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Costing Schizophrenia

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Keywords

Accounting; Mental health; Schizophrenia, Public policy, Inscription, Social accounting, Cost shifting

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Costing schizophrenia

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Abstract

This article looks at a particular subset of mental illness in Australia: schizophrenia, and reflects on how the direct costs that fall within the parameters of the health budget are privileged (inscribed), compared to how indirect costs that fall outside this boundary fail to be inscribed appropriately. This article concludes that, from a social accounting point of view, this boundary is arbitrary and an example of poor accounting.

Keywords: Accounting; Mental health; Schizophrenia; Public policy; Inscription; Social accounting

1. Introduction

Schizophrenia is expensive. No one doubts that. This article argues that some costs – the direct costs – are far more visible than others, particularly the indirect ones. Accounting makes some costs visible (or ‘inscribed’); whereas, other costs are silenced. Sometimes they are silenced by being outside accounting’s ‘entity assumption’; sometimes they are silenced by being difficult to quantify. In either case, this article shows that by inscribing some costs and ignoring others, accounting practices privilege direct, quantifiable costs above other costs. From the viewpoint of social accounting ([Ball & Seal, 2005](#)), this failure to balance and consider all stakeholders constitutes flawed accounting.

The object of this paper is to investigate the extent to which healthcare reform (particularly that relating to mental health) in Australia has reduced the field of the visible because it is reinforcing a more “corporate” view of the provision of healthcare services. Recent health reform in Australia has tended to change the relationships between doctors and managers and has seen similar major structural changes in Australia to those experienced in New Zealand and the United Kingdom ([Perkins et al., 1997](#)).

[Cleary \(2003\)](#) summarised the changes well:

In many Western countries, the advent of the 1990s brought significant and sometimes turbulent changes to the delivery of mental health services ... During the 1990s, a plethora of policies were released that aimed to shape a new era in mental health care reform. In fact, the 1990s have been described as the 're' era—reform, reorganize, redesign, reshape and reallocate ... Complex service changes have occurred at an unprecedented rate and have had a significant impact on the care provided to mental health consumers as well as those involved in service delivery, in particular, mental health nurses in acute inpatient facilities, who have witnessed first hand the resultant chaos.

Consistent with current mental health policy (in countries such as Australia, New Zealand, the United Kingdom, USA, and Canada), acute inpatient facilities are now part of comprehensive health services, with the community the preferred treatment setting. However, the demand for inpatient beds has remained high. Increased rationalization of health services, increased patient acuity, decreased length of stay and changing patient expectations of services have all been factors influencing traditional mental health nursing activities ([Cleary, 2003, p. 139](#)).

[Morgan and Willmott \(1993, p. 16\)](#) state clearly the position taken by some schools of thought that government should be “business-like” in its policy making:

The growing use of accounting controls in the public and services sectors is not unrelated to the rise of the New Right political philosophy that takes for granted the superiority of private sector disciplines where accounting is comparatively well established.

[Dillard \(1991, p. 9\)](#) raised the question of whether advanced capitalist societies had become so used to looking at reality through the lens of accounting that we had almost forgotten that there were other lenses and that accounting was a social construction and so reflected dominant ideologies. [Morgan and Willmott \(1993, p. 6\)](#) also commented on both the interrelationship between accounting and notions of economic efficiency and the arbitrariness of “The Market” so beloved of economic efficiency in delivering things that people actually value.

To set the context for the current push towards business like government policy making, it is necessary to briefly explain the scandalous situation in mental health funding in the early 1990s in Australia. The [Burdekin Report \(1993\)](#), and the media reports that arose from the Burdekin Report's hearings in the months leading up to the Report's release in 1993, led to the public being scandalised at the real condition in which “community care” had left people with mental illness and their carers. [Whiteford and Buckingham \(2005, p. 396\)](#) commented on the situation in the early 1990s and also the policy response to the situation:

In 1992, after a decade of adverse publicity and a series of public inquiries into mental health services, all Australian governments adopted a National Mental Health Policy. The policy, implemented through a series of 5-year National Mental Health Plans, became known as the National Mental Health Strategy ([Whiteford & Buckingham, 2005, p. 396](#)).

[Fig. 1](#) shows the flurry of reports and responses that occurred in response to the scandals.



Fig. 1. Milestones in the development of the Australian Mental Health Strategy 1991–2003. *Source:* [National Mental Health Report \(2005, p. 1\)](#).

