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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 parametres 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

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> 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 inter-relationship 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.

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