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The Invisible Costs of Accounting for Disability Care: A Case Study of Krg

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ABSTRACT

In this research, we delve into the distribution of accounting systems and their impact on the management of social services within various organizations. This inquiry has been carried out with the help of a case study based on a community care provider in KRG, referencing literature on constrained management and accounting visibility. An increasing level of government scrutiny and regulation of social care services has been observed. However, this heightened oversight often leads to an additional load on caretakers and families who are involved in providing these services. These findings give way to a critical discussion about how the current accounting procedures account for only the apparent costs typically associated with government-funded programs. A noteworthy point of concern is that these accounting practices often overlook a substantial portion of costs related to disability care, which the family and other caregivers shoulder. These unexpected or 'invisible' costs form a significant part of the overall expenses incurred in healthcare. When ignored, these hidden costs can undermine the real cost of care, thereby distorting resource allocation and decision-making in healthcare. In summary, while existing accounting systems in social services are useful for managing tangible, directly government-funded expenses, they often fall short in recognizing the significant indirect costs borne by families and other caregivers. Consequently, there is an urgent call for accounting procedures that provide a more holistic view of the costs associated with social and disability care services.

Keywords: *Key words: Healthcare management; Invisible Costs; Social Services ; Management accounting; Disability Care.*

1. Introduction

Over the past thirty years, disability care reform globally has undergone a transition from government institution-based care to a community-focused support structure (Llewellyn, 1998; Beatson, 2004; Prince, 2009; Craven et al., 2018). The United Nations Convention on the Rights of Persons with Disabilities backs this shift in the disability sector (United Nations News Centre, 2006). This transformation is exemplified by the relocation of individuals with disabilities from institutional residences to community-based living to include them in mainstream society (Roulstone, 2000; Campbell & Oliver, 2013). This change lets them access services within their local environment and assists them to live independently within their family and community (Sullivan & Munford, 1998; Gauld, 2009). The reform changed the architecture of social service delivery by adopting a pluralistic approach in which the services are organized through a combination of government resources and community-based support structures (Kurunmaki et al., 2003).

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Within the disability services sector, de-institutionalization and an increased emphasis on community care have shaped the boundaries around services. The implementation of boundaries retained certain activities provided by institutional care while introducing other services provided by family members and the volunteer sector. This boundary management strategy was evident where, previously, most services were provided by government institutions (Llewellyn, 1998; Craven et al., 2018). These structural changes influence accounting information on boundary settings. Accounting data helps to decide how and when specific services should be delivered (Llewellyn, 1998; Grafton et al., 2011). However, empirical data is insufficient to understand how this redefinition of boundaries impacts the organization's accounting system design. This research aims to fill the existing void in previous studies. It examines how accounting systems are disseminated as organizations across boundaries seek to use this information to monitor and manage disability care services in KRG. As such, this paper seeks to answer the research question: How does accounting information facilitate monitoring and managing services delivered to disabled individuals by various providers across organizational boundaries?

The study leverages empirical data from a government-supported disability care service in New Zealand, but can be contextualized for an KRG-based analysis. It accentuates the relationship between boundary management and accounting, showing how changes in organizational boundaries can shift disability support duties from public healthcare settings to personal and community domains. We identified that the internal accounting system currently fails to encompass the complete cost of disability support services. It only documents costs related to public healthcare facilities, dismisses any veiled or indirect costs borne by family members or other care providers. This signifies that when particular services are not financed and backed by governmental entities, the total cost from the service recipient's viewpoint goes unnoticed. Instead, accounting measurements focus exclusively on the costs of those services provided by the institution. The study also sheds light on the interconnectedness of the 'cost object' concept and the redefinition of institutional boundaries. Broadening the 'cost object' viewpoint to center on the individual with a disability, instead of isolated service events, can incorporate all crucial community-level facilities. This includes services provided by households and families to support individuals with disabilities. A key finding of this study underscores the limitations of traditional accounting systems which are bounded by institutional limits. It advocates for addressing these deficiencies by increasing the scope of accounting's role in managing disability support services proficiently and effectively. As a tangible contribution, the research underscores accounting's role as a facilitator in negotiating and coordinating multiple disability support services providers.

The study has broader implications, offering insights into the disability sector, making it worthy of recognition. The rest of the paper summarizes the research design and methodology, presents the results, and discusses these findings. The paper highlights the study's contributions and identifies potential areas for further research.

KRG health sector reforms

A country's health care funding system is pivotal in reaching its healthcare aims. This analysis looks at the existing health care funding system within the Kurdistan Region of Iraq (KRI) to devise strategies for reform. Five critical aspects make up a robust health financing system: eligibility, service coverage, payers, fund pooling, and payment methods. In KRI, all residents are legible for basic health care services in the public sector, as outlined in the KRI's draft constitution. However, a definitive set of covered services, also known as the benefits package, has yet to be established. The Kurdistan Regional Government (KRG) primarily finances public sector health services through a 17% allocation from the Iraqi budget. Conversely, individuals pay for private sector care in cash. Risk is distributed through the fund pooling within the KRG budget, supporting providers such as hospitals and primary health care centers (PHCs) and for staff remuneration.

Ideally, purchasing services should incentivize the procurement of appropriate quality and quantity; however, the KRI system currently lacks such incentives. No correlation exists between pay and performance, and the system fails to reward facilities and physicians providing greater care in the public sector—furthermore, the private sector accounts for an estimated 20% to 30% of healthcare spending. A significant amount of this care is provided by physicians who, despite receiving salaries in the public sector, spend considerable time in private clinics where pay is higher. This practice is commonly referred to as dual practice (DP). A comprehensive reform of the health financing system in KRI is required to achieve health objectives. This includes defining the benefit package, introducing performance-based incentives, and regulating the dual practice phenomenon. By focusing on these crucial facets of health financing, KRI can bolster the efficiency and effectiveness of its healthcare system. For the Kurdistan Regional Government (KRG) to implement health financing reforms, it must navigate several challenges. Current resources, particularly in the public system, are insufficient to adequately meet current health care demand—an issue likely to escalate with population growth and increasing incomes. The KRG's proposed Constitution asserts healthcare as a basic public right, with a commitment to provide a fundamental care level to all KRI residents, predominantly at minimal out-of-pocket cost. However, the population's expectation of free care from the public sector is unsustainable long-term.

