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A Comparative Insight into the Public Sector Accountability Project: Healthcare in South Wales and New South Wales

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Abstract

This paper provides a comparative review of the manner in which accountability objectives are acquitted for the same public sector function delivered in two different jurisdictions: health services financial reporting for the regional governments of Wales in the United Kingdom and New South Wales in Australia. Archival research methods are used to identify and analyse similarities and differences at the whole of government and service delivery levels. Even though the nature of the health services is very similar and organisational similarities dominate, reporting differences are of enough significance to support the conclusion that NPM reforms have been implemented in different ways with different impacts on accountability considerations. Thus, national differences do matter in the analysis of those reforms.
Comparative Accounting for Health: South Wales and New South Wales

Mark Christensen and Howard Mellett

1. **Introduction**

Judging from the enormous accounting literature that cites New Public Management (NPM), the academic research community is of the belief that some phenomena constitute an observable collection of reforms that justify the NPM label. Frequently, Hood’s (1991; 1995) work is cited and some specifics are delimited within two cardinal elements: a (reduced) degree of distinctiveness from the private sector and the extent of rules operating to maintain buffers against political and managerial discretion. Within these elements a number of more specific elements have been identified by Hood (1995, p 96) including explicit: formal measurable standards and measures of performance and success. In order to better appreciate NPM processes and their impacts on accountability issues, this paper examines the manner in which the results of public sector health care facilities are reported in regions of two different countries, South Wales in the UK and New South Wales (NSW) in Australia. Both of these countries have, in the last three decades, moved the provision of public services in line with the ideas of NPM and, as a feature within this general movement, have adopted the principles associated with New Public Financial Management (NPFM). As well as the pursuit of NPM, the two countries also have political structures with common features relating to health care in devolved responsibilities and so have been required to deal with associated reporting tasks which can be categorized as accountability acquittals.

In both countries the introduction of NPM as it exists today can be traced to developments that gathered pace in the 1970’s. As a result, large areas of commonality can be identified between them but, at the same time, it is shown that the outcomes, in terms of accountability through annual reports, are not identical. These dissimilarities are identified and explanation sought in the context of organisational differences. Broadly, the questions being investigated are why two similar countries with largely the same drivers arrive at different forms of report and to what extent are differences in the mode of providing public health care reflected in the annual reports, including the financial elements.

The research method is archival and uses three steps to address the research questions based on publicly available data from two locations (South Wales in Wales and the North Coast in NSW). First, the organizational structures and contextual circumstances of the two locations are outlined. Second, the contents of the accounting reports produced by the entities within each organization are described. Third, differences between the form and content of the reports are identified and potential explanations for the differences sought in the contexts of each jurisdiction; similarly, areas of commonality are also covered. Consideration is also given to the purposes for which the reports are prepared.

In the UK the reporting process, including the use of accruals based accounts, grew through the adoption of a managerial approach to delivering public services with, in the case of healthcare, the introduction in the early 1990’s of a quasi-market with a clear divide between the purchaser and provider. The rationale was for the National Health Service to mimic the private sector use of the market to allocate scarce
resources and drive efficiency while at the same time providing care free at the point of delivery. The Assembly Government provides NHS care through Local Health Boards and Hospital Trusts and, although the purchaser-provider division has been maintained, the system used in Wales is under review with the suggestion being to abolish the internal market and broadly replace it with central planning.

The general position in Australia is similar with universal health care being provided through Medicare but the quasi-market approach was not adopted. Instead there has emerged a dual – and confused – allocation of budget-driven responsibilities such that the Federal Government funds primary and aged care whilst the State Governments – such as NSW – fund and operate public hospitals. The NSW Department of Health (DoH) introduced an area management model in 1986 and by 1993 this had developed to give Area Health Services responsibility for delivering hospital services within centrally determined budgets. This structure continues but has been subject to a number of reorganisations aimed at establishing catchments that are small enough to capture the needs of their inhabitants but large enough to be able to deliver a comprehensive service. However, significant pressures are emerging where Area Health Services allow programs to reach the point of full expenditure and resultant decisions to curtail services produce volatile controversies. Associated with this is jurisdictional competition over health delivery between the Federal and State governments with cost-shifting practices that are not consistent with rhetoric of optimized health service provision.

The annual reports of both jurisdictions are prepared in compliance with NPFM principles and so use accrual accounting. In Wales, summarised reports are prepared that show separately the aggregate results for Local Health Boards and NHS Trusts; the accounts for individual Boards and Trusts are also available. New South Wales operates a similar system. The New South Wales Department of Health produces a report covering all the activity it funds and the North Coast Area Health Service (NCAHS) reports on a similar basis; in both cases there are separate reports for the parent organisation and the consolidated results.

At a general level the reports have contents in common. Stated accounting policies are similar and there is a statement of inflows and outflows of resources, a balance sheet and a cash flow statement. However, there are differences when a more detailed comparison is carried out. Some differences are technical (such as different reporting periods) whilst others are more significant. At the care delivery level, the annual report of a Welsh Trust closely mimics that of a private sector company. It starts with a narrative commentary on the activity undertaken during the year and describes any significant developments. The accounts are summarised but there is a note that a full set is available on request. The NCAHS provides a full set of accounts that includes budgeted amounts alongside the actual results. At the central level the consolidated Welsh accounts do not provide a narrative while those of the NSW DoH include a commentary as well as financial statements with budget information.