Funding for mental health also increased from 1993 to 2002 to some extent ([Whiteford & Buckingham, 2005](#)) but only to the extent that it mirrored the rise in general health spending:

In 2002, total spending on mental health services was \$3.1 billion, a 65% increase in real terms since 1993. As a proportion of overall health expenditure, this is similar to mental health expenditure in other developed countries. In terms of a service-costing approach, specialised mental health services accounted for 6.4% of Australia's recurrent health expenditure in 2001–2002. Using an alternative disease-costing approach, the Australian Institute of Health and Welfare (AIHW) estimated that Australia spent 6.2% of recurrent health expenditure on mental health care in 1993–1994. This is comparable to 6.6% in the Netherlands and 7.3% in the United States, although comparison between countries is difficult because of the differing ways expenditure and services are counted ... While the 65% increase appears impressive, it only paralleled growth in overall government health spending during the decade ([Whiteford & Buckingham, 2005, p. 396](#)).

Unfortunately, this rise in spending commensurate with the rise in spending of general Australian health costs has not eliminated the problem of people with mental illness and their carers being marginalised and “falling through the cracks” of the system. This paper argues that there is something about the way that governments reckon “costs” that is fundamentally flawed and that may be leading to poor policy and funding decisions. This flaw is that many of the costs of mental illnesses such as schizophrenia are hidden by accounting (or any business based lens of analysis) because they do not directly impact on the budget controlled by the institutions making the funding and policy decisions.

This paper argues that (through accounting) some costs, the direct costs, have a voice and are taken “into account” in policy decisions. Other costs, the indirect costs, are silenced and ignored. In mental illness, unfortunately, the majority of the costs are indirect. For example, [Access Economics \(2002\)](#) calculate that approximately two-third of the total quantifiable social costs in the case of schizophrenia are indirect. That being the case, these costs are not appropriately inscribed into our policy making process, and are effectively silenced or at least muted.

In order to see how accounting-type thinking has reduced the visibility of some (indirect) costs and enhanced the visibility of other (direct) costs, some authors claim

that the role of accounting in something wider than might be understood by the general public:

The systematic understatement of accounting's significance is reflected in the images of accountants in popular culture: as the technician, the innocuous bookkeeper, the “ink-stained wretch”, the record keeper whose lack of creativity and imagination makes him trustworthy ([Tinker, 1985](#), p.xv.).

Because of its clean, mathematical appearance and dull reputation, accounting is sometimes used as something of an “umpire” in disputes. Also, because of the emphasis placed on the canny, thrifty, business-like use of the public purse, accounting is extremely influential in policy decisions.

Why has accounting and other numerical type information been privileged above other forms of information in the area of mental health funding? Several possible answers have been given to this question. Perhaps such information has been so influential because it is an easy basis on which to make a decision ([Boyce, 1997](#) and [Gorz, 1988](#); [Mauders & Burritt, 1991](#)). Perhaps this is because it is readily defensible ([Macintosh, 1994](#) and [Richardson, 1987](#)).

[Gorz \(1988\)](#) raised a number of interesting reasons why quantification allowed for ease of decision making:

Quantitative measurement as a substitute for rational value judgement confers supreme moral security and intellectual comfort: the Good becomes measurable and calculable; decisions and moral judgements can follow from the implementation of a procedure of impersonal, objective, quantifying calculation ... ([Gorz, 1988](#), p. 121).

[Mauders and Burritt \(1991, p. 15\)](#) pointed out that calculation could act as a substitute for deeper, more complex decision making and could then be defended by reference to a formalised set of sums—however, unrepresentative those sums might be of reality. [Gorz \(1988, p. 107\)](#) also commented extensively on the difficulties and dangers that were inherent in the incautious over-emphasis on numbers in decisions. Firstly, money (although acknowledged as a useful tool) was neither a panacea nor an accurate universal standard of measure. Where problems were thought of in monetary terms only, solutions might also be formulated only in terms of money.

[Boyce \(1997, p. 11\)](#) raised the possibility that accounting was so very influential in policy evaluation because it was easy:

Like any tool, accounting can have significant influence in structuring the tasks for which it is used ... As presently used, it supports a tendency to focus exclusively (or excessively) on a calculative dollar-basis for public discourse and decision-making. Dollars are easy to ‘account’ for, dollar calculations can be made to look ‘objective’, and, when the dominant political rationality emphasises financial efficiency and budgetary restraint, it is easy to see how financial accounting calculus can become a dominant aspect of public decision-making.

[Macintosh \(1994, p. 153–155\)](#) illustrated how accounting can be used as ammunition in wars of self-interest or as a symbol of our society's need to be seen to be rational in

decision making. In justifying (or rationalising) a decision, accounting had the mantle of such objective accuracy that (whatever the reality) it sometimes went unquestioned as the prime determinate of policy. [Morgan and Willmott \(1993, p. 8\)](#) also emphasise that the great and pervasive influence of accounting was partly due to its invisibility and pervasiveness and partly to do with its (bogus) mask of being “highly technical”, “esoteric and remote”.