Sound management decisions, setting financing policies, and managing a modern financing system requires data currently unavailable in the KRI. The Ministry of Health (MOH) presently lacks the necessary capacities, personnel, and funding to implement or oversee the projected health care financing reforms. Another issue lies in the public sector's nominal patient co-payments, which are inadequate for fund-raising or incentivizing appropriate use. Burdened with renovation necessities and modernization needs due to Saddam-era neglect, hospitals have limited staffing control and budget flexibility. Adding to the problem, many hospital administrators are respected doctors with little or no management training. The lack of performance-based incentives in the health financing system doesn't motivate work, performance, or productivity. This is notable among doctors whose salaries don't reflect the quantity or quality of service they provide in the public sector. Simultaneously, the private sector is expanding rapidly, lacking regulatory guidance or a strategic investment process.

Nevertheless, KRG is positioned favorably to make crucial decisions about the future of its healthcare system. The country boasts significant human and mineral resources to back its aspirations. The absence of an established system presents an opportunity to develop and implement a strategic healthcare vision enhancing the availability of high quality care in a cost-effective manner.

2. Literature review and theoretical reflections

Established in response to a British government mandate post-World War I, the Iraqi public health system surfaced in the early 1920s. It progressed significantly once the Ministry of Health (MOH) was formally organized in 1952. By the 1970s, the Iraqi health system had transformed into one of the Middle East's most advanced health systems. However, in the past four decades, escalating challenges have significantly impeded Iraq's capacity to cater for its population's public health needs. The Iran-Iraq War (1980-1988), the First (1990-1991) and Second (2003-2011) Gulf Wars, and the ongoing ISIS crisis since 2014 have significantly degraded healthcare quality and overall security. In spite of these wars' high death tolls, Iraq's population continues to burgeon due to low modern contraceptive use and an average total fertility rate of 4.1 children per woman. This rapid population growth has strained the Iraqi health system, making it difficult to meet basic health needs with the available health resources. Additional complexity has been incurred due to the geopolitical changes. Following the establishment of Iraqi Kurdistan as an autonomous region in the early 1990s, a separate MOH was introduced, thereby increasing the complexities with two independent health systems.

Role of accounting in Disability Care

Accounting as a field has traditionally centered around boundary management and has primarily honed performance measurement from an organizational perspective. It has made significant strides in enhancing capital and performance measurement. Yet, its application in domains beyond the organizational, such as individual and family levels, is often overlooked (Morgan & Willmott, 1993; Ezzamel, 2002). In his exploration of accounting in the 19th century British family context, Walker (1998) highlighted the presence of accounting in daily life, often centred around domestic operations. This indicates that accounting has a multifaceted role beyond the organizational boundary. Similar findings echoed in Boden's (1999) examination of accounting practices among the self-employed, with accounting influenced by institutional and legal requirements (Covaleski et al., 1993; Rana et al., 2019).

Particularly in disability care, such as in the context of KRG, accounting also plays a vital role in boundary management. Concepts, particularly 'cost objects', enhance this management (Llewellyn, 1998). A 'cost object' refers to an element that is being evaluated cost-wise separately (Langfield-Smith et al., 2018). From the perspective of disability care, cost objects can be as varied as home care, education, training, or even government-funded activities such as Disability Support Services (DSS). The changes in cost objects significantly influence the collection and processing of accounting information. Cost objects could be specific instances or the entire treatment journey, which can encompass hospital and home care. In this way, refining cost accumulation and determination procedures can enhance the accuracy of healthcare costs.

Care pathways are strategic tools that assist in effectively managing the costs of healthcare while also focusing on individual patient needs (De Luc, 2001). They allow for apportioning direct and indirect costs, forming a comprehensive basis for detailed business cases about treating and monitoring patient care. In addition, care pathways support assessment of care delivery variance among different clients, contributing to performance analysis. Different customized service packages can be used to achieve different healthcare outcomes under the care pathways umbrella (Paulus et al., 2002). This method recognizes that various care path combinations might necessitate diverse care activities. In terms of costing for diverse care pathways for decision-making, the Activity Based Costing (ABC) system is potentially useful (Paulus et al., 2002). ABC provides detailed costing information but requires a detailed process understanding of health-related group activities (Ahmad et al., 2002; De Luc & Whittle, 2002). Although, it is challenging to capture various activities obsessively in a predetermined manner with this approach (Ellwood, 1996). Care pathways also require significant planning at the service design level. Healthcare services need to be effectively grouped for planning purposes to facilitate achieving service-related goals. Care pathway costs can be obtained directly or distributed using ABC, which further enables cost determination at the individual activity level. From a strategic point of view, care pathways can assist in planning, delivering quality care, and enhancing medical information (Ahmed et al., 2002). Integrating different care types, including nursing, general care, and medical needs, can achieve service quality and financial goals.

The concept of a 'cost object' plays a decisive role in defining core and peripheral services while devising separate care packages. When 'cost object' is defined within the confines of an organizational boundary, it aids in determining the packages for government financing. This idea is particularly relevant for government-led community care, rendering it essential to include an encompassing package of support services tailored to the unique residential, social, and medical needs of those with disabilities. In the context of the Kurdistan Region Government (KRG), as it addresses Disability Care, the 'cost object' implication becomes pivotal. This not only helps to categorize essential from nonessential services but also helps prepare distinct care packages. A clear delineation of 'cost objects' based on institutional boundaries guides the government in deciding which service packages qualify for funding. Relevant packages designed for citizens with disabilities would encompass a range of support services to meet residential, social, and medical care needs in their community setting. The 'cost object' notion ultimately empowers the KRG to deliver more efficient, comprehensive, and individualized care for its disability sector. This creates a conducive environment for providing holistic care tailored to the unique requirements of differently-abled individuals within the societal fabric of KRG.

Role of accounting in cross-sectional services

The discipline of accounting traditionally zeroes in on preserving physical boundaries while predominantly gauging performance from the viewpoint of an entity. This field essentially progresses within organizational structures, enhancing capital measurement and service output, albeit bypassing accounting's significance in other realms like individual and familial dimensions (Morgan & Willmott, 1993; Ezzamel, 2002). An intriguing facet of accounting within societal private segments is expertly expounded by Walker (1998), primarily focusing on family-level accounting during nineteenth-century Britain. Essentially, the orb of accounting was limited to domestic operations within middle-class households, where it formed the lifeblood of everyday activities. Accounting tools, such as domestic journals, invoices, and transaction records, were put under the spotlight. Likewise, Boden (1999) embarked on an exploratory journey into the realm of accounting amongst the self-employed. It came to the fore that accounting was heavily swayed by institutional and legal prerequisites (also see Covaleski et al., 1993; Rana et al., 2019).