The paper contains a detailed comparison of the reports’ contents and finds differences in terms of funding sources that affect the resource flows document. It also appears that in Wales a private sector report presentation approach is reflected at the local trust level while in NSW it is used for the central DoH. Correspondingly, the appearance of the all Wales reports is more consistent with traditional governmental accounting, as is also the case with the NCAHS reports. This reflects the degree of autonomy that is intended to be enjoyed by the various entities and the constitutive
nature of public sector financial reporting. In Wales the trusts are described as self-governing with a separate board of directors while in NSW the central body has more influence at the local level. Such differences may be more apparent than real as politicians at the centre are keen to have structures that enable their strategy, as set out at election time, to be translated into action.

The research concludes that the call to set NPM in the context of the locality where it is operated is important. Annual reports produced in two similar countries with similar NPM drivers reveal different power balances and solutions to funding health care delivery. Only a relatively small area of activity is covered but it still reveals alternative approaches to the common requirement on states to deliver health care and hence shows how the NPM project is not uniform in its mode of application and outcomes. National differences remain and significant variables in explaining these differences are political context, budgetary system and the pervasive culture surrounding accounting systems at an organisational level. Further, it is shown that these variables influence the accountability outcome which in turn needs to be considered as a socially constituted result rather than a technically determined metric arising from stated reporting requirements.

The paper’s structure is as follows: next (Section 2) provides a review of the relevant literature and after that the methods and data sources used are briefly described. Section 4 is presented in two parts: each part exposes one of the two comparative cases. Section 5 discusses the similarities and differences found in the comparison and then reaches conclusions regarding the comparisons.

2. Literature

In 1992 Broadbent and Guthrie reviewed the state of public sector accounting research as reflected in material published in journals, highlighting the international nature of the developments taking place which lead to the call for studies based on international comparisons. This call took place against the background of reforms in the delivery of public services generally termed ‘new public management’ (NPM) or, more specifically, ‘new public financial management’ (NPFM). As described by Olsen, et al, the changes in the management and control of public sector activity included two important features, there is an international dimension and an adoption of a ‘seemingly endless list of accounting-based techniques’ (1998, p. 18). Within these techniques, Broadbent (1999, p. 55) notes her sense that ‘there is more work that is now concerned with the financial reporting aspects of public sector accounting’, this aspect being consistent with the ideas of accountability that accompany NPFM. A subsequent study (Broadbent and Guthrie, 2008) analysed 452 papers from eight journals and found that 182 related to the UK and 117 to Australasia, 83 dealt with external reporting and 46 were comparative studies. Thus, the geographical locations of this paper’s interest are relatively well researched but the specific topic, comparative external reporting, has not been subjected to extensive investigation.

The value of comparative studies is enhanced if it is possible, a priori, to set out likely differences and similarities; their presence or absence then add to the richness of the comparison. A large amount of work was carried out in the private sector context that investigated the existence and identity of clusters of countries exhibiting similar approaches to accounting. This was particularly concerned with the moves towards international harmonisation when countries were starting from significantly different positions that had evolved in relative isolation over a long period of time. A review of
this literature indicates that there are a number of alternative approaches to classification and these produce different outcomes (d'Arcy, 2001) to the extent that different clusters result depending on the attributes selected (p. 328).

Some studies start with the view that accounting is a social phenomenon and so differences between societal types could be expected to produce different approaches to accounting (Fechner and Kilgore, 1994) while similar societies will produce similar rules. Others suggest that accounting is the product of its environment and its manifestation at any time is the result of evolutionary pressures that allow those aspects most fit for purpose to flourish while those not so suited perish (Watts and Zimmerman, 1986). An alternative is to consider technical issues such as how accounting standards are set and what particular accounting and reporting practices are used; it is possible that these, by looking at outcomes, are reflecting underlying environmental aspects (Puxty, et al, 1987). The institutionalization of supranational accounting standards can also be viewed as a profoundly political activity, reflecting the relative power of organized interests and actors (Dillard et al., 2004).

One common grouping that was found, not unexpectedly when looking at accounting practices, was 'British Commonwealth' which, if correct, would link the UK and Australian practice (for example, Frank, 1979; Nair and Frank, 1980; Douppnick, 1987) while d’Arcy’s (2001) more recent study based on financial accounting rules and practices critiques previous research and finds that ‘the Australian system seems to have an outsider position’ (p.336) and that ‘the British system belongs to the European cluster’ (p. 342). However, d’Arcy’s (2001) findings have been questioned (Nobes, 2004; d’Arcy, 2004) and the conclusion drawn is that there is no single approach to classification that would allow the extent to which the UK and Australian systems are similar to be identified. This conclusion is consistent with the work of Guthrie, et al (1999, p. 213) that reported the results of a comparative study of eleven countries and found that they 'reveal that the type and degree of [NPFM] activity varies significantly from country to country' but that this variety has not been given sufficient recognition.