[Richardson \(1987, p. 341–343\)](#) stated that accounting had become such a very powerful arbiter in our society partly because of its “association with independent professionals”. Accounting also had a role in structuring relationships between parties and being both a means of control (for example, via budgets) and a means of sanctioning or constraining behaviour. [Richardson \(1987, p. 348\)](#) noted that accounting in the public sector served three purposes. Firstly, it provided a symbol of state efficiency. Secondly, it provided a language (“rhetoric”), which allowed certain issues to be highlighted and others obscured. Thirdly, it was used as a legitimating tool to evaluate public service actions and to praise or punish these actions by reference to accounting.

Accounting, then, is not an objective, value-free, scientific undertaking. At least as far as the questionable assumptions we call “The Monetary Assumption” and “The Entity Assumption” go. The assumption that all things shall be put into dollar terms serves to either hide or at least to de-value those things that are difficult or impossible to quantify. The entity assumption obscures those costs (externalities) borne by anyone outside the “direct cost” parameter. What effect has this misuse or misunderstanding of the appropriate use of accounting had? [Johnson \(1990, p. 105–106\)](#) stated the difficulties from a mental health practitioner's viewpoint:

The fact is that politically, it is extremely fortunate that so many of the costs of caring for chronically mentally ill people are hidden, because that fact covers up a lot of problems. For one thing, responsibility is diffuse and accountability even more ... But as in three card monte, what you see is not necessarily what you get, and nowhere is that principle in operation to greater effect than in obscuring the whereabouts of the mentally ill, not to mention the costs of keeping them there. Strictly from the states' point of view, the mentally ill were and are better off living somewhere “in the community”, where they are on somebody else's entitlement rolls and maybe even in someone else's catchment area ([Johnson, 1990, p. 105–106](#)).

2. Spending on mental health in Australia 1992–2003

After the scandals and reforms of the early 1990s, the Australian Government began the National Mental Health Strategy (see [Fig. 1](#)). This reform resulted in the spending on (direct costs of) mental health by the various Australian states and territories being collected and compared on an annual basis. It also resulted in tighter federal monitoring of how much and what each individual state and territory was paying for direct mental health costs from its budgets and it also resulted in some additional federal funds being provided for mental health.

[Fig. 2](#) and [Fig. 3](#) illustrate some key national figures on where the funding for mental health programs (such as do exist) is coming from. It can be seen from [Fig. 2](#) that the

three main sources of (specifically) mental health funding are private health insurers (a small increase from 1992 to 2003 of 16% based on constant prices) it is instructive to note, however, what a small portion of costs are delivered by the private insurers; the Australian (Federal) Government (a substantial increase of 134% from 1992 to 2003), but still meeting a minority of mental health costs compared to the individual states and territories; states and territories are by far the largest providers of specific mental health funding and this funding has risen in constant dollar terms by 49% between 1992 and 2003).

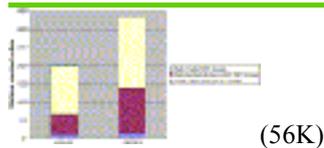


Fig. 2. National expenditure on mental health by the three main funders. *Source:* [National Mental Health Report \(2005, p. 2\)](#).

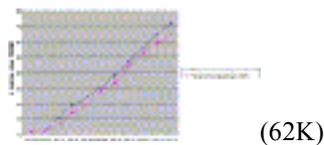


Fig. 3. Growth in government mental health spending compared with overall health expenditure. *Source:* [National Mental Health Report \(2005, p. 2\)](#).

[Fig. 3](#) shows that, impressive as these spending figures in [Fig. 2](#) may seem, they have done little more than increase mental health spending in line with the general health costs in Australia over the period 1992–2003:

Let us see how these national figures break down into actual services for people with mental illness and their carers in Australia's most populous state, New South Wales. [Fig. 4](#) presents some figures of interest. Particularly, note under the “inpatient services” section of [Fig. 4](#) that the number of total hospital beds available in N.S.W. has actually fallen from 1992 to 2003 as has the per capita expenditure on inpatient care in constant dollar terms. The number of inpatient mental health beds available per head of population has fallen considerably from 44.3 per 100,000 in 1992 to 31.3 per 100,000 of the N.S.W. population in 2003. From this, it would seem that [Whiteford and Buckingham's \(2005\)](#) claim that spending on mental health in Australia having only increased in line with general health spending is borne out in the actual level of service provided. Having noted this, it would appear from the “service mix” section of [Fig. 4](#) that spending on community based services has indeed increased from 30% of total mental health spending in 1992 to about 47% of total mental health spending in 2003.



