Alcoholism and the Medical Cost Crunch

Researchers are trying to establish the cost-effectiveness of treatment for a disorder that is still largely a hidden burden on the health care system

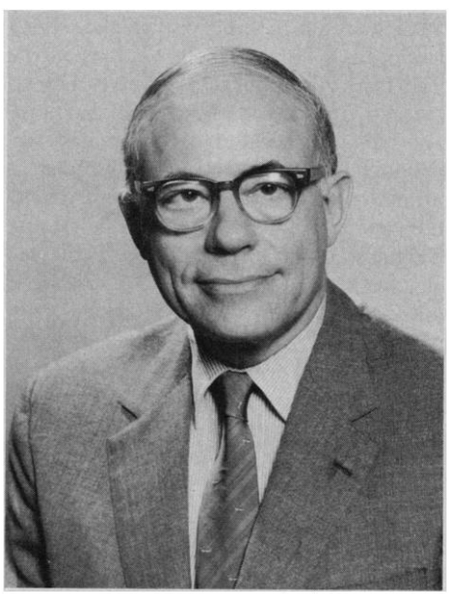
San Diego

ALCOHOLISM treatment programs have grown enormously in the past decade. How, in the present climate of health care cost containment, are costs going to be kept down, particularly in the absence of hard data on the cost-effectiveness of alcoholism treatment? The question is an urgent one, as health care costs rise by 7.7% a year—seven times the rate of the consumer price index—consuming almost 11% of the gross national product.

This and related issues were addressed at a recent conference attended by representatives from industry, government, insurance companies, and health professions, and sponsored by the University of California at San Diego.

Alcoholism and alcohol abuse are the nation's number one health problem in terms of costs to the economy, which amount to about $117 billion a year, most of it in lost productivity. Despite the enormous publicity accorded alcoholism in recent years, most alcoholics still go untreated for that disease, and the vast majority of those who seek medical care are not diagnosed as alcoholics. Thus, the disorder (and, to a lesser extent, drug addiction) operates anonymously to swell the ranks of the patient population, its consequences being treated under an almost limitless number of headings including liver disease, gastrointestinal disorders, heart disease, and psychiatric problems. Indeed, according to Enoch Gordis, the new director of the National Institute on Alcoholism and Alcohol Abuse (NIAAA), an estimated 25 to 40% of people in general hospital beds are being treated for the complications of alcoholism.

The direct treatment costs for alcoholism amount to about $13.5 billion a year, according to the NIAAA. But, said Henrik J. Harwood of Research Triangle Institute in North Carolina, only $1 billion of that is administered by specialists in alcoholism, with the rest coming through general medical care. Harwood reported that a review of the 1983 National Hospital Discharge Survey indicated that only 1.3% of discharges had a drug or alcohol-related code (1.1% of them alcoholic) despite epidemiological data indicating that 20 to 40% were probably alcoholic. For example, he said, 60 to 90% of all liver disease is alcohol-related; yet only 14% of those discharged after treatment for liver disease were identified as alcoholics.



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Other hospital surveys have come up with similar discrepancies. Norman G. Hoffmann of the University of Minnesota (St. Paul) reported on a study of 300 orthopedic, surgical, and internal medical patients hospitalized in Vermont and Minnesota. He found that 33% of the men and 12% of the women were active alcoholics. An additional 27% of the men and 12% of the women met formal psychiatric diagnostic criteria for alcohol abuse but were asymptomatic at the time. Fewer than 3% of the group were "borderline" cases. Hoffmann noted that the less alcoholism is linked to the primary diagnosis, the less likely it is to be recognized by hospital personnel. But the fact is, he said, "alcoholism is probably the most common disorder to be found in hospitals."

Another survey was conducted by Fred Goldman of the New School for Social Research on seven New York community hospitals. Examination of hospital charts revealed a 20.1% prevalence of alcohol- or drug-associated problems, 75% of which involved alcohol. The principal diagnosis was causally related to substance abuse in 56.6% of the cases.

There is no question at this point that alcoholism has long constituted a huge hidden drag on the health care system. Studies have shown that practicing alcoholics utilize health services at about four times the rate of nonalcoholics, and that families of alcoholics incur twice as many medical costs as other families.

Yet insurance carriers have only recently gotten into alcoholism coverage in a big way. It was not until the early 1970s that they began to cover alcoholism as a treatable illness rather than as a self-inflicted disability.

The number of people whose insurance plans cover alcoholism treatment is growing rapidly. For example, one survey indicates that 68.5% of private sector employees now have such coverage, compared with 36.2% in 1981, according to Gail A. Jensen of the University of Illinois.

Coverage has traditionally focused on expensive inpatient detoxification and rehabilitation. But more and more states—23 at present—are now mandating alcoholism coverage (an additional 14 require that it be offered as an option). So carriers are increasingly shifting to outpatient programs and other alternatives to hospitalization.

Sensible progress depends to a great extent on the result of cost benefit and cost effectiveness studies, of which there are still very few. It is easy to sum up the findings to date: in terms of cost, treatment is better than no treatment. Alcoholics spend less on medical care after treatment than before.

The most recent completed study was on a population of federal employees, covered by Aetna Insurance Co., conducted for NIAAA by Harold Holder of the Pacific Institute for Research and Evaluation and the Human Ecology Institute of Chapel Hill, North Carolina. The researchers looked at 2934 claimants for alcoholism services over a 4-year period (two-thirds of them were male, a proportion that pertains in most such studies). Their conclusion: "total health care costs declined significantly following treatment of alcoholism." The alcoholics showed a general rise in health care utilization for the 3 years preceding treatment, peaking in the final month before treatment. Health care utilization declined gradually after treatment, and within 2 to 3 years treatment costs had been offset by the

subsequent savings, particularly among those under 45.