Turning to the public sector, there have been a number of studies that deal with individual countries. Apostolou, et al (1992) reviewed developments in the US; they identified the GASB as the main driver and the underlying concepts as being related to accountability and interperiod equity (p. 1124). Part of their conclusion was that 'changes will result in governmental financial statements more closely resembling business financial statements' (p.1144). Wallace (2004, p.10) noted that in Australia there is a belief that 'standards for governments should be as similar as possible to those of private sector companies' but that the difficulties likely to be met when international harmonization is attempted can be exemplified by the different approaches identified within one country, the US, when considering different levels of government. The use of accruals accounting is not the only matter for consideration, the Chair of GASB recognized that the public sector should report Service Efforts and Accomplishments but that it is not possible to prescribe the format in which this should be done and he considered its publication should remain voluntary (Attmore, 2007) whilst evidence is emerging that Service Efforts and Accomplishments reporting has not succeeded in its limited implementation in NSW (Christensen, 2008). Similarly, the need to consider more than simply the financial accounting statements was supported by a call for multi-dimensional reporting was made by Williams and Amatnie (2008).
The drive for the international harmonization of accounting practices in the public sector is not underpinned by the needs of an international capital market as is the case with the private sector. Harmonization will result as a matter of course where public sector accounting is based on that used in the private sector; as the latter harmonizes so the former must follow. Comparability might be one feature that is considered desirable and this has particular relevance in the European Union where comparable transparency is associated with awarding and monitoring grants; measuring compliance with the Treaty of Maastricht is also important. Common accounting may also be anticipated where countries pursue similar approaches to the adoption of NPM. Benito, et al (2007) examine the extent of harmonization by measuring compliance with International Public Sector Accounting Standards and both Australia and the UK are placed in the group of countries with greatest conformity. In both central and local government Australia is given a higher compliance rating than the UK, but this may be due to the fact that UK public sector standards are only now moving to International Standards; previously they used UK national ones. Identifying such a grouping confirms Pina and Torres (2003) which viewed this as an outcome of the use of NPM.

Parker and Guthrie (1993) examine the accounting and accountability consequences of the move in Australia from 'an ethos of public sector administration to one of public sector management' (p. 63). They note that 'many of the issues ... are common across public sectors in the Western economies' and go on to call for an 'accountability framework ... based on a recognition of the uniqueness of the characteristics of public sector organizations' (p. 75). A particular feature of the Australian position is that it has adopted a 'sector neutral' approach to accounting standards; that is, the ones used in the private sector are applied in the public sector although not without controversy (Newberry, 2001, 2002). In contrast, it has been argued that in the UK 'more attention is paid to the needs of public sector users' (Ryan, et al, 2007, p. 474) and that this is possible because private sector standards are adapted where necessary to suit public sector requirements. As a result, it may be anticipated that some differences will emerge when comparing accounting reports from the two countries.

Potential differences in approach can be seen when looking at attempts to produce a conceptual framework to cover accounting for public sector activity. In the UK the ASB produced a Statement of Principles for private sector accounting and subsequently issued an interpretation of this for public benefit entities (ASB, 2007). The emphasis was placed on economic decision usefulness with particular reference to funders and financial supporters as the defining class of user' (p. 9); by meeting their needs, it was assumed that all other information needs would also be met. A similar exercise was undertaken by IPSASB which produced a discussion paper proposing a Conceptual Framework for General Purpose Financial Reporting by Public Sector Entities (IPSASB, 2008). This takes a more general approach to the users of reports and their needs while noting that individual countries have taken different approaches (p. 18). These alternative approaches highlight potential problems when attempting to apply accounting concepts and standards in the public sector that have been developed in the private sector context. Additional tension has been created by the private sector move towards meeting economic decision usefulness and downplaying accountability and stewardship aspects in its conceptual framework. Such concerns were noted by a monitoring group that raised the significant issues, relative to the private sector, of adequacy of the emphasis on
accountability/stewardship; a need to identify a broader group of users, including primary user, and an overemphasis on cash flows (Monitoring Group\(^1\), 2008, p. 4). The absence of a universal consensus on the fundamental issue of the objectives of reporting suggest that differences between countries are to be expected.

With the abovementioned literature in mind, we turn to the more copious literature on accountability in a public sector context. That literature is larger than can be meaningfully reviewed here but an increasingly strong theme therein is worthy of note here: that accountability is a subject so mired in ambiguity as to be a chameleon (Sinclair, 1995) and constituted more of power relations and social structures than metrics of disclosure, measurement and reporting (Ebrahim, 2009). It is those power relations and social structures that can act in ways to interfere with the conventional wisdom of ‘more disclosure equals more accountability’. For example, Strathern (2000a) notes that increases in transparency can best be considered within their anthropological context where to make some things visible is a deliberate – perhaps strategic – decision to make other things less visible such that readers of accountability reports may well need to ask ‘what does this visibility conceal?’ In part this is recognizes the point made by Garfinkel (1967) over 30 years ago that most accountability regimes will be an alignment of organizational rhetoric and practice with wider considerations outside the organization giving the account.