(149K)

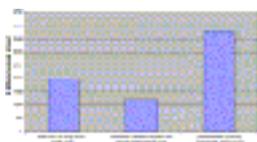
Fig. 4. Indicators of Mental Health Service Provision in New South Wales. *Source:* [National Mental Health Report \(2005, p. 66\)](#).

Why, then, given all of the scandals and policy criticisms in the early 1990s has spending on mental health risen only in line with general spending on health in Australia? And why has the provision of some services (for example, the number of mental health beds available per head of population in New South Wales actually fallen? It is the contention of this paper that this may have occurred because so many of the costs of mental health are hidden by accounting.

2.1. Direct versus indirect costs of mental health

The dichotomy between direct and indirect costs is acknowledged in the [National Mental Health Report \(2005\)](#) as is shown in the following quote and in [Fig. 5](#).

Indirect costs to government of mental disorders. The figures presented in the preceding sections only count the cost of providing specialist mental health services and do not reflect the total costs to government arising from mental health problems in the Australian community. However, people with mental disorders often require access to a complex array of other health and community services such as income support, housing and accommodation services, community and domiciliary care and employment and training opportunities. The costs associated with all these services represent an important part of total government outlays that are attributable to mental disorders. Previous National Mental Health Reports have estimated these ‘indirect’ costs to be significant, and likely to outweigh the cost of providing specialised mental health care. However, up to date information has not been available previously to quantify the claims ([National Mental Health Report, 2005](#), p. 29).



(79K)

Fig. 5. Estimated direct and indirect costs to the Australian Government of mental illness 2002–2003. *Source:* [National Mental Health Report \(2005, p. 3\)](#).

Note that the preceding quote from the [National Mental Health Report \(2005\)](#) is very instructive from the point of view of this paper. The above quote suggests that the problems of indirect costs borne by stakeholders other than the specialist mental

health services do exist and are severe (see [Fig. 5](#)) but that because they are difficult to quantify they remain unsubstantiated “claims” rather than “facts”. Another important point to note from the quote above and from [Fig. 5](#) is that the National Mental Health Policy appears to acknowledge only those costs that are not only “known” in a quantified accounting sense, but also only those costs that also fall on the Australian Government. This is a major departure from the “Social Costs” approach taken by [Access Economics \(2002\)](#) in its costing of schizophrenia that will be discussed later in this paper.

In looking at how direct costs are privileged above indirect costs in mental health policy making, this paper will sometimes need to use general mental health spending figures (for example, from the [National Mental Health Report, 2005](#)) instead of spending figures relating to schizophrenia only (as discussed in the [Access Economics, 2002](#) report). This is necessary because the comprehensive mental health figures are available (the [National Mental Health Report, 2005](#), includes data up until 2003 in its analysis), whereas, specific schizophrenia—related figures are not as easily accessible at this point.

As late as 2001, however, the emphasis in making treatment and funding decisions was still very much biased towards the costs being calculated from the point of view of the service provider (in this case, the health care system). [Singh, Hawthorne, & Vos \(2001\)](#) pointed out just how widely costs varied in the issue of whether or not to provide the drug “Clozapine” as a medication option to people with a mental illness depending on whether one looked at the very narrow costs and benefits to the health care system directly linked to providing Clozapine, or looked at the much wider costs and benefits of providing Clozapine as a treatment alternative from a social perspective.

3. What costs are associated with schizophrenia?

This section of the paper takes a social costs view of one particular subset of mental health costs (Schizophrenia) and contrasts the way that the social costs are arrived at in the [Access Economics Report \(2002\)](#) into the social costs of schizophrenia with the way in which mental health costs in a very narrow sense seem to inform government policy (as exemplified in the [National Mental Health Report, 2005](#)). The difference between the social costs ([Access Economics, 2002](#)) view of what costs should be taken into account, and the narrower view presented by the [National Mental Health Report \(2005\)](#) is quite profound. Note, however, that the [Access Economics \(2002\)](#) report still limits itself to quantifiable costs. This paper goes slightly further than Access Economics and explores the difficulties of quantifying some costs associated with untreated mental illness.

[Fig. 6](#) is sourced from [Access Economics \(2002, p. 31\)](#). Of the total costs included by Access Economics, only about \$661 million are direct health costs. Considering that the total direct and indirect financial cost of schizophrenia was found to be \$1847 million, direct health costs represented less than 36% (or roughly one-third) of the financial costs relating to schizophrenia in Australia in 2001.