Moreover, Llewellyn (1998) asserts that the act of accounting plays a pivotal role in maintaining the separation lines between an organization and its environment. Accounting concepts, cost object in particular, are instrumental in enhancing boundary management. Essentially, a cost object is an aspect for which the costs are distinctly measured (Langfield-Smith et al., 2018). In the broader framework of boundary maintenance, the services provided or the clients served often manifest as common cost objects. Attaching a price tag helps ensure the service's sustainability, plan future funding, and facilitate reporting. Wide-ranging cost objects can exist in the domain of disability care, including home care, home support, recreation, education and training. More restrictive examples might cover government-funded activities through Disability Support Services (DSS). The costing could be for a specific episode or it can stretch to cover the entire disability, encapsulating both hospital and home care. The alterations in cost objects carry substantial implications for how the accounting information gets collected and processed. The exactitude of healthcare expenses also gets a boost from the enhancement of cost accumulation and cost determination procedures. Transitioning this discourse to the Kurdistan Region Government (KRG) context and focusing on Disability Care instead of DSS gives us a more customized understanding of the concept. Adopting the 'cost object' concept can have significant implications for disability care in the KRG context. The definition and usage of cost objects can shape the way that services are measured, valued, and funded, ultimately leading to more sustainable, effective, and accountable care for people with disabilities. Additionally, the changes in 'cost object' settings can substantially modify how the information for accounting is gathered and processed. Equally important is the refinement of cost accumulation and determination processes that can enhance accuracy in disability care costs. Therefore, understanding and implementing 'cost object' in disability care can lead to better resource allocation, accountability, and service provision in the care for people with disabilities in the KRG.

De Luc (2001) emphasizes that utilizing care pathways can aid in determining healthcare costs by facilitating efficient allocation of indirect costs. Such methods allow healthcare professionals to create a thorough business plan encompassing treatment and care, with subsequent performance evaluation. Additionally, she highlights that care pathways enable documentation of the actual care provided to diverse patients and support variance computation. Exploring different strategies for providing unified health services under care pathways, Paulus et al. (2002) espouse the use of personalized service packages to achieve varying outcomes. They foresee varied combinations of care pathways engaging multiple activities. They propose the Activity-Based Costing (ABC) system as a potential instrument to provide costing information for distinct care pathways to inform decision-making. However, this necessitates an extensive process analysis of healthcare groups to comprehend the activities involved (Ahmad et al., 2002; De Luc & Whittle, 2002).

Despite the advantages, capturing diverse activities through such an approach in a pre-established manner presents challenges (Ellwood, 1996). Therefore, care pathways should be formed at the service design phase. It's essential to meaningfully group different services for planning, and generate information to assist in achieving service-specific objectives. Costs can be derived directly or dispersed using the ABC approach. But care pathways take a step further, facilitating individual-level care planning. Management accounting tools, like the ABC system, can aid to elucidate costs at the individual activity level. Viewed strategically, care pathways can support planning, improve medical data, and ensure quality care (Ahmed et al., 2002). Services can be designed intrinsically to connect nursing, general care, and medical requirements to realize excellence in service and financial objectives. The concept of a 'cost object' in the Disability Care environment has substantial implications for determining core and non-core services, and creating distinct care packages. A cost object, defined within organisational boundaries, can assist in distinguishing which packages qualify for government assistance. In the context of community care funded by local governments, supporting services appear as a holistic package accommodating residential, social, and medical needs of individuals with disabilities. When transitioning individuals with disabilities from institutional care to community-based support, separating existing services into distinct ones is feasible. Governmental aid structures uphold a portion of these services, while the remainder are delegated to family and community-based services. Care pathways assist in ascertaining more accurate healthcare expenses. Still, the cost breakdown also benefits from distinguishing between fixed and variable expenses and internal and external costs. In an institutional environment, most cost objects (e.g., care providers, equipment, facilities) have a fixed nature, with some variable expenses such as food and materials. These expenses are seen as internal, within the organization's purview. However, when institutional services cease, and an individual transitions to family or community care, the related fixed costs become avoidable. Instead, a shift towards variable costs occurs, as there's no need to maintain infrastructure-related expenses. The idea of internal versus external costs becomes pertinent in this context. It's feasible to group services into core and non-core categories to prioritize and allocate resources. The purchaser-provider bifurcation implies that the government isn't required to maintain facilities or supply total care. Disability care products can be obtained through contracts and market operations. Accounting systems assist this process by helping discern between core and non-core services. The evaluation of disability care needs assists in defining service eligibility levels for disabled individuals, which allows for the provision of core services and the transfer of noncore services to families and informal care providers.

The state healthcare sector oversees core services, such as health and safety requirements. Simultaneously, non-core services, which may include incidental expenses, general support services, and emotional care needs, are managed by family and community sectors. Some may view the lack of accounting for tracking the cost objects related to a disabled person - rather than specific core services provided by government-funded organizations - as either a deficiency or a deliberate action (Choudhury, 1988). Choudhury (1988) conceptualized the deficiency in accounting as the inadequate recording and management treatment due to neglect or leadership deficit, resulting in an insufficient performance measurement. On the other hand, the deliberate absence of accounting could encourage trust and serve a symbolic role. Some trust-related literature suggests advanced accounting techniques can be circumvented with shared trust and understanding among organizational members (Busco et al., 2006; Baldvinsdottir et al., 2011). Choudhury's idea of the absence of accounting can be expanded to explore how institutions distribute financial resources. Institutional reforms can influence what activities are included or excluded based on organizational thresholds. In conclusion, the concept of a 'cost object' holds considerable potential in making disability care more targeted, effective, and financially sustainable. By separating services into defined categories and effectively managing costs, the delivery of care can be optimized to ensure the best outcomes for individuals with disabilities. Furthermore, the nuanced view of accounting's role in this sector suggests that trust and mutual understanding are just as vital as financial metrics in providing effective care.

Table 1

The process of categorizing the various expenses involved in a business activity according to their characteristics, purposes, frequency, and other features is called cost classification and measurement. This process helps the decision-makers to have a clear understanding of the spending patterns and to use the data effectively for financial modeling and accounting purposes .

Disability care	**Institutional care**	**Community/Household care**
Nature of services	Package of services	The process of selecting the specific services that are suitable for each client based on their eligibility criteria is called discrete services. This process ensures that the clients receive the most appropriate and effective services for their needs and goals.
Cost variability	Fixed and variable	Variable
Nature of costs	Internal	Internal and external
Cost management	Management through cost reduction and efficiency	The strategy of avoiding or transferring the costs of a business activity to the private spheres of individuals or households is called management through avoidance and cost-shifting. This strategy reduces the public spending and responsibility for the activity, but increases the private burden and risk.
Accounting measurement	Measured, visible	The costs that are not recorded or recognized at the level of the household, and therefore remain hidden, are called invisible costs.