Increasingly, a theme within the accountability literature is that a useful theoretical frame with which to understand accountability issues is provided by the work of Foucault (1991) – especially his concept of ‘government’ as a state of acceptance of those being governed “in recognition that the state’s effectiveness is measured by its capacity to influence the behaviours of individuals” (McKinlay and Pezet, 2010, p. 487). Scholars who have used Foucauldian concepts with respect to accountability often invoke the Panoptican effect of surveillance (Foucault, 1977): an individual’s knowledge that they are being observed will influence self-reporting on their behaviour. Thus the visibility of accountability reports (Opfer, 2001) will lead to organizational impacts (Strathern, 2000b) and will influence managerial control systems (Cowton and Dopson, 2002). Related to this is an ambivalence found in the phenomenon that transparency can be associated with a form of self-censorship that “potentially robs accountability of much of its communicative value” (Roberts, 2009, p. 963). Thus this limited review of the accountability literature highlights that studies of accountability need be prepared for perverse outcomes where visibility, transparency and accountability reporting may not acquit expectations of the reporting process\(^2\).

3. **Methodology and data sources**

The research method applied in this paper is one of a desk study. The study’s primary data sources were reports of the organisations under study in particular the mandated annual reports. In analysing those reports and making comparisons between them across the two countries, recourse has also been made to secondary data sources such

\(^1\) This group consisted of the Chairs and Senior Staff of the Accounting Standards Boards of Australia, Canada, New Zealand and the UK

\(^2\) A pertinent instance of one of the many possible variables leading to this conclusion is provided by Ezzamel et al (2004) in their study of devolution in the United Kingdom. Of relevance to the Welsh component of our study here, Ezzamel et al note that politicians in devolved states can feel overwhelmed by accountability-based information. This is a good illustration of Strathern’s point that increased visibility may not equate to increased accountability.
as press documents, associated management commentaries and other official publications such as websites that are not mandated by annual reporting legislation or regulation. Given the growing controversy over performance in the health services field, another source of data was various enquiries commissioned by different levels of government in both the United Kingdom and Australia. Some of those enquiries facilitate our contextualised understanding of the pressures under which the reporting agencies currently find themselves.

4. The comparative cases

This section outlines the background against which health care is delivered in the two research sites and goes on to consider the routine accounting that takes place.

4.1.1 The NSW and the North Coast Area Health Services

NSW constitutes a significant part of the Australian national economy with 6.8 million residents making up almost a third of Australia’s population. Of the six Australian States, NSW has Australia’s dominant economy, valued at $320 billion in 2005-06 or about 33% of Australia’s GDP. This is one third larger than that of the next State, and the NSW capital, Sydney, alone accounts for almost one quarter of Australia’s GDP. The NSW economy is larger than each of the national economies of Hong Kong SAR, Thailand, Malaysia, Singapore, the Philippines and New Zealand.

Whilst the Australian Constitution establishes that health care provision is a responsibility of State Governments, in recent decades the Commonwealth Government has become active in providing funding and some provision of health care. Thus whilst State Governments administer hospitals and health departments, they depend to a large extent on Commonwealth Government financial support in doing so. Making this more complex is the fact that the Commonwealth Government funds and operates the Medicare system by which citizens have subsidized access to doctors for primary health care. A further significant aspect of the context of health reporting is that as the State health systems have come under strain of expanding demand and limited funding, so it has become a contested area between the State and Commonwealth levels of government. As a consequence, the Commonwealth Government has threatened to take control of health provision3 and heated political controversies have emerged in every State. These controversies have been pronounced in NSW where it has become common for the mainstream press to lead with front page headlines such as: “Casualties of a sick system: deaths blamed on emergency cost cutting” (10 January 2009); and, “Crippled system left for dead: hospitals are leaving a trail of unpaid bills (31 January 2009).” Thus in the context of heightened political sensitivity surrounding health as a function of the NSW Government, it is apposite to examine the attestation regarding its performance at both a State and regional level.

At a whole-of-State level, the Department of Health (DoH) is the lead agency for achieving five of the NSWG’s priorities in its State Plan:

- Improved access to health care
- Improved survival rates and quality of life for people with chronic illness

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3 Whilst the Commonwealth Government has indicated an intention to assume control of health care, contingent upon performance, it is unclear as to whether such a change could be constitutionally acceptable.
• Improved health through reduced obesity smoking, illicit drug use and risk drinking
• Improved outcomes in mental health
• Reduced avoidable hospital admissions.

In order to contribute to those priorities the DoH delivers health care and controls health policy through a network of eight Area Health Services, five Statutory Authorities and 21 affiliated health organisations; see figure 1. The majority of the DoH’s budget is expended by the eight Area Health Services and this paper will examine in some depth one of those Services: the North Coast Area Health Service. In its reporting the DoH provides extensive detail on non-financial and financial performance. Annually it provides a comprehensive report of about 300 pages. That report complies with the Annual Reports Act in format but appears to provide information beyond the bare minimum required by that Act. The 2006/07 report consisted of 84 pages of financial reports, 20 pages of funding and expenditure details, and a predominantly non-financial performance report of 50 pages in addition to 132 pages of descriptive material covering matters such as governance, service delivery, statistics, services and facilities, glossary of terms and a compliance index.