(59K)

Fig. 6. Summary of direct and indirect costs of schizophrenia Australia 2001. *Source:* [Access Economics \(2002, p. 31\)](#) and adapted by author.

However, decisions that affect the level of help, support and treatment provided for people with schizophrenia are largely made by institutions whose accounting boundaries (budgets) only encompass the direct, health-related, one-third of costs. Perhaps this silencing of the indirect costs associated with schizophrenia might explain why mental health services appear to be so under resourced in comparison with the need for them and the costs of going without them.

[Access Economics \(2002, p. 1\)](#) notes that Australia spent only 1.2% of health spending on schizophrenia, compared to between 1.6 and 2.6% in comparable countries. Although [Whiteford and Buckingham \(2005\)](#) suggest that the general, overall level of Australian spending on mental health in general (rather than schizophrenia in particular) is comparable to other developed nations.

3.1. How are the direct costs of schizophrenia constituted in the [Access Economics \(2002\)](#) report?

[Fig. 7](#) shows how the bulk of direct costs (\$661 million) for schizophrenia was derived ([Access Economics, 2002, p. 18](#)). Of this, \$653 million was from direct health system costs. The majority of these direct health system costs (\$395 million) was from hospital expenses, with another \$152 million from other health services expenses, including spending on community mental health services.

Health Cost	Cost (\$ million)	Percentage of Total
Psychiatric hospital	395.0	59.8
Other health services	152.0	22.9
PHARMACEUTICALS	12.0	1.8
Non-hospital	22.0	3.3
Quarantine	5.0	0.8
Private hospital	12.0	1.8
Pharmaceutical	12.0	1.8
Self	12.0	1.8
Discretion	7.0	1.1
Research	5.0	0.8
LEAF	12.0	1.8
Other	82.0	12.4

(21K)

Fig. 7. Components of direct health costs for schizophrenia 2001. *Note:* adapted from [Access Economics \(2002, p. 19\)](#).

The balance of the direct costs of schizophrenia (\$8 million) was made up of the direct costs associated with the suicide of people with the disease, and the costs spent on suicide prevention and management associated with people with schizophrenia ([Access Economics, 2002, p. 20](#)).

3.1.1. How are these direct costs inscribed?

Following LaTour, the idea of accounting numbers as inscription ([Robson, 1992](#)) is that numbers are the dominant metaphor of accounting ([Morgan, 1988](#)) and assist in enabling action at a distance ([Robson, 1992](#), p. 686).

These direct, quantified, inscribed numbers, which are the known and acknowledged costs of schizophrenia in Australia, are then in a position to influence public policy and health spending. They are caught and quantified and find their way into our budgets. However, this is not true of the indirect costs of schizophrenia. While some of these do appear, spread across a variety of government budgets (such as welfare or correctional services budgets), they are hidden amongst other budget items for these government sectors and so lose impact (are muted).

3.2. How are the indirect costs of schizophrenia constituted in the [Access Economics \(2002\)](#) report?

According to [Access Economics \(2002, p. 31\)](#), the indirect costs of schizophrenia make up about 61% of the total, quantifiable costs of schizophrenia. Without entering the debate about the strengths and weaknesses of quantification, most (roughly two-thirds) of the costs of schizophrenia are ‘externalities’ to the budgets of the institutions making the decisions that most affect the provision of treatment and support for people with schizophrenia. These indirect figures do not find their ways directly into the health budgets of Australia. To an extent, they fail to be inscribed in a mobile, combinable way ([Robson, 1992](#), p. 697), and so fail to be ‘inscribed’.

In the language of inscription ([Robson, 1992](#), p. 701), the most powerful (and thus influential) elements in action at a distance are those that are mobile, stable and combinable. These are the inscriptions that will influence decisions (including funding decisions) made by those removed from the direct context of mental health (that is, government policy makers). Indirect costs would not be inscribed in a mobile, stable, combinable way to decision makers where they can influence policy and spending. As ‘externalities’, or items that do not directly fall within Australian health budgets, they fail to be meaningfully inscribed, and are silenced.

Access Economics included four categories of indirect costs: patient earning costs, carer costs, welfare costs and criminality costs, as shown in [Fig. 6](#). These categories exclude costs that cannot be quantified. But even given this limitation, social accounting requires that stakeholders’ costs (for example, those borne by people with mental illness, their carers and the welfare and forensic sector) be taken into account in thinking about just policy outcomes ([Ball and Seal, 2005](#), p. 460). This is discussed below in this paper.

