence claims excluded
Taxpayer's equity –Public Dividend Capital	169	+29 Short term loan included

Note:
[1]The Private Finance Initiative.
Source: Ellwood 2008.

rather than to account for how money is spent, but a distorted view of 'profit' is provided.

The disclosure notes provide information such as depreciation and audit fee but no indication of spending by health care activity. The appearance of adherence to GAAP is maintained without regard to the nature of the publicly funded service. However, it is only the appearance of accounting as a commercial undertaking: the trust pays a dividend despite making a loss (deficit) for the year and carrying a large cumulative deficit. A dividend is paid on the public dividend capital at a rate equivalent to 3.5% of the Trust's relevant assets. Such payments to 'owners' would not be permissible under Company Law.[10]

The apparent accounting for healthcare as if it is a private good creates obfuscation. There is confusion with regard to recognition, classification and measurement of assets and liabilities. There is a lack of a capital maintenance concept, both in the treatment of depreciation and the payment of dividends, and several issues relating to accounting boundary issues (e.g., provisions within the NHS; NHS brokerage.)

The NHS is claiming to report for public goods as if they were private goods based on real market transactions, but producing statements that are not understandable to the public and are misleading to accountants familiar with accepted commercial practice. Some (e.g., Audit Commission, 2006) argue that there should be greater adherence to GAAP. This would remove some anomalies such as the accounting for the PFI and asset revaluations but it could increase volatility (e.g., volatility through fair value measurements[11] and prior year adjustments under IFRS).

DISCUSSION

Accounting for Public Services (Goods)

Accounting for public services, as illustrated by the NHS in England, underwent (repeated) radical reform from the 1980s: use of product costing; devolved budgeting[12] and the introduction of accrual accounting based on that used in profit-making entities. Often the later reforms echo many attributes of earlier versions – as Mark Twain noted, 'history does not repeat itself but it rhymes'. The introduction of such accounting technologies is widespread in the UK, Europe, Scandinavia, the USA, Australia and New Zealand (Ellwood, 2002; Luder and Jones, 2003; Nasi, 1999; Barton, 2005; and Newberry, 2001).

These accounting developments or NPFM are seen as a corollary of NPM. They follow public choice theory and make governments more businesslike (Self, 1993). Adoption of commercial accounting practices (NPFM) is seen as a necessary part of this approach (Barton, 2005; and Olson et al., 1998). The benefits as summarised by Evans (1995) are: better measurement of costs and revenues including comparisons between years; greater focus on outputs

rather than inputs; more efficient and effective use of resources, e.g., through charges for fixed assets; full cost of providing a service can be compared with outside suppliers; a better indication of the sustainability of Government policy; improved accountability; better financial management; and greater comparability of management performance results. However, it is unlikely that accounting technologies can be supplanted from the commercial sector without modification or introduced unilaterally to achieve these benefits.

Accounting for public goods is concerned with accounting for a good or service, the nature of which requires universal access i.e., it provides important public benefit (it is not primarily provided for profit). The accounting should serve the equitable distribution of and the access to the public good or service (i.e., definable attributes of a public service). The accounting also plays a part in democratic accountability and, in modern public services, new public benefit entities such as NHS foundation trusts claim to engage with local stakeholders (communities). These issues relate to various aspects or forms of accounting. Public policy, finance, management accounting and financial reporting are interrelated. Cost-based pricing spans management accounting (product costing); finance mechanisms (quasi market transactions via separation of purchasers, PCTs, and provider hospital trusts and the Payment by Results system); and financial reporting (income received based on national tariff). The Private Finance Initiative while a capital investment funding mechanism is interrelated with financial reporting; performance measurement and budgetary control. A more macro or holistic approach to accounting technologies and the public policy domain is useful. The success of NPFM is indistinguishable from that of NPM which is itself difficult to interpret and has evolved over time (Lapsley, 2009).

The overview of health service development in England shows problems in the technical accounting when applied to a public service in the era of NPFM:

- Difficulties in identifying meaningful cost objects (health specialties; HRGs; patient)
- How to measure costs (shared costs, concept of value, accounting boundaries, asset recognition)
- Difficulties in relating cost to price (cost structure, location and financial volatility)
- Budgeting (incentives, equity and control of public expenditure)
- Performance measurement (dimensions of performance, financial e.g., break-even, VFM, public social benefits)
- Financial reporting objectives and concepts.