Insert Figure 1 about here

The DoH Annual Report provides data and interpretation for 33 performance indicators of which four are of a financial nature. The four financial indicators provide data on: the net cost of services (an accrual measure of the Department’s difference between total expenses and retained revenues); general creditors aged in excess of 45 days; variance against budget for major and minor capital works; and, the weighted average differences of actual funding from formula funding. Those four indicators are grouped as being representative of performance relevant to the strategic direction titled “make better choices about the costs and benefits of health services”. The remaining 29 indicators relate to the DoH’s other strategic directions as noted in the State Health Plan, viz:

• Make prevention everyone’s business (health promotion and illness prevention)
• Create better experiences for people using health services
• Strengthen primary health and continuing care in the community (access)
• Build regional and other partnerships for health (integration)
• Build a sustainable health workforce (human resource management)
• Be ready for new risks and opportunities (adaptation)

The layman style of language used to explain the strategic directions is reflected in the annual report’s performance indicators but the financial reports provide a contrast in that it has a technical appearance. The financial reports comply with Australian Accounting Standards (including the Australian Equivalents to International Financial Reporting Standards) and the Public Finance and Audit Act. As such they are constituted by the usual Operating Statement, Statement of Recognised Income and Expense, Balance Sheet, Cash Flow Statement and Notes. However, these reports are prefaced by six pages in which data on budgeted allocations and expenditure against budget feature prominently. Thus an emphasis on spending seems to have been considered relevant by the report preparers. Additionally, the financial reports are
preceded by the Independent Audit Report (whereas many private sector annual reports will provide the Audit Report after the financial statements) and so it may be argued that the DOH is concerned to reinforce an accountability and control perspective.

The DoH Annual Report can be seen as an umbrella which shelters the reports of the various Area Health Services responsible for direct health care delivery to the citizens of NSW. It is to those reports we now turn by considering the 2006-07 North Coast Area Health Service (NCAHS) Annual Report. The report is available on the NCAHS website and is presented in two documents: the Annual Report (100 pages) and the Financial Statements (41 unnumbered pages). Although presented as two separate pages on the website, it is apparent that this is one Report that like the DoH Annual Report complies with the relevant legislation. Additionally, the first webpage ends at the Auditor-General Office Statutory Audit Report and leaves the financial reports to the interested reader in a separate webpage.

The NCAHS Annual Report consists of eight sections:

1. Profile, purpose and goals
2. Performance summary
3. Health services
4. Health support services
5. Our people
6. Our community
7. Freedom of Information
8. Financial report

Most of the NCAHS report is non-quantitative information but the performance summary shows data and interpretation for 43 performance indicators, many of which are comparable in nature to the indicators in the DoH report. Of the NCAHS indicators, only three are of a financial nature but the report nevertheless reflects a concern with financial performance. That concern is shown in the ten pages headed "Financial Report" immediately preceding the financial statements. Those pages commence with seven dot points explaining a 0.4% above-budget expenditure variance. They also include identification of all programs with reduced expenditures as well as those programs where expenditure increased by more than 10%. Thus within the financial data, there is an emphasis on spending and allocations. Additionally, as observed in the DoH Report, the presentation of the audit certificate ahead of the financial statements (and in a separate location on the website) seems to indicate an emphasis on accountability which exceeds the actual contents of the accounting reports.

In summary of the DoH and NCAHS Reports:

- Both reports present voluminous comprehensive performance indicator data and qualitative information that appear to be responses to the active controversies surrounding the political and social context of health care in NSW;
• The accounting statements are presented in compliance with relevant accounting standards that reflect a common conceptual framework and a private sector appearance

• Whilst the accounting statements are prepared on an accrual basis, they provide little discussion or analysis of the accrual nature of the statements (including the status of assets and liabilities)\(^4\)

• A strong sense of accountability is conveyed in both reports.

4.1.2 South Wales and All Wales

Wales constitutes a relatively minor proportion of the UK national economy. Its population is 2.98 million, which is 4.9% of the UK total, and its economic output, measured as gross value added, is £44.3 billion, which is 3.6% of the total. It can therefore be seen that, in terms of economic activity per head of the population, Wales lags behind the UK average.

Responsibility for delivering healthcare to its population has resided with the Welsh Assembly Government since 1999 when practical recognition was given to the fact that the UK comprises four countries, England, Northern Ireland, Scotland and Wales.\(^5\) Prior to 1999 Wales was run as a department of the central government but now the Assembly, elected by Welsh voters, has responsibility for a diverse set of programmes, such as, education and training, the environment, health and health services, highways, housing and industry. Central government retains responsibility for national matters, for example, defence and foreign policy.