3.2.1. Giving voice and form to the silenced costs of schizophrenia

Following the categories chosen by [Access Economics \(2002\)](#), this article considers the indirect costs associated with schizophrenia in the following categories: people with schizophrenia, their carers, welfare sector costs and forensic costs. The sources from which the following evaluation of indirect costs is drawn are: the [Burdekin](#)

[Report \(1993\)](#), the [National Mental Health Report \(2005\)](#) and various reports put out by mental health support groups, charitable organisations and newspapers.

3.2.1.1. People with schizophrenia

[Access Economics \(2002, p. 31\)](#) includes in its calculation of the indirect costs of schizophrenia the quantifiable costs involved in loss of earnings, absenteeism, net present value of mortality burden and tax forgone from people with schizophrenia. These quantifiable costs have been calculated at \$748 million in 2001 (see [Fig. 6](#)).

To flesh out (or make visible) the lived experiences that go with these numbers, it is necessary to explain that there is a dearth of appropriate treatment and supported housing for people with schizophrenia in Australia. This may be due to the small proportion of the costs of schizophrenia that are inscribed and thus appropriately acted on. For example, [Fig. 4](#) gives as the number of supported housing places for people with a mental illness (any mental illness, not just schizophrenia) per 100,000 head of population in New South Wales as 14.8 in 2003.

The seminal [Richmond Report \(1983\)](#) suggested that in order for ‘community care’ of people with mental illness to be just and fair, the government should fund an ‘integrated community network’ that allows people with mental illness a ‘normal community environment’ and provides them with ‘adequate follow-up’. [Burdekin \(1993, p. 341\)](#) noted the bureaucratic shuffling between the departments of housing and the departments of health in Australia, where each claimed that housing for people with mental illness was the other's problem. The result of each department denying responsibility was that people with mental illness wound up with very little help with their housing and, with that vital stability element absent, often fell through bureaucratic cracks into homelessness and marginal accommodation such as boarding houses.

The precise extent to which homeless people in Australia suffer from schizophrenia is difficult to gauge, because that population is so a transitory and ignored. [St Vincent de Paul \(2001, p. 6\)](#) guesstimated that between 25 and 50% of homeless people presenting at the Matthew Talbot Hostel in Sydney had some form of mental illness. The *Down and Out in Sydney* report ([St Vincent de Paul, Sydney City Mission, The Salvation Army, Wesley Mission and The Haymarket Foundation, 1998, p. 2](#)) suggested that 75% of homeless people had at least one mental disorder. Perhaps people who have the organisational skills that allow them to present at a hostel are less likely than the general homeless population to suffer *severe* mental illness. Other alarming statistics from *Down and Out in Sydney* (1998, p. 7) include that 58% of homeless people in or contacting inner Sydney hostels and refuges run by St Vincent de Paul, Sydney City Mission, the Salvation Army, Wesley Mission and the Haymarket Foundation had been physically attacked or assaulted; 55% had witnessed someone being badly injured or killed; 68% of women admitted to having been indecently assaulted and 50% raped.

3.2.1.2. Carers of people with schizophrenia

[Access Economics \(2002, p. 31\)](#) included in its calculation of the indirect costs of schizophrenia the quantifiable costs involved in carer costs and tax forgone by carers

being less able to work outside the home as causing a total of \$112 million in indirect financial loss (see [Fig. 6](#)).

Amongst the categories of costs that carers have to bear, the following less-tangible cost categories have been gleaned ([Burdekin Report, 1993](#)): exhaustion, uncertainty and lack of information, lack of coordination and follow-up, stress and added responsibilities. These are discussed below.

3.2.1.2.1. Exhaustion

[Donnelly \(2006\)](#) (as cited in [Burdekin, 1993, p. 455](#)) of the National Carers' Association explained the sheer weariness involved in being a carer. Carers might be called upon at any time, around the clock and around the calendar. Crises were frequent and generally extremely stressful. There was no time off and no respite for carers. They had huge responsibilities, but often very little control over circumstances, which served to make the job even more tiring. They save the government a huge sum of money. They get very little in return.

3.2.1.2.2. Uncertainty and lack of information

[ARAFMI \(2006\)](#) (the Association of Relatives and Friends of the Mentally Ill) made a submission to the [Burdekin Report \(1993, p. 462\)](#) which noted that when people were discharged from hospital (often still quite ill), carers were 'left in the dark, expected to pick up the pieces', while often not being properly informed of the medication and treatment regime that the person discharged should be on. This lack of information made their job exceptionally difficult.