Often these issues transcend different accounting technologies. Financial reporting forms the basis for performance measures such as break-even, return on

capital; determines value to be included in costs and subsequently (indirectly) in transfer prices within the NHS. How services are financed has implications for access to services and equity. Further accounting research is necessary to identify how accounting can be improved to meet the nature of modern public services – transplanting individual commercial accounting technologies may not succeed because the environment and purpose it serves is different. For example, the Payment by Results system is intended to 'reward efficiency' but by having a pricing system based on full average cost it merely rewards additional activity – even high cost trusts gain (provided their *marginal* cost is lower than tariff), but an efficient low cost trust will experience financial difficulties if its activity is reduced. Currently a 'Market Forces Factor' is paid as a lump sum to reflect higher input costs according to geographical areas[13] but if work was done to investigate how a transfer pricing system could reflect cost structure and cost behaviour (with a fixed sum plus a tariff more reflective of marginal costs) the accounting may be better able to achieve its technical role. Thus accounting needs to be carefully designed *for* context.

Many studies consider the interrelationship of specific accounting technologies and context. Broadbent and Guthrie (2008) review twenty years of public services accounting research and identify hundreds of articles addressing specific accounting areas including 188 on management accounting/budgeting and 83 on external reporting. Following Burchell et al. (1980) authors use a variety of research approaches to study how accounting relates to social and organisational practice or culture. Similarly, van Helden (2005) when reviewing public services management accounting research 1999-2001 found:

> Researchers are primarily interested in the way in which technical accounting innovations are used, including the organizational and contextual factors that influence the use of these techniques (2005, p. 112).

Various lenses are used to explain the interaction; post modernist e.g., using Latour (Preston et al., 1992); institutional theory (Brignall and Modell, 2000); contingency theory (Luder and Jones, 2003). Different views of the power of accounting are adopted: Ellwood and Newberry (2007) see accounting as playing an important role in institutionalising neo liberal principles. Several academics question whether all the claims of commercial accounting are justified (Stanton and Stanton, 1998) and the motives (Christensen, 2003). Others highlight problems in application of NPFM (Ellwood, 1996; and Barton, 2003) and show how the accounting technologies are not serving intended purposes, have serious drawbacks or encourage manipulation (Ellwood, 2008; Ballentine et al., 2007; and Vinnari and Nasi, 2008).

However, there is 'a lack of shared understanding emanating from public services accounting research' (Broadbent and Guthrie, 2008) and 'there remains a need for more technical accounting research, albeit technically contextual accounting research' (2008, p. 150).

Accounting for Public Interest (Good) and Stakeholder Engagement

The basic question is the purpose of financial reporting for public services: are the needs of shareholders in the private sector and the stakeholders in the public services the same? Christiaens and Rommel (2008) argue for accrual accounting reforms only in businesslike (parts of) governments. They make three main arguments against the use of accrual accounting for the non business-like parts of government.

Firstly, they argue 'enterprises are established with the purpose of achieving economic results, and therefore they offer inputs to gain revenues' whereas generally government organisations obtain resources in order to provide services. They conclude that it would be controversial to evaluate a government in terms of its profit or loss as one could posit that the higher their profit, the lower their provided services since certain amounts of resources could still be transferred into services (Christiaens and Rommel, 2008, p. 68).

Secondly, Government revenues are resources to be spent leading to targeted outcomes such as safety, healthcare, education, justice and so on. While the adoption of commercial accrual accounting in government appears to result in a profit or loss the real outcomes are public, social services and therefore the relevance of a profit or loss is dubious.

Thirdly, public spending results from non exchange transactions – there is no direct causal link between certain received amounts (taxes, subsidies, donations and grants) and the service costs.