The Welsh Assembly is funded by a central government grant; it has no tax raising powers and cannot raise loans. The amount it receives to deliver the functions for which it is responsible is based on the Barnett formula which, in general terms, divides the total UK spend on these areas, set by Central Government, according to relative population size. Once it receives its block grant, the Assembly has to divide the total between its various responsibilities. Evidence suggests that differences are now emerging as spending patterns diverge: between 1999/00 and 2004/05, spending on health has grown by 65% in England - from £818 per head to £1,350 per head; 57% in Scotland - from £997 per head to £1,563 per head; 57% in Northern Ireland - from £940 per head to £1,476 per head; and 55% in Wales - from £917 per head to £1,421 per head (Adams and Schmueker, 2005). These changes also reflect different priorities pursued by the separate jurisdictions, for example, Wales abolished prescription charges for drugs while England has retained charges and Scotland and Northern Ireland are moving towards their removal; this pattern is also now reflected in the number of items dispensed per person which ranges from 15.1 in England to 19.9 in Wales (CIPFA, 2008, p. 30). Although Wales is developing its own health strategy, it remains subject to pressures that arise as UK national issues and, given the

\(^4\) As an example, the NCAHS Report notes a remarkable turnaround of a deficit of $3.45 million in workers compensation to a surplus of $2.09 million in a 4 year period without explaining the basis of such a large change.

\(^5\) English health matters continue, somewhat anomalously, to be decided by the UK Government in Westminster, Scotland has a Parliament and, like Wales, an Assembly governs the health aspects of Northern Ireland.
relatively small size of the other three countries, English matters tend to dominate the agenda.

The overall strategy being pursued in Wales is contained in a policy document entitled *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century* (WAG, 2005). The vision it sets out aims to:

- improve health and reduce, and where possible eliminate, inequalities in health
- support the role of citizens in promoting their health, individually and collectively
- develop the role of local communities in creating and sustaining health
- promote independence, service user involvement and clinical and professional leadership
- re-cast the role of all elements of health and social care so that the citizen will be seen and treated by high quality staff at home or locally - or passed quickly to excellent specialist care, where this is needed
- provide quality assured clinical treatment and care appropriate to need, and based on evidence
- strengthen accountability, developing a more corporate approach in NHS Wales so that organisations work together rather than separately
- ensure full public health engagement at both local and national levels.

Its intention remains to achieve these through a series of strategic frameworks, each covering three years. Although the above aims include reference to ‘accountability’, there is no indication of which stakeholders it is intended to address. There are six further references to accountability in the document but all of these are internally orientated rather than considering external reporting, although the public is mentioned in the context of improving information (p. 15).

Local Health Boards (LHB) and Health Commission Wales provide the link between the Assembly Government and the trusts; the structure is outlined in Figure 2. There are currently 22 LHBs and their boundaries are ec-terminus with those of the Local Authorities. They commission hospital treatments provided by NHS trusts and other independent healthcare providers. In 2007 – 2008 the anticipated health revenue allocation is £5.1bn together with capital investment of £316m which together account for approximately 38% of the Assembly’s Total Managed Expenditure.

Insert Figure 2 about here

Local Health Boards are free to acquire health services from any appropriate source and are not limited to facilities in a particular geographical area. Taking the Cardiff LHB as an example, it receives about 7.8% (£398 million) of Assembly expenditure on health and it spends £239.47 million of this with NHS Trusts of which £225.93 million (94%) goes to the local Cardiff and Vale Trust. The LHB prepares an annual report that includes a set of summarised accounts. The bulk of the report is narrative and has sections that report on the extent of achievement of its stated vision and

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6 For example, the web page NHS Choices appears to relate to the UK as a whole, but any direct references are only to English aspects.

7 The Health Service in Wales was reorganised in 2009. The split between purchasers and providers was abolished and a reduced number of Local Health Boards took over both planning and delivery of services for their resident populations. No annual reports or accounts have yet (July 2010) been published for the new structure.
values. Thus, for example, there are 2 or three pages each on such aspects as
Improving Health, Engaging the Public and Developing Partnerships. The
Remuneration and Finance Report covers 16 sides but contains a limited set of
financial statements showing how it performed against its resource limit together with
a cash flow statement, an operating cost statement and a balance sheet. The LHB in
fact incurs relatively few costs on its own behalf, these being only the running costs,
and owns few assets as it performs as an agent by providing a conduit to pass money
to healthcare providers.

The bulk of healthcare is provided by NHS Trusts; these are separate entities that
mimic private sector companies, but a policy difference emerges when compared with
England where Foundation Trusts have been established that have greater autonomy.
Welsh trusts have an appointed board of directors comprising executive and non-
executive directors and their meetings are open to the public, apart from restricted
areas of the agenda. They produce an annual report, containing a set of summarised
accounts, and also hold an Annual General Meeting although attendance by the public
is generally poor (Hodges, et al, 2004). Accounting plays an important role in their
control as they have to remain solvent, break even in terms of income and expenditure
and pay a ‘dividend’ calculated as 3.5% of net assets shown in the balance sheet
assets, including fixed assets at an approximation of their current value. While the
dividend uses the same term as that used in the private sector, this charge is non-
optional and has more in common with an interest charge.

Cardiff and Vale NHS Trust is the exemplar site for this aspect of the paper; it is one
of the largest Trusts in the UK, with 14,000 staff and an annual income of nearly £640
million; £239 million of this comes from the Cardiff LHB. The services it provides
encompass community care in patients’ own homes, clinics and health centres, and
outpatient, inpatient and emergency care in hospitals together with mental health
services and specialist dental care. In total, it manages nine hospitals and sixteen
health centres and clinics and its annual report and accounts provides details of these
activities and a summary of the underlying finances.