Another study, by Holder and J. B. Hallan, of public employees in California, yielded similar findings, and a 5-year follow-up of 90 families of alcoholics showed a reduction in monthly medical expenditures of $72 per person, bringing them to the same level as a comparison group of nonalcoholic families. A 1978 study of health maintenance organizations, done by the Group Health Association of America, found a 40% reduction in outpatient medical visits by alcoholics 4 years after treatment.

Of particular current interest is a 4-year study being conducted by NIAAA and the Health Care Financing Administration (HCFA) to determine whether the inpatient alcoholism treatment supplied under Medicare and Medicaid reduces subsequent health care costs. This is the largest cost offset study to date, covering about 8500 alcoholics in six states. Most data have not yet been analyzed, but Paul Lichtenstein of HCFA reported that among New Jersey Medicaid patients, "total health care costs were significantly reduced after treatment." About 44% of the group underwent detoxification only and 23% of the group were readmitted within the year. Among the rest, however, health costs had come down to the level of the control group after 2 years.

A great debate has long raged in alcoholism treatment circles over the cost-effectiveness of inpatient treatment and whether, and for whom, it is preferable to outpatient detoxification as well as rehabilitation. In its extreme form, the debate is between the medical model and the "social recovery model" of rehabilitation. The latter, heavily based on the principles of Alcoholics Anonymous, emphasizes mutual self-help in residential or walk-in settings and entails no medical treatment for detoxification in the vast majority of cases (medical problems are referred to appropriate providers).

The social model, which prevails in California, is gaining increasing attention not only because of the much reduced costs, but also because there is no persuasive evidence that the setting has any differential effect on patient outcomes. Robert I. Reynolds, administrator of the San Diego County program, reported, for example, that in contrast to inpatient rehabilitation, which costs $400 a day, the social recovery program costs $53 a day for detoxification in a residential setting and $33 for "primary recovery services." Al Wright of the Los Angeles County Department of Health Services said that a 42-bed county program costing $1.4 million had been shut down and the money was instead going to support eight nonmedical residential programs with 140 beds.

Many speakers expressed dissatisfaction with the high costs of inpatient programs, whose superiority have not been demonstrated, but which are becoming increasingly elaborate as droves of for-profit institutions have entered the alcoholism rehabilitation industry. Treatment costs would probably be offset far earlier if more carriers shifted the focus of coverage to outpatient services (those that cover rehabilitation are locked into the 28-day inpatient rehabilitation model). But research is still inadequate as a guide to future directions—existing studies tend to be too small, to lack control populations, and to have unrealistically short follow-up periods.

Gordis pointed out that effective treatment of alcoholism is still being inhibited at many levels by the stigma attached the disorder—in the demands for cost-benefit studies (which he said are more stringent than those generally required for purely medical problems), in failure to recognize the disease in medical patients, failure to refer recognized cases, and in the "skepticism many have about the efficacy of alcoholism treatment." He said a more sophisticated level of research is required to help identify subsets of alcoholics and match them with appropriate treatments. All we know for sure at this point, he said, is that "treatment of some sort is far better than doing nothing at all." ■ CONSTANCE HOLDEN

A second article will discuss research on the treatment of alcoholism.

Soviets Interested in Study on Economic Conversion

In 1984 the U.S.–U.S.S.R. Symposium on Conversion from Military to Civilian Economy met for the first time in Moscow. Tensions between the United States and the U.S.S.R. were running high then, and the Soviet government was undergoing internal change. Thus, there was no strong commitment on the part of Soviet officials to study ways of rolling back defense spending, related shifts in the two nations' economies, and planning needs for economic conversion. The symposium, an outgrowth of discussions initiated by American economist Seymour Melman in the early 1980s, subsequently fell dormant after the first meeting.

But now, Melman reports that there is renewed support in the Soviet Union for exploring economic conversion concepts. The Columbia University professor was in Moscow earlier this month to attend the International Forum for a Nuclear-Free World, For the Survival of Humanity. The event provided him with the opportunity to press Soviet officials to start a new U.S.–U.S.S.R. study effort on economic conversion. Georgy Arbatov, head of the Soviet's Institute of the USA and Canada, and officials of the State Planning Committee "have been strongly supportive of the idea," says Melman. "I have never before encountered this level of support for this line of work."

The heightened interest in shrinking the military-industrial complexes of the United States and U.S.S.R. Melman contends, stems from General Secretary Mikhail S. Gorbachev's goal of overhauling the U.S.S.R.'s economy. Melman left the Soviet Union on 17 February with the impression that demilitarization is an "indispensable part" of the government's plan for economic reconstruction.

Soviet interest in taking up the economic problem again was conveyed to Melman in recent meetings that included Yeugeny Primakov of the Institute of World Economy and International Relations, Deputy Foreign Minister Michael Petrovski, Vadim Kirichenko of the Economic Research Institute, and Arbatov. Melman predicts that discussions will begin within a year, but first an agenda for research and discussion must be worked out. The symposium likely will be sponsored by the American Council of Learned Societies and the Soviet Academy of Sciences.

Melman says he has discussed his activities with members of Congress. The Executive Branch, however, has not been briefed on his activities, he adds, because it has "shown no interest in the economic conversion perspective." Indeed, the idea would appear to run counter to the Reagan Administration's strong defense posture.

Since the mid-1960s, Melman has argued in numerous papers and books, including *Our Depleted Society* and *The Permanent War Economy*, that high defense expenditures have contributed to the erosion of industrial competence in the United States. He has called for a conversion from a military to a civilian economy. But, he notes that every president since John F. Kennedy has "followed the lead of the Pentagon in opposing such legislation." ■ MARK CRAWFORD