Christiaens and Rommel (2008, p. 61) therefore conclude, 'the accounting framework underlying accrual accounting is not in harmony with the governmental context because of differing accounting objectives and accounting systems' but that in Belgian hospitals 'medical services are individually provided per patient in an exchange transaction' and hence such organisations can be enterprises whose main activities are economic. In England after the phased introduction of the national tariff (Payment by Results) since 2005, the funding may be more closely linked to activity but few would argue that profit is the primary motive of publicly funded hospitals. Thus what is considered a public good or service is country-specific (Broadbent and Guthrie, 2008). Even within businesslike parts of government it is debatable whether a commercial accounting approach (i.e., GAAP designed for profit-orientated bodies) is suitable as within these bodies, wealth creation may still not be a primary focus. Barton (2003) entertainingly shows how the Australian Ministry of Defence appears to be Australia's most profitable business despite having no sales and obtaining all its funds from government. NHS Foundation Trusts show large surpluses and even larger cash balances[14] despite receiving the vast majority of their income from within the NHS (funded from central taxation).

According to Hutton's definition of a public good or service (as adopted by Broadbent and Guthrie, 2008), the public is concerned to see universal access and equity, these values would be placed higher than 'profit'. This context

would affect the appropriateness of accounting technologies – for example, an appropriate measurement for fixed asset value and consumption is likely to be replacement cost i.e., linked to continuity of service provision rather than historic cost or fair value. Context matters; accounting is not independent of its purpose.

The question then turns to what is the purpose of the accounting and the appropriate form of account for public services. Mack and Ryan (2006) undertook a large survey that shows that Australian governmental accounting based on general purpose financial reports (applying Australian GAAP) is frequently not meeting user-needs. In the US, the Governmental Accounting Standards Board (GASB) White Paper (2006) emphasises the lack of a wealth creation objective in bodies providing public services and cites several other crucial differences that generate user demand for unique information: the broader stakeholder perspective; the involuntary nature of taxes rather than a willing exchange of comparable value between two parties in a typical business transaction; the need to monitor actual compliance with budgeted public policy priorities; and the unlikelihood of bankruptcy and dissolution. This is not to claim that taxpayers are not concerned with the financial position of a public benefit entity such as a NHS trust, but that a commercial style balance sheet cannot denote taxpayer liability or the 'asset' that the government holds in the power to raise tax revenues. Furthermore, government or taxpayers do not have the benefit of limited liability.[15]

There has also been a call for simpler reporting and more transparent accounting. In the US, GASB has pushed a move towards 'Popular reporting' in local governments (GASB, 1992) and in Australia, the Queensland government, has mandated the inclusion of a Community Financial Report (CFR) in local authority annual reports that is in a form readily understood by the community (Stanley, Jennings and Mack, 2008).

An alternative approach to accrual accounting could be based on a more dynamic model (rather than a static model based on the balance sheet – particularly given the problems highlighted in the NHS trust balance sheet above). Dynamic models emphasise the operating statement. Vinnari and Nasi (2008) explain how the Finnish local government accounting system adopted in 1997 is strongly dynamic in nature:

> [T]he Finnish dynamic accrual accounting model lies in the categorizing and recording of transactions, i.e. the bookkeeping of revenues, expenditures and finance transactions, and in periodic income measurement. Transactions are measured and recorded at their historical costs and at the exchange prices of the transaction date. The matching principle is applied at the closing of the accounts…The Profit and Loss (P/L) Statement is the primary financial statement in dynamic accounting thinking, and the Balance Sheet has more or less only the role of transferring the balances of different assets and liabilities accounts to the next accounting period (Vinnari and Nasi, 2008, p. 100).

An accounting system that focuses on service provision (the operating statement) rather than the balance sheet may be more appropriate in serving public interest

(good). It could be argued that the partial accruals approach adopted for UK health authorities followed this approach prior to the 1982 reforms.

There has also been a call for a wider data set embracing the nature of the public good and the wider public interest. In the context of public hospitals in New Zealand, Van Peursem and Pratt (1998, p. 137) suggest that:

> Reports should be disclosing costs relative to non-financial accomplishments, removing the traditional 'revenue' reporting, providing consistent and comprehensive information on non-financial activities including the availability and quality of services, providing more extensive disaggregation to enable sensible comparison, disclosing budgetary information and valuing assets alternatively . . . . . We conclude from our analysis, therefore, that accountability in terms of the public interest has not been adequately achieved in these statements [based on private sector accounting standards].