At a superficial level the annual report bears considerable similarity to those of the
private sector; this is consistent with the original aims of setting up trusts in the early
1990’s as they were intended to be largely autonomous entities competing through
price to provide health care in a quasi-market (Department of Health, 1989). For the
year ended 31 March 2008 it contains 62 pages divided into sections:

- Chair and Chief Executive’s message
- About Cardiff and Vale NHS Trust
- Our Trust Board
- Operating and financial review
  - Championing safe health care
  - Providing effective care
  - Providing efficient care
  - Delivering care with compassion
  - Celebrating success
  - Our plans and future
  - Operating and financial review supplementary information
- Reports
  - Statement of internal control
  - Clinical Governance report
• Summary annual accounts
  o Summary financial performance and tables
  o External Auditor’s report
  o Cardiff and Vale NHS Trust Annual Report 2007-2008

The balance of the report can be seen in the pages devoted to each aspect. Seven pages give an overview of the trust, thirty four cover the Operating and Financial Review, ten contain reports on such aspects as internal control and governance and finally eleven provide a summary set of accounts, including performance tables that show the extent of achievement of payment and management cost targets and the remuneration of directors. There are positive statements that the trust met its required financial obligations and had a clean audit report.

5. **Comparison and discussion**

Comparisons tend to lean towards identifying similarities and differences between the matters being compared. That natural inclination is followed here and Table 1 summarises these dimensions.

<table>
<thead>
<tr>
<th>Similarities:</th>
</tr>
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<tbody>
<tr>
<td>Both sets of accounting reports comply with NPFM principles</td>
</tr>
<tr>
<td>Accounting policies and their descriptions are similar</td>
</tr>
<tr>
<td>Emphasis on accountability is comparable</td>
</tr>
<tr>
<td>Importance is given to non-financial matters</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Differences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NSW and the all-Wales reports preserve their public sector nature whereas the Welsh Trust reports mimic company reports</td>
</tr>
<tr>
<td>The Welsh reports provide a summary of the financial statements whereas the NSW reports provide both a summary and the full statements</td>
</tr>
<tr>
<td>The NSW commentaries on financial data emphasise budget and expenditure matters (such as explanations of minor over-expenditures, comparison of budget to actual expenditure, aging of creditors)</td>
</tr>
<tr>
<td>Whilst the NSW reports are comprehensive, they create opportunities for readers to avoid the complexity of their financial statements (for example, providing a summary of the financials and the Auditor Statement in a document with the management discussion but without the full audited statements).</td>
</tr>
<tr>
<td>The NSW reports have greater emphasis and content on performance indicator data than do the Welsh reports.</td>
</tr>
</tbody>
</table>

Table 1: Summary of key similarities and differences between NSW and Wales health reporting
The similarities demonstrate strong compliance with NPFM precepts and efforts on the part of both jurisdictions to satisfy external demands placed on them to account for their use of resources. This is not a surprising finding in that both Australia and the UK have been reasonably early adopters of NPM reforms and thus reforms such as accrual accounting have been implemented widely. A further similarity is that the health services delivery function has been one in which significant public and political interest in both jurisdictions has impacted on the reporting by agencies with responsibilities in that field. However, in this respect differences seem to emerge in the comparison. For example, the NSW response to significantly increased controversy surrounding its health services field has been to underplay the financial side of its affairs whilst dwelling on non-financial performance measures and discussions. Within its external financial reporting there is a concentration on budgetary compliance rather than using financial data to analyse performance in detail (for example, cost per service). Such a response can be best understood applying a Foucauldian frame that highlights how the panoptic effect of accountability reporting has impacted on the decisions of the NCAHS and the DoH in their reporting choices. That is, as external pressures on the DoH have risen and been transferred to its Area Health Services, so the reporting outcomes have added emphasis on non-financial matters and a reduced emphasis on financial statements.

The reporting approach in Wales derives from the Thatcher reforms of the 1990’s and can be seen as being a response to an emerging financial crisis in the NHS. At the time the UK was spending less than 6% of GDP on the NHS while trying to accommodate advances in medical care in general and, in the South East of England, the consequences of moving to a broadly population based method of funding distribution instead of the previous incremental historical one which shifted resources to the regions. Press coverage was also unfavourable with a continuing drip feed of critical stories, often dealing with an individual patient’s problems, that fed the idea that something must be done. After reviewing the options a small team proposed the introduction of a quasi-market in which money would follow the patient and the payment would come from funds held either by the patient’s general practitioner or a Local Health Board. Implicit in the revised funding arrangements was that efficient trusts would attract more patients, with the associated greater income, and so would flourish.

Research has shown that little use is made by the public of the annual reports of public sector bodies. It could be that their presence itself fulfils an accountability role and so they serve a useful purpose in a ritualistic way. The general use of information, as well as accountability, is to monitor and control expenditure in accordance with the strategic plan. The organisation in South Wales appears to be more fragmented than in New South Wales with fewer links between centrally determined strategy and the material in the reports. This is consistent with the idea of trusts being self-governing entities that are driven by the demands of the local population, as expressed through the LHBs, rather than being under central control.