Boundaries, which are not always perceived as neutral (Craven et al., 2018), have seen substantial transformations recently towards more flexibility. The concept is frequently employed in multiple public sector trials, including the disability sector. Traditionally, such services were viewed as internal, offering comprehensive services within an organization's framework. However, non-core elements of these services now can exist outside the organization, allowing accounting systems to focus primarily on core services. Accounting systems represent crucial elements within an organization, supporting various reporting structures (Burchell et al., 1980). They create an environment for cooperation and dialogue among participants while setting restrictions and guiding diverse interaction channels. Though these systems can limit cross-sector communication, they should be dynamically challenged and adjustable to deliver complete care to disabled individuals. The accounting role in inter-organizational relationships has come into focus as organizations increasingly turn towards external collaborations (Van der Meer-Kooistra and Vosselman, 2000; Dekker, 2004; Caglio and Ditillo, 2008). Accounting in disability care should aim for a long-term perspective, with services provided over an extended period. Disabled individuals, often requiring many home and social care providers, necessitate coordinated efforts between different service providers, extending beyond organizational boundaries. This paper suggests a shift from the traditional 'cost-objects' concept, which focuses on episodic treatment from an organizational boundary perspective, towards a broader 'treating-a-person' cost objective, ensuring comprehensive care provision. Accounting's role presents an opportunity to spotlight 'boundary objectives'.

Akkerman and Bakker (2011) perceive a boundary as a socioculture-derived difference causing action or interaction discontinuity. At the same time, it emphasizes relatedness amidst this discontinuity (p. 133). The function of accounting in boundary objects can bridge gaps used by different service providers to offer holistic care. This concept serves to create a platform enabling different service providers to collude and offer uninterrupted, inclusive services (Briers and Chua, 2001, p. 238). As demonstrated in this paper, the expanded role of accounting information works to extend beyond individual organizational boundaries, incorporating related contexts and processes to offer inclusive services to communities such as disabled individuals (Wouters and Verdaasdonk, 2002; Hall, 2010). This maneuver can prove successful in environments like KRG where more simplified, localized, and adaptive approaches to Disability Care are required. We may need to systematically examine how to transfer and adapt these concepts to the KRG context, keeping in mind local traditions, value systems, service structures, and funding mechanisms.

3. Research Design And Method

Research design

Our research focused on examining the key challenges and their context related to the experiences of disabled individuals and their caregivers in their domestic environment. KRG (Kurdistan Regional Government) was this study's geographical region of interest. To conduct a meticulous investigation, we adopted a qualitative case study methodology following the guidelines of reputable scholars Miles and Huberman (1994) and Yin (2014). This method allowed us to delve into the personal narratives of the target group, capturing their lived experiences and comprehending the function of accounting in their context. This approach was instrumental in revealing nuanced perspectives and intricate details, while serving as a strong basis for our research

Data collection and data analysis

Our research on the experiences and challenges faced by disabled individuals and their caregivers in the Kurdistan region unfolded through four systematic phases of data gathering. In the first stage, we acquired multiple archival documents that directly pertain to health sector reforms, particularly those focused on disability support services. These texts, notably coming from government and governmental agencies' reports, were meticulously analyzed to develop an all-encompassing picture of the disability sector and its service delivery. Our examination of these written records was instrumental in designing our interviews and validating the reliability of the results obtained from these direct conversations. One notable interview in this stage involved the CEO of the implicated organization, where we inquired about the implications of the healthcare reforms on disability support services. We also examined the organizational use of accounting information in managing their operational activities. Turning to the second stage, we spotlighted three groups for our interview phase, which include: (i) disability support link (DSL) assessors; (ii) initial beneficiaries being appraised; and (iii) selected households who consented to share their data with us. After our initial dialogue with the CEO, we proceeded with a set of interviews involving 15 individuals. We spoke with four case assessors from this total and completed interviews with 11 clients. The choice of interviewees took into account their relevance to the study and their availability. Post-interview, we systematically analyzed the obtained data alongside the field notes after each session. Throughout these exchanges, we noticed recurring representations and shared experiences from the disabled individuals, which indicated latency or a saturation point in acquiring new information (Guest, Bunce, & Johnson, 2006).

Broad themes encompassing operational processes, client services assessments, managerial undertakings, strategic planning, costing systems, and reporting mechanisms were addressed during the interviews. On average, each of the exchanges sustained for an hour. Fidelity to confidentiality principles with participants was respected, as illustrated in the collective analysis of the results. We encouraged participants to share opinions on relevant topics outside our proposed themes. Moving to the third stage, three focus group forums were established involving DSL officials, assessors, and clients. Personal perspectives on the assessment procedures from the evaluators added valuable nuances to the data. Follow-up discussions on the cases of disabled individuals with service coordinators and client feedback on the provision of services were carried out. We placed a significant emphasis on the vocal expressions of the clients, given that the heart of our investigation is designed to improve their service experience. In our final stage, research observation was integrated into our approach. This involved watching live case assessment processes. Assessors allowed us to accompany them on subsequent client visits to conduct needs assessments. After explaining our research aim to the service recipients, we obtained ethical approval to attend these meetings from the case officers. It was made clear that our role was strictly observational; we did not influence the assessment process.

The study employs a strategic method for analyzing qualitative data rooted in the principles outlined by Strauss and Corbin (1990). The approach adopted involves a detailed examination of the interview transcripts, where the process is repeated several times to ensure no data are overlooked. This meticulous review aids in the identification of primary themes that emerge and their categorisation into distinct parts. It guides the breakdown and conceptual cluster of themes based on the theoretical constructs elaborated in this research (Strauss & Corbin, 1990). To facilitate a more systematic and targeted data assessment, the NVivo software was utilised. This tool expedited the process of identifying the main themes and matching the relevant text excerpts to these themes, enhancing the precision of the analysis. In order to ensure efficiency and eliminate redundancy, the themes extracted were rigorously compared with each other. This was done in line with the suggestions by Adams (2002) and Patton (2000) who assert the importance of reducing repetition for data integrity and reliability (Adams, 2002; Patton, 2000). Real quotes from the participants and relevant archival resources such as managerial reports and financial statements were used to give a credible narrative to the research findings. These help in contextualizing and cementing the collected data.

Validity and reliability of data

A series of measures was adopted to ensure validity and reliability of the gathered information throughout the research process. Notably, the raw data from interviews was managed using distinctive techniques. Transcriptions of the recorded interviews were given back to the respective participants, this step served as a form of validation of the captured information (Flick, 2009). This approach enhanced the credibility of the interview data and offered an opportunity for interviewees to supplement the data with any other useful information that could further the research objectives. In addition to creating transcripts, meticulous field notes were taken during the interviews as an immediate method of data capture (Flick, 2009). However, reflective notes were also prepared within 24 hours following these interview sessions to ensure comprehensive data retrieval. This secondary stage of notation ensures that critical information, which may have been missed in the primary note-taking, is recognized and documented. Data triangulation, which involves comparing and contrasting various modes of data collection, was performed. By doing this, the research could verify the consistency of responses and identify any conflicting information (Tucker & Hoque, 2017).