Accrual accounting may be a more appropriate way of accounting for a public service than merely cash accounting, but there appears to have been little debate about the form it should take. What valuation system is appropriate? What is the function of the balance sheet? Under what circumstances can a public sector body be said to make a surplus or meet its break-even target? Debates over these matters of importance seem to have been largely overlooked in the haste to apply accrual accounting along the lines of those adopted for profit-making bodies (Barton, 2005; Newberry, 2001; and Simpkins, 2006). NPFM has developed without clear consideration of the differing contextual implications for financial reporting.

Difficulties are apparent in financial reporting for public services which reflect both the nature of the account and the level of engagement with the local community or stakeholders. Relevant information is related to service performance, commercial style financial performance (profit) is not meaningful without service performance (Christiaens and Rommel, 2008). Analysis of expenditure by service and comparison with budgets are likely information requirements but this would be supplemented with performance information. In England a performance framework for NHS trusts provides wide ranging accountability for services (performance against key targets and performance standards) but this is not integrated with the annual financial reporting regime through the Annual (Financial) Report though such integration is necessary for proper evaluation. As Christiaens and Rommel (2008) point out, financial performance is inadequate as a measure of performance in publicly funded bodies as a financial surplus may represent a foregone opportunity for service provision or services of unduly low quality. A further consideration is the information necessary to engage local communities, as Broadbent and Guthrie (2008) acknowledge, there is little in the literature to suggest that 'citizen shareholding' provides a valid argument for public involvement.

Commercial companies interact primarily with those segments of society that fulfil their mission of generating a return on investment for shareholders. Public goods/ services are provided in accordance with public policy goals. Capital

assets are generally held to deliver services without an intention to generate a return and they are characterised by an ownership interest that cannot be sold, transferred or redeemed. Therefore, to look at financial information without integrated, audited information on the provision of public goods has little meaning

Delivering public services in the UK is devolved to semi autonomous bodies including the foundation trusts as new public benefit corporations in the NHS in England. These entities are seen as a way of combining the social responsibility of the public sector with the entrepreneurial flexibilities of the private sector and providing the means to more effectively involve stakeholders such as citizens, service users and staff. Government policy is to 'devolve power from the centre' (Department of Health, 2000, p. 11, and the Local Government and Public Involvement in Health Act 2007). 'Shifting the Balance of Power' is described as 'the programme of change brought about to empower frontline staff and patients' (Department of Health, 2002a, p. 1). The guide for the introduction of foundation hospitals suggested 'Whitehall has too much power. Communities have too little power' (Department of Health, 2002b). However, there is a mismatch between espoused public policy (greater public involvement and empowerment) and current financial reporting of 'public goods'. If the intention is to engage public bodies with their communities as espoused (Communities and Local Government, 2008), then appropriate mechanisms and appropriate forms of account are needed.

This indicates a need for further research for accounting to achieve the purpose of public interest and community engagement. A consideration of stakeholder theory and how accounting could assist in stakeholder engagement (along the lines set out in Figure 4) may lead to accounting achieving the public service policy objective much better than the translation of commercial reporting into public benefit entities.

Engagement with stakeholders is likely to require the pursuit of alternative mechanisms for interaction such as regular meetings/ presentations to stakeholder groups (similar to the relationship some large companies have with institutional investors but the information needs will be quite different), involving stakeholders in setting performance targets and designing new performance indicators and providing interim reporting arrangements. Research on different ways of integrating and disseminating information in a timely and useful way together with work on where there are gaps in information requirements and how stakeholders can move further up the ladder of community/ stakeholder engagement is needed. The Government has set up elaborate structures for public involvement in public benefit corporations such as foundation trusts (members, governors and non-executive directors) but has so far assumed that the financial reporting should follow that for 'private goods'. To really engage and empower communities we will need to design accounting that is appropriate for public interest. This design will also need to consider how the various accounting technologies interrelate.

Figure 4

Management Approach and Stakeholder Engagement and Influence

Stakeholder Engagement	*Management Approach*	*Stakeholder Influence*
Power	12 Stakeholder control 11 Delegated power 10 Partnership	Forming or agreeing decisions
Involvement	9 Collaboration 8 Involvement 7 Negotiation	Having influence on decisions
Tokenism	6 Consultation 5 Placation 4 Explaining	Being heard before a decision
Non participation	3 Informing 2Therapy 1 Manipulation	Knowledge about decisions

Source: Adapted from Friedman and Miles (2006) and Arnstein (1969).