3.2.1.2.3. Lack of coordination and follow-up

A variety of carers (for example, [Lanson, 2006](#), as cited in [Burdekin, 1993, p. 462](#)) commented on the dearth of follow-up and discharge planning after an episode of hospitalisation for severe mental illness.

3.2.1.2.4. Stress

The stress and strain on mental health carers, and on anyone else living in the household, was commented on by many carers. For example, [Bacon \(2006\)](#) (as cited in [Burdekin, 1993, p. 471](#)) and [Ormorod \(2006\)](#) (as cited in [Burdekin, 1993, p. 472](#)) both reported the edginess and overwhelming stress and responsibility that came to a household caring for someone with a mental illness.

Spokespeople for a variety of carer support organisations also highlighted issues that increased stress on carers and their families. The [AMIA \(2006\)](#) (as cited in [Burdekin, 1993, p. 471](#)) noted the unreasonableness and dangers inherent in expecting frail, elderly parents (generally mothers) to care for large (sometimes psychotic) adult children with no help. [Lococo \(2006\)](#) (as cited in [Burdekin, 1993, p. 471](#)), representing the Support Group for Relatives of People with a Psychiatric Disability, and [Carberry \(2006\)](#) (as cited in [Burdekin, 1993, p. 471](#)), representing the Association of Relatives and Friends of the Mentally Ill, made submissions to the Burdekin Enquiry which spoke of the severe stress that becoming carers brought to the other children, to marriages and to the mental health of carers. Comments included that the

cost of family and other relationship breakdowns and mental stress indirectly cause an increase of costs to the government via health, social and legal services in the long run.

The stresses placed on carers and other family members are extreme. As in other areas of mental health, lack of support services makes the task even more difficult.

3.2.1.2.5. Added responsibilities

[Kinnear and Graycar \(1983, pp. 81–83\)](#) reinforce that the burden of care falls disproportionately on women, and that the personal costs to these women (and those men who take on the carer role) was often very high. Many had to give up work to become carers, and thereby often became dependent themselves, either on a man or on the state. Such a decision was deemed in women to be no less than their duty. Men were seldom expected to make such sacrifices, although some did choose to.

[Kinnear and Graycar \(1983, p. 85\)](#) also drew several conclusions about the outcomes of moving the onus of care to the families of dependent relatives in Australia:

The picture that emerges is of a caring situation, which involves disruption and adjustment, often resulting in the isolation of the caring family from almost all other informal and formal networks. In turn, this isolation increases the pressures that result in cumulative social, emotional and financial costs. It is notable that family care entails these heavy costs because embodied in the current rhetoric is the belief that community care is a less costly form of care.

As with most of the costs that fall on mentally ill people themselves, costs that fall on carers because of the policy of deinstitutionalization were not directly accounted for in mental health budgets. They might show up indirectly in increased health care costs, in taxes lost because carers were unable to work outside the home, in the costs of divorce and counseling as the strain told on families. But the direct costs were ‘externalities’, and were not accounted for in any state's or territory's mental health budget.

3.2.1.3. Welfare sector

[Access Economics \(2002, p. 31\)](#) has included the following costs under the heading of ‘welfare’: disability support, sickness allowance and newstart payments. These indirect costs were estimated at \$274 million in 2001. As these are relatively reasonable costs to quantify and are inscribed at least to the point where they are noted in welfare budgets, even if they are indirect as far as Australian health budgets are concerned, no further comment needs to be made on these costs here.

3.2.1.4. Criminality

[Access Economics \(2002, p. 31\)](#) includes in its categories the costs of people with schizophrenia being imprisoned, and police and legal costs, and calculates them at \$52 million in 2001. In order to place the less quantifiable aspects of criminality in context, it is important to understand how poorly Australian jails (in general) deal with schizophrenia.

Because of the lack of psychiatric assessment of prisoners in New South Wales ([Burdekin, 1993, pp. 753–754](#)), it was difficult for the [Burdekin Report \(1993\)](#) to estimate the number of prisoners with schizophrenia with any certainty. However, according to [Burdekin \(1993, p. 754\)](#): ‘A startlingly high proportion of prisoners (82%) had suffered at least one “mental disorder” at some point in their lives’. However, in this case, the term ‘mental disorder’ included alcohol and drug abuse. Drug abuse is positively correlated with mental illness (either as a causative factor or as an attempt to self-medicate), most people would not consider drug abuse to be a mental disorder.

A [Sydney Morning Herald Editorial \(2001, p. 12\)](#) put the criminalisation of mental illness bluntly:

Several recent studies show the State's prisons are, in part, last stop, old-style lunatic asylums. But politicians, in the senseless battle to outbid each other in law-and-order auctions, ignore these inescapable and shameful findings.