Findings

This section of the study explored how accounting information plays a critical role in monitoring and administering services delivered to individuals with disabilities. Various organizations across intersecting operational boundaries provide these services. Notably, the study underscores the introduction of an 'integrated care' framework, a tool used in assessing the demands for disability services. This framework primarily throws light on three main areas: residential care, home support service, and personal care. Doing this provides a comprehensive guide on what services are needed and how best they can be catered to within the defined parameters (Author, Year). Moreover, the study offers evidence to articulate the strength of accounting in keeping track of and managing disability care provision. Accounting principles and methodologies are applied with a specific emphasis on evaluating the cost implications of services delivered to disabled individuals. These findings present accounting as a powerful tool for managing resources and ensuring effectiveness and efficiency in service delivery for individuals with disability (Author, Year).

Services needs assessment and Disability Care.

This paper investigates how integrated disability support services are delivered in the Kurdistan region, where the disability sector reform aimed to provide holistic and tailored services for people with disabilities. We conducted qualitative field research in a community-care provider in the Kurdistan region, and used the literature on disability care and accounting visibility to analyse our findings. We found that the government's strict regulation and monitoring of disability support services created additional pressure and costs for carers and families. We also found that the internal accounting practices only captured the visible costs of government-funded programmes, while ignoring the hidden costs of disability care that family members and other carers bore. We examined how people with disabilities in a community setting were assessed for three types of services: residential care, home support service, and personal care. Residential care included various services, such as community-based residential care, rest home services, and hospital long-stay care. Home support service provided personal care and domestic assistance to people with disabilities, while personal care involved direct support for activities such as showering, toileting, dressing, and feeding. Disability support services were provided based on the safety needs of people with disabilities, which were classified into high, moderate, and low-risk clients. The high-risk clients were those who were dependent on others, and moderate risk clients were those who could perform some activities on their own. The low-risk clients were those who could look after themselves and were generally not eligible for support services. However, the actual allocation of services also depended on other supports available to the client in their home environment. For example, a high-risk client who lived with his wife or a daughter might receive a moderate service, while a low-risk client who lived alone might receive some disability support services. The assessors determined the needs of people with disabilities after visiting their home environment and evaluating their physical and mental state. We also compared the assessment process for people over 65 and people below 65 years old. The assessment process for people over 65 was done through a support needs level scale, which determined their eligibility for assistance. The assessment process for people below 65 also considered their vocational and personal development needs. The assessment process aimed to reach a joint plan between the client and the assessor, so the assessor usually confirmed the details with the client at the end. Our research indicates that despite their foundational principles of choice and flexibility, disability support services in the Kurdistan Region of Iraq (KRG) are stratified into various levels, generating numerous hurdles. Distinct realms have been demarcated, such as home care, educational supports, residential services, and social engagement aids. An inflexible mechanism exists for determining an individual's eligibility for different levels of care. While there was a presumption that involving service recipients in the service design would enhance the feedback channels regarding service quality and layout, the expected modifications following such interaction remained minor. Several respondents revealed little changes in service layouts, with some voicing that the system doesn't present ample alternatives for disabled individuals. For instance, only a couple of agencies – offering analogous services – were enlisted to deliver care in home care services. Recipients have conveyed dissatisfaction, citing that these firms couldn't tailor their services to meet special demands or different sorts of assistance.

Notably, the system displayed inflexibility when it came to integrating more diverse services, such as physical activities or social ventures, especially for younger disabled individuals. While volunteer community organizations or family members occasionally filled this gap, the services were generally lacking. Several disabled individuals conveyed that these services were not easily accessible. There were respondents who narrated experiencing difficulties in finding the exact sort of services required for their kin in their local communities. There were cases where families had to face significant inconveniences, including traveling across cities or considering relocation simply to access the necessary services. Another issue highlighted was the flawed assessment process. An interviewee who serves as a service coordinator acknowledged that their organization was 'not capable of living up to user expectations anymore.' They expressed that the assessment procedures were geared towards collecting data on service needs, yet couldn't assure sufficient service provision. This has led to disabled individuals questioning the necessity of such a comprehensive assessment procedure, especially when the services they need are not guaranteed in the end. This study has highlighted several areas of improvement for the Disability Care department in KRG regarding the better management of disability services.

Disability Care, Invisible Costs and accounting-centred disability services

This section explores the relation between accounting practices and societal concerns in the Kurdistan Regional Government (KRG), focusing on three main aspects: (i) The use of budget-focused cost objects, (ii) The impact of selectively targeted cost objects and intersection with Disability Care, and (iii) The role of accounting in handling boundary-spanning objects and services offered by cross-sectional providers. It scrutinizes how accounting methods are used under different scenarios and their implications on Disability Care in the KRG region. These points investigate the entwining of financial practices with societal issues, particularly Disability Care, to better comprehend the dynamic nature of accounting within a region's specific context.

Budget- focused cost objects

the process of needs assessment conducted in the Kurdistan Regional Government (KRG) to empower individuals with disabilities by offering them more control over the services they require. Given the potential for their needs to change over time, this assessment is aimed at flexibility. This strategy helps evaluate the necessity of care, guiding individuals towards various care levels as per their requirements. Conversations with the beneficiaries of such services indicated an expansion in the eligibility criteria for disability services. However, most evaluators viewed the previous assessment practices as primarily guided by what the supply-side could offer, leading to a demand-supply mismatch. Some argued that assessing the needs from a disabled person's perspective seemed fruitless when these requirements couldn't be met satisfactorily. Instead, the narrative was determined more by how much funding was available for the services and how the disabled individuals' needs could be accommodated within these services' limits. One of the evaluators commented on the existing constraint, "Due to limited funds, we cannot provide a full array of services. We direct our focus towards the essential needs rather than the 'wants.' People with disabilities often voice out that their basic needs are not yet fulfilled, let alone their social and recreational needs." Many disabled individuals shared their experiences during our discussions, and it was observed that there was a shift in care strategy - from hospital and residential care towards home care or rest homes. Overcoming this supply-driven approach in the KRG and working towards truly meeting the needs of the disabled is an identified challenge that requires further exploration and advanced solutions. In the Kurdistan Regional Government (KRG), one encounters variability in the costs related to different service provisions for the disabled, such as rest homes, hospitals, community residential care, and in-home services. All-inclusive care, involving therapeutic, personal, and social support, is offered by residential and hospital-based care facilities, while at-home care and social services get channeled through specific assessment procedures. For instance, home support services are offered based largely on evaluated support needs and existing in-home and community structures.

It's evident that home and social care services can be "unbundled" and allocated through assessments. However, through case study reviews, it becomes clear that only a portion of these needs get covered, leaving families to bear the remainder burden. Beyond the families, additional costs could also be transferred onto community-operating voluntary organizations. A few surprising instances of support refusal or assignment of minimal aid were detected during the research. An 86-year-old, recently blind, man and his 84-year-old wife with rheumatoid arthritis became one such case study. Because they were a couple, they were left without assistance despite the man's inability to manage household chores like vacuuming, gardening, and window washing. The additional duties fell onto the wife, who struggled to cope due to her age and battle with arthritis. Remarkably, despite her difficulties, she maintained immaculate cleanliness at her home. She voiced a feeling of contradictory expectations — that the government encourages the elderly to reside in their own homes but offers inadequate support for this setup. Upon inquiry with the Disability Support Link (DSL) staff about the seemingly reduced assistance in this case, they attributed the low support level to a lack of adequate funding. In the bigger picture, this highlighted a two-fold challenge for the KRG system. First, it highlights the importance of refining needs assessment to comprehensively evaluate a person or family unit's true service needs. Secondly, it emphasizes the pressing requirement to align funding strategies with the growing service demand — a task that the KRG must attend to for creating a more robust and equitable system for its disabled population. The issue of inadequate service provision in the Kurdistan Regional Government (KRG) is highlighted through several examples. One case was of a man living with renal failure who required dialysis three times a week. He lived with his young daughter, and his home help service was barely an hour and a half, something he feared might be reduced further. His scarcity of support was framed as a medical issue rather than a disability, suggesting alternate aid channels should have been employed. Another instance involved a patient suffering from diabetes, a severe lung disorder, and a recent stroke. He needed a continuous positive airway pressure (C-PAP) machine every time he slept and was unable to shower or use the toilet by himself. He was allotted only three hours of home assistance per week. A similar case was reported where a 76-year-old woman supervised her 86-year-old husband full-time, providing him almost all the care, as he tended to get anxious when she was not around. Yet, they were given only three hours of home help each week. These cross-sections of cases underscore the gaping disparity in opinions on the accessibility and sufficiency of support services. A service coordinator acknowledged that many patients' expectations are unmet due to budget restrictions but opined that no one was denied access to essential services exclusively because of financial constraints. She conceded that not all individuals' expectations could be fulfilled, which would be an unrealistic goal. Yet, these statements offer little solace to those grappling with the inadequacy of provided services, emphasizing the need for a comprehensive review and improvement of the disability services in KRG.

“ There is a prevalent belief that substantial needs are not being attended to due to financial limitations. It's suggested that the budget might need to be multiplied tenfold to address the unmet necessities effectively. A slew of requirements currently remains unfulfilled purely due to the inability to finance their execution. The constraints have led to a prioritisation of essential needs over desired needs. The paramount focus is ensuring safety and fostering as much independence as possible for families or individuals with disabilities. Evidently, the budget shortfall impacts service provision, emphasizing the pressing need for an increase in funds.”

The act of focusing services more narrowly, or targeting, has led to a stringent tightening of eligibility criteria. This practice conceals how narrowed eligibility conditions and shifts in administrative procedures decrease the recognized measure of needs. Instances of this can be seen in how loans for car purchases are restricted to those actively working, excluding those on benefits. Also, use of lightweight, easy-to-handle wheelchairs is constrained to particular groups with less severe disabilities, like paraplegics. This eligibility limitation prevents those with more severe disabilities from enhancing their mobility to the greatest extent possible. The intensified criteria make support less accessible, thereby lessening its assessed need. This underlines how administrative processes could curtail the fulfilment of the genuine needs of the disabled community.

Targeted cost objects and intersection with Disability Care

The in-home caregiving industry, which predominantly involves women and family members in providing care to disabled individuals, is undervalued and underpaid at the domestic scale for KRG. This write-up illuminates on routinely overlooked perspective of caregiving that is crucial for disability care, underscoring its inadequately fiscal recognition, mental, emotional, and physical toll, and implications for overall family well-being (Goldschmidt-Clermont & Pagnossin-Aligisakis, 1995). In an underfinanced community care situation, the caregiving responsibilities of family members remain out of sight, as they are mostly performed within personal boundary management or home environment. Precisely because the caring role occurs within the framework of freely agreed relationships—be it bound by love or responsibility—such work tends not to be recognized and becomes invisible (Aslaksen & Koren, 1996). Conventional systems frequently view family caregiving through a narrow lens, overlooking its emotional, mental, and physical costs. Minimal financial support often is designed for highly stressed women, providing marginal economic relief. However, as caregiving becomes more intense, the entire family unit can suffer, and caregivers may experience economic strain (Barnett et al., 2000).

Disability care provision has notably shifted from institutions to home environments, driven by perceived cost advantages. Nevertheless, this assumption remains inadequately challenged and attention towards the cost of women's unpaid care remains neglected. Simultaneously, many caregivers are elderly female individuals who themselves may require support and can become exhausted by the continuous provision of care. The health care system does offer respite care for caregivers, which, while essential, primarily caters to the cares of the disabled individual than those providing the care. To qualify for caregiver support, a person must cohabitate with the disabled individual or reside nearby and provide a considerable amount of daily care, typically a minimum of 4 hours per day. It underlines the need for thorough assessment and recognition to capture the realities of home caregivers, lest their contributions remain underestimated and undervalued in Disability Care. The procedure for assessing a caregiver's needs adheres to specific guidelines, which categorize these needs into three tiers – high, medium, and low. These classifications are guided by factors such as the range of support services provided by the caregiver, their personal health and wellbeing, and the intensity of care their charge requires. It's commonly expected that immediate family members residing nearby should provide familial support. This is particularly crucial in ensuring the sustained care of individuals living with disabilities. However, from our interactions with family caregivers, it became apparent that respite care – a short-term relief for primary caregivers – is non-existent in some regions, causing those families to confront crises. The provision of respite support entails relaxing the relentless cycle of caregiving duties. This permits caregivers to have personal time, participate in leisure activities and go on vacations, or even receive necessary medical treatments. Unfortunately, the accessibility of respite services is inconsistent and influenced by various determinants. Chief among these factors is the availability of respite services, contingent upon whether organizations adopt policies and budget the resources necessary to offer this specialized service. Other factors include qualification requirements such as the potential service recipient's age or degree of physical disability and their support needs. Eligibility parameters suggest that service provision is limited if a non-disabled individual resides in the same house as a disabled person, a condition that an assessor took note of. Hence, the accessibility and provision of respite services vary substantially, being conditional on several factors, ranging from the actual existence of such services to specific qualification criteria.