CONCLUSION

A modern public good or service is defined as one that is available universally and has to be provided equitably. Efficiency is often fostered through market style arrangements, and social democracy, through public engagement. Accounting for (a) public good/service is classified into two perspectives: accounting for the nature of the public service/good i.e., the social benefits (not economic profit) requiring universal availability or access and equitable distribution; and the public interest (good) that serves accountability and citizen engagement. NPFM collectively refers to the accounting technologies or techniques employed to achieve public service reform. An examination of the main accounting technologies used in the NHS in England in recent decades shows problems when transplanting individual technologies, designed for private goods traded in unregulated markets, to assist public service reforms. It is suggested that accounting technologies interrelate much more in public services.[16] It is difficult to disentangle the accounting technologies from the public service reform, but an overview of the accounting shows difficulties relating the techniques designed for private goods effectively in the context of public services, similar (accounting) reforms return or persist with slight modification. It is suggested that further research on accounting technologies including interrelated accounting technologies such as transfer pricing and analysis of cost structure and behaviour could possibly aid public service reform. The reporting for public (good) interest and stakeholder engagement seems to be particularly out of alignment with public service reforms, there is a mismatch between the current reporting model based on shareholder wealth creation and the interests of local

communities. Financial reporting appears wrongly focused and misleading, but financial reporting forms a basis for resource and performance measurement and provides the public account. There are many potential approaches to achieving improved accountability which are worthy of investigation, although community engagement is espoused and elaborate structures set up, an appropriate form of account and mechanisms of engagement seem to have received little consideration and are ripe areas for further research.

NOTES

1 Samuelson defined a public good as one 'which all enjoy in common in the sense that each individual's consumption of such a good leads to no subtraction from any other individual's consumption of that good'.
2 Economists have found virtually no pure public goods. Lighthouses were used as an early example but Coase (1974) was able to show that even lighthouses were traditionally associated with provision in the private sector.
3 Giddens (2000) outlined the Third Way as a programme for modernising centre-left politics and is closely associated with Tony Blair's New Labour reforms in the UK.
4 Guthrie et al. (1999) noted a 'seemingly endless' list of accounting techniques and identified five categories of NPFM reforms: changes to financial reporting systems; commercial style market orientated management systems and structures; development of performance measurement; devolvement/ delegation of budgets; and audit (including value for money and citizens' charters).
5 Broad categories were: large acute, mainly acute, partly acute. Cost statements were also produced for various functions such as laundry, catering, boiler houses.
6 Heavy investment in four Management Budgeting sites in 1983 led by two firms of management consultants to develop patient product cost information based on manufacturing standard cost systems had proved expensive failures.
7 An overall quality score is determined for the costing system and rated gold, silver or bronze according to the level of financial resources of individual cost buckets and a quality score for the allocation methodology.
8 Mild accrual accounting according to Chan (2006). He categorises degrees of accrual accounting from mild accrual to strong accrual. Strong accrual includes current and long term liabilities. An earlier paper also identified radical accrual which in addition includes the present value of future revenues and social policy commitments.
9 The case, Worcestershire Acute Hospital NHS Trust (WAHT), provides public healthcare from three main locations: a new, privately-financed hospital in Worcester, the Worcestershire Royal Hospital, a traditional district general hospital in Redditch and a Treatment Centre in Kidderminster (developed from a traditional hospital in 2004 to provide largely elective care on a day or short stay basis).
10 The Companies Act 2006 provides general rules on dividend distributions which are to be made only out of profits available for the purpose.
11 The 2008 financial turmoil shows the instability in mark-to-market accounting, for public goods there is frequently only a hypothetical or thin market.
12 Management budgeting, resource management, GP fundholding, practice-based commissioning.
13 This work is a black box, not transparent to Trust accountants.
14 University Hospitals Birmingham Foundation Trust had income of £424m for the year (all but £30m from within the NHS), showed a surplus for the year of over £20m and held cash balances at 31 March, 2008 of over £71m.
15 Events in 2008 in the banking sector indicate this unlimited liability for taxpayers may also relate to commercial organisations but it is long established in relation to public goods and services.
16 For example, the lack of real competition or contestable markets requires price regulation related to cost, which depends on value used for financial reporting, which in turn plays a part in determining financial surpluses that are reported and used in performance measurement.

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