It was clear to [Burdekin \(1993\)](#) that conditions in jails were not therapeutic for people with mental illness. Singling out New South Wales prisons for ‘especially severe condemnation’, [Burdekin \(1993, p. 761\)](#) cited a number of aspects of prison life as being particularly detrimental to inmates with mental illness. Conditions for both male and female prisoners with mental illness were extremely difficult. The consultant psychiatrist to the New South Wales Prison Medical Service [Jolly \(1993\)](#) (as cited in [Burdekin, 1993, p. 771](#)), commented that the system of segregating people having a psychotic episode would ‘almost inevitably predict a worsening of the psychotic condition’.

4. What is accounting's role in this?

It would seem incongruent that the state would choose to pursue a policy that imposes far greater costs than it saves. That is, it would seem bizarre to any discipline other than accountancy. In accountancy-related thinking, such a decision makes sense. Accountancy takes a very narrow perspective. If told to account for a policy change from the perspective of a state government, it will tend to do so by only accounting for items that directly affected that particular, narrow entity. ‘Externalities’ (that is, costs that fall somewhere other than on the narrow entity being accounted for) are ignored. This is the outcome of the entity assumption.

[Boyce \(1997, p. 14\)](#) pointed out the useful mystification that accounting causes in other (non-accounting acolytes) as a reason for its defensibility. Accounting brought with it the ‘aura and social authority of expertise’, and could be used to ‘validate the existing power-based normative order of society’. The way that accounting abets and is implicated in economic rationalism has been widely discussed and elegantly argued by others (for example, [Boyce, 1997](#); [Morgan & Willmott, 1993](#); [Rose, 1991](#)).

4.1. A role for social accounting?

[Gray \(2001\)](#) suggested that social accounting should take into account information about the position and views of people most directly affected by policy decisions (the

stakeholders). In the context of the (lack of) funding for schizophrenia-related treatment and support programs, this would allow the indirect costs of not providing adequate support to gain visibility or become ‘inscribed’ ([Robson, 1992](#)) and thus to be taken into account.

5. Schizophrenia in context

This article has examined mental health in general as well as schizophrenia in terms of direct and indirect costs. To place the schizophrenia within the broader context of mental health spending, [Access Economics \(2002, p. 18\)](#) notes that schizophrenia held only the third-largest place in Australian direct spending on mental disorders in 2001 (see [Fig. 8](#)).

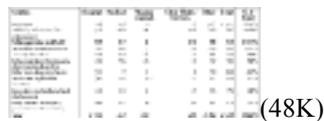


Fig. 8. Direct costs of schizophrenia and other mental disorders Australia 2001. *Source:* [Access Economics \(2002, p. 18\)](#).

Above schizophrenia, in terms of direct spending, came dementia and affective disorders (including depression). It would make an interesting further study to explore whether these other mental disorders have the same public policy outcomes as schizophrenia because of their similarly dispersed (and thus not effectively inscribed) indirect costs.

6. Discussion and conclusion

Australian spending on mental health (in constant dollar terms) has increased only at the same rate as general health spending from 1992 to 2003. This is to be considered in the context of the amount of scandal that was raised by the dearth of “community care” programs and spending in the wake of the [Burdekin Report \(1993\)](#). This article argues that one reason for this is that the indirect costs of some mental illnesses (such as schizophrenia) outweigh the direct costs by a factor of 2:1 and that is taking into account only those costs that are quantifiable. This is because we, as a society, appear to privilege only direct and quantifiable costs. These become inscribed and are factored into the policy making calculus.

[Morgan and Willmott \(1993, p. 10–13\)](#) specifically enquired into the role of accounting in “New Right public policy and the use of accounting techniques to engineer reforms in the public sector”. They found this role often produced “perverse consequences”. These authors also noted the pervasiveness of accounting as “the language of business” and how accounting “melts into the background as a natural, invaluable and uncontentious feature of economic life”. They suggested that accounting had succeeded in positioning itself “at the centre of debates about economic efficiency and capitalist rationality” ([Morgan and Willmott, 1993, p. 16](#)).

Indirect costs (or costs not fully open to quantification) are of no account in the language of accounting, and are thus ignored. This article has explored the way in which accounting numbers may be used to legitimise under resourcing of mental health because so many of the societal costs of mental illness are indirect or difficult to quantify and thus fail to be inscribed into our business-lensed policy decision.

Social accounting, as exemplified in this paper in the [Access Economics \(2002\)](#) report into Schizophrenia, could play a role in overcoming this silencing of many of the costs relating to schizophrenia and the policy injustice that has come from this obscurity.

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Vitae

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