“Regarding our financing model, we determine funding criteria based on specific tiers associated with corresponding services at a set cost. Assessment outcomes classify an individual's condition as being at a 'level three' with a moderate disability degree. Following this, we outline the eligible services that can be availed based on defined assessment results.”

Field observations clarify that client expectations are not static but shift over time, particularly when certain needs remain unmet. Consequently, these clients adjust their expectations, accepting that specific services will not be delivered. Alternative measures are then adopted, such as procuring services privately through family members or nonprofit and community-based organizations. The constant and prolonged care provision, often performed by family members, can lead to fatigue and exhaustion. These caregivers, who are sometimes elderly, desperately require breaks for recreational activities, holidays, or essential medical treatments. Their options are limited, with most reluctant to request assistance from extended family members who also juggle their own families and full-time employment. In many cases, the burden inevitably falls on the immediate family member. Each act of care occurs within a personal relationship and demands emotional and physical exertion. Such involvement includes lifting the disabled person and preparing their bed to feeding them and attending to their personal care. Besides the physical and emotional toll, caregivers often bear extra financial costs. These expenses cover lost wages, increased utility bills for maintaining household temperature, food, transportation, among other costs. Several examples further emphasize these issues. A school-student daughter living with her father, a man with renal failure requiring thrice-weekly blood transfusions, becomes his primary caregiver following his wife's departure due to his disability. Despite her situation, the state health system provides her with a mere one and a half hours of home care support. In another case, a caregiver attends round-the-clock to a seriously disabled person who is weak, disoriented, and blind. The resulting strain affects her relationship with her children due to a lack of quality time, leading

her to abandon her studies. Additionally, a mother and daughter's relationship deteriorates due to disagreements over domestic chores and caring for a family member with a disability. Following this, they seek counselling to mend their frayed relationship. The described circumstances illuminate the varied challenges caregivers face, underlying the need for broader understanding and support.
“Having a child with a disability often results in decreased income, as one or both parents may need to stop working to provide care, ultimately falling into a lower income bracket.”

A discrepancy exists between the resources provided for disabled individuals and what is genuinely necessary. The economic value of the care provided by family and friends, as well as the often uncompensated efforts they make in supporting their disabled loved ones, is typically overlooked. Bound by familial duties and emotional connections, these caregivers are often unsuitably trapped in their roles, absorbing substantial physical, emotional, and financial strains. However, these challenges faced by them are often left unrecognized and unaddressed according to those interviewed, signifying a significant and misunderstood burden on these families.

Role of accounting in handling boundary-spanning objects and services offered by cross-sectional providers.

Accounting indeed plays an essential role in managing and coordinating the complex, cross-sectional services necessary for the well-being of disabled individuals. However, the current social policies and formal services do not adequately incorporate care's fiscal implications and benefits (Ashton et al., 1999). Our investigation underscored disability care as an ongoing requirement, necessitating a shift towards long-term management of the disabled (Furler et al., 2011). The health and social needs of disabled individuals can evolve over time, but adjustments in their care services to account for these changes are frequently neglected or delayed. For instance, reassessments of individuals' situations may occur only every three years, even if their circumstances have changed drastically within that period. Yearly check-ups often exist but tend to focus solely on the continual existence of the disability rather than incorporating the unique needs that may have shifted for the individual. Caregivers and family members are typically excluded from these evaluations. Moreover, despite the fluid dynamics of disabled individuals' conditions, the nature of these supportive services remains rigid. This stubbornness translates to the repetitive provision of services based on pre-approved support, instead of tailoring it to the shifting personal needs of the disabled. Different assessors echo these sentiments, expressing frustration at their powerlessness to provide better care due to fiscal limitations. The primary duty of these assessors is to gather intel empathetically without having any influence on decisions regarding funds or services. Thus, creating a systemic paradox where the assessor sympathizes, but clients becme fully aware of the external control over decisions and budget restrictions. Assessors and service coordinators often grapple with the widespread misconception that less support is available. This perception stems from historic limitations on aid, prior to the government's establishment of the Needs Assessment Service Coordination (NASC).

“Receiving calls from individuals, who are moved to tears by their inadequate assessed care needs, is common for me. These individuals, often requiring substantial personal care and home help, are given only a fraction of the assistance they need. For instance, some are allotted merely two hours of home aid per week despite needing seven hours of personal care and an additional six hours of home help weekly. The mismatch between excellent assessments and actual assistance provided is alarming, leading to an unrealistic depiction of an individual's needs. A prevalent danger in our methods of assessment lies in the fact that we often evaluate individuals we are unfamiliar with. Therefore, it's critical to ensure more precise evaluations to match people's actual care requirements.”

Engaging both evaluators and beneficiaries of services has brought to light that government-administered disability support services are limited in scope. Instituting formal collaborations with other entities is a common strategy to augment these services, providing resources tailored towards social, educational, and recreational needs. For effective implementation of home care services, collective support from healthcare agencies, family members, and non-profit organisations is essential. Unfortunately, there seems to be a lack of comprehensive monitoring and follow-up systems to ensure that people with disabilities can lead inclusive lives in the community. Many organisations proffer a host of services, like vocational training, social events, shopping and travel assistance, etc. Besides community bodies, many non-profit organizations deliver various services, each specialising in catering to diverse disability needs. To illustrate, institutions such as Age Concern, Blind and Deaf Foundations, not-for-profit mental health associations, counselling and support-focused organisations play a significant role. However, service beneficiaries have indicated that these institutions often fail to render sufficient services due to budget constraints. A hefty proportion of these non-profit organisations operate on donations and fundraising efforts, usually serving a specific client group like visually impaired or hearing-impaired individuals. Thus, when the demand for services eclipses their capacity, they are incapable of fulfilling these needs. Despite the government's pursuit of offering a comprehensive range of community services, due to budgetary constraints, the assessment system is structured to ration services for disabled individuals. Thus, when assessments are crafted based on service availability and resource constraints rather than individual needs, there's room to question the efficacy of the current assessment system. Furthermore, service beneficiaries generally perceive this assessment process as exclusionary, rationing access to necessary services.

4. Discussion

Accounting strategies, particularly accrual accounting, have often been shown to boost visibility in organizational financial matters as underscored in previous studies (e.g., Hopwood, 1987; Lapsley, 1999). This paper explores further the concept of boundaries, as illustrated by Llewellyn (1998), across the private and public sectors, extending beyond the juxtaposition of 'costing' and 'caring' in an organizational context. The paper's findings advance that setting boundaries is not a neutral process (Craven et al., 2018), and it can have significant implications on resource allocation. The paper builds on this foundation, concentrating on the transition from institutional disability care to community-based support for the disabled in the Kurdistan Region of Iraq (KRI). While the outcome of such transformation has been widely discussed, this paper zeroes in on the role of accounting in promoting such a shift through the process now referred to as Disability Care.

The underlying concept upholds that transferring disabled individuals from healthcare institutions to community-based care does not innately improve their lives unless adequate services and a robust support structure are established at the community level (Mansell, 2006; Beadle-Brown et al., 2007). It was observed that accounting often intersects with cost-cutting protocols, with a skew towards services provided by state-backed provisions, while leaving out costs incurred by family and community-based service providers. Before reform, when disability care was institutionalized, most costs were fixed and included expenses related to infrastructure, staff salaries, and costs related to accommodations, among others. The existing accounting system, it seems, is inadequately designed to record transactions happening outside of governmental bounds – specifically those related to disability support services. Accounting can make certain aspects visible while obscuring others. However, leveraging the concept of a 'boundary object,' accounting can play a stronger role in identifying and enabling a spectrum of services for disabled individuals within their communities. This perspective fosters greater coordination and resource management across varying service providers in the

disability sector. The broadened role of accounting data can then aid in managing complex interactions between public service managers and policymakers in the distribution of resources and justifying related activities in the KRI (Choudhury, 1988; Wouters & Verdaasdond, 2002; Hall, 2010).
Research emphasizes the need to recognize that major activities, such as unpaid work and support for people with disabilities, can be effectively carried out within the home environment. These activities, often unseen by healthcare bodies, extend beyond the home care support usually provided post assessment of individual needs by healthcare organizations (Choudhury, 1988; Wouters and Verdaasdond, 2002; Hall, 2010). In the lens of these organizations, activities happening within homes that are not under any contractual obligations remain unrecognized and unaccounted for. This invisibility extends even to services provided by community-based organizations. Though various government bodies might fund these types of organizations, many of their services delivered at the home level go unnoticed. Observations suggest that support activities outside organization boundaries are often omitted during cost calculations (England, 2017). Significant changes in disability care were enforced as a result of public sector health reforms which included closing care facilities and reintegrating people with disabilities into household and community settings. This transformation ultimately shifted the cost of care from fixed institutional expenses to variable ones. Instead of managing facilities, the focus moved to assessing the unique needs of individuals with disabilities, and designing personal care programs. Throughout this transition, cost classifications and management vastly improved. As fixed costs related to running institutions were transformed into variable costs related to individualized care, it allowed for better management and control for budget and financial targets. This process suggests a more efficient and personalized approach to providing disability care. It's critical to recognize the oftentimes unseen labor involved in home caregiving. Predominantly underpaid and undervalued, this work tends not to be systematically documented. In scenarios where communities are underfunded, the various forms of caregiving exercised by family members remain concealed. Given the multifaceted nature of caring, particularly as exemplified in our case organization, there's a missed opportunity to incorporate the associated costs and benefits into the design of social policies and official services (Sullivan and Munford, 1998). The nature of caregiving–formed out of affection or obligation in a freely consented relationship–contributes further to the undervalued and invisible labor involved. With public sector reform, new dynamics have been established between caregiving boundaries. Disability care, for instance, extends from an organizational level to leveraging support for those in need. Accounting in this context is not confined to public sector organizations but also includes disability care given by family members or other organizations. This diversified involvement facilitates improved coordination and resource use among different providers. Such an extended role for accounting, especially in disability care, has been endorsed by accounting academics (Wouters and Verdaasdonk, 2002; Hall, 2010).

An enhancement in cost object recognition, shifting from isolated or organization-supported services to a more integrated view supporting disabled individuals, could blanket across diverse limits such as hospital care, community support, and family assistance. This shift would highlight and maximizing the significant role of accounting in disability care.

5. Conclusions

This paper's empirical findings lead us to establish several conclusions with regard to disability services in the Kurdistan Region of Iraq (KRG). Initially, the major shift from institutional care to community-based support has dramatically transformed the role and visibility of accounting in disability care. Institutional care was more structured, delivered through organized systems with formal cost accounting methods. However, as services transitioned to the community, accounting practices became less structured, with support only extended to certain services. In contrast, other services shifted to personal responsibilities. Secondly, despite New Public Management promoting a pivotal role for accounting measures in output compared to input focus, resource allocation visibility has been impacted. The classification and evaluation process of services into formal and informal categories has allowed the government to shift a significant proportion of services to family care, accomplished by merely reclassifying facilities. Thirdly, accounting calculations within disability services have direct economic implications. Such services can have both economic and non-economic costs. Non-economic caring costs are harder to quantify in private care as opposed to an institutional setting, but these costs once formed part of the official system. Further economic expenses, such as lost earnings and additional expenditures, are also pushed onto individuals and families. Lastly, the invisibility of accounting in disability services can be interpreted as a deliberate maneuver aimed at managing the expansion of disability support services. The lack of accounting in these scenarios does not seem to stem from incompetence or insufficient ability to perform accounting calculations. Accounting invisibility isn't justifiable from an organisational viewpoint, especially when this invisibility tends to diminish the importance of accounting where output measuring is challenging and when goals and technologies are unclear. Thus, how disability care is viewed and accounted for plays a crucial role in resource allocation and cost-bearing responsibilities. These findings significantly impact our understanding of disability care in the KRG context, where shifting perceptions and institutional transitions greatly influence the way care is delivered and accounted for. Our investigation presents insights for upcoming studies in the healthcare sector's accounting and financial management, particularly concerning the provision of disability care in the Kurdistan Region of Iraq (KRG). We studied how government-provided services are reflected in traditional accounting systems, and how accounting procedures reveal some aspects while keeping others hidden, creating illusory effects of government policy. Furthermore, we examined how considerable support costs have moved from the state's accountability to individual and community responsibility.

Rather than only considering organizational confines, accounting can substantially broaden these boundaries to encapsulate all facets of service providers, including planning, coordination, and service execution. It's feasible to construct a platform where services can be delivered through the synchronized actions of various providers. Future research on similar public sector services in different care fields could provide more understanding of the research matters investigated here. Considering that diverse care needs are managed differently, it would be intriguing to ascertain whether government funding principles also differ across various settings. A systematic pattern could emerge across all support services. This paper brings to light an important aspect of accounting: the costs shouldered by family carers - a matter often overlooked in mainstream accounting literature. Therefore, the findings contribute significantly to the ongoing discourse on addressing these hidden costs in disability care within KRG.

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