8 In some years in the 1980’s this fell as low as 5.1%
9 A full account of the process by which the policy developed can be found in Edwards and Fall (2005)
6. Conclusion

The findings are consistent with the proposition that the UK and Australia can be located in the same group in the context of their approach to public sector accounting. They both use accruals accounting and include financial accounts and narrative in their annual reports. On the other hand, sufficient differences have been found to support the contention that comparative international studies should be sensitive to the likelihood that local differences will emerge. This is of significance when carrying out international comparisons but the benefits of any increase in imposed uniformity should be weighed against the need to be able to fit with local culture.

Another finding from the comparisons made here is that attempts to impose uniformity in reporting are likely to fail because of unique factors implicit in the public sector dilemma of accountability. As noted by Strathern (2000a, 2000b) and Tsoukas (1997), the accountability project flounders on some paradoxes such as ‘more information, less understanding’ and ‘more information, less trust’. Equally, it is suggested here that more uniformity, especially if imposed across national borders, would not be appropriate means to address the dynamics of power and knowledge that underpin the accountability outcomes of public sector services.

The existence of international differences is not surprising when the users of General Purpose Financial Reports (GPFR) are considered. These are given as (IPSASB, 2008, p. 18):

- taxpayers, ratepayers, and similar “involuntary” resource providers;
- citizens and other recipients of services from government;
- the legislature and oversight bodies;
- elected or appointed officials and their staff;
- donors, including international organizations, and other voluntary providers of resources;
- national accountants and government statisticians;
- present and potential institutional and individual lenders, including purchasers of government bonds and other debt instruments;
- “fee-for-service” consumers of services;
- suppliers and employees;
- the media; and
- representatives of, or advisors to, these user groups.

It can be seen that an international dimension is lacking. There is mention of international organizations and lenders may not necessarily be based in the reporting country but there is no global dimension as is found with large corporate enterprise. Also, in the case of healthcare, the funders do not have a direct say in the running of the organisations; control is exercised by elected politicians and so the ultimate funders, the taxpayers, can exercise only indirect influence. The absence of multinational considerations raises the question of why it is desirable to have harmonisation of accounting policies in the public sector. Local accounting practices reflect local influences and structures; full harmonisation would require the adoption of similar delivery mechanisms; uniform reporting may not be possible where, for example, one country provides integrated care directly at local level funded through local taxes while another fragments care delivery and funds some of it locally and some nationally.
While accounting in the private sector develops in the context of capitalism and the 'two most prominent, vitally interested actors in the quest for such institutionalization are the IASB and the US FASB' (Rodrigues and Craig, 2007, p. 754), the public sector agenda is driven by IPSASB as part of the NPM agenda. However, the NPM project cannot draw on the fundamental objective of resource allocation through profit measurement and reporting and so seeks legitimation through attempting to offer the organisations affected a way forward that they perceive to be the best or most appropriate. To be successful, this must be absorbed into the belief system. The state and professions as the main actors may be able to impose isomorphism but there can be variability in the extent to which this belief system is accepted locally so that a decoupling can occur (Mellett et al, 2007). The outcome at the national level will be determined by the relative power of the organizational actors 'who support, oppose, or otherwise strive to influence it' (DiMaggio, 1988, p. 13).

This comparison has shown that, although global commonality can be found in the adoption of NPM at a general level, differences emerge when it comes to the detail of implementation. Accounting information and the other material contained in the annual report are contingent on the path that brought the individual organisation to its present form. To understand in detail why a common international trend using similar principles has not brought common accounting outputs requires an appreciation of the drivers, including possibly the individuals involved (Jones and Mellett, 2007). It is clear that 'one size fits all' does not apply as, from within similar frameworks, different outcomes have emerged. This initial study indicates avenues for further research to uncover richer explanations for its findings and also suggests that there may remain local differences despite moves towards international harmonisation, such as the use of international accounting standards.
Figure 1: The Structure of Health Service Delivery in New South Wales.

NSW GOVERNMENT  
(as a funding source, facility owner and constitutionally responsible jurisdiction)  

NSW MINISTER FOR HEALTH  

2 MINISTERS ASSISTING THE MINISTER FOR HEALTH  

DIRECTOR-GENERAL OF HEALTH AND HEALTH ADMINISTRATION CORPORATION  

8 AREA HEALTH SERVICES  

HEALTH DELIVERY FACILITIES (MOSTLY PUBLIC HOSPITALS)  

FEDERAL GOVERNMENT  
(as a funding source)

5 STATUTORY HEALTH CORPORATIONS
Figure 2: The Structure of the NHS in Wales

WELSH ASSEMBLY GOVERNMENT
(funding source)

MINISTER FOR HEALTH AND SOCIAL SERVICES

DIRECTOR OF NHS WALES

3 REGIONAL OFFICES

22 LOCAL HEALTH BOARDS

HEALTH COMMISSION WALES (SPECIALIST SERVICES)

14 NHS TRUSTS
(facility owner)

CENTRAL GOVERNMENT
(as funding source)
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