DOCUMENT RESUME

ED 288 170 CG 020 345

AUTHOR de Miranda, John
TITLE The Public Sector: A National Resource for Alcohol and Drug Treatment.
PUB DATE 87
NOTE 23p.
PUB TYPE Viewpoints (120)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Alcoholism; *Community Programs; Drug Abuse; *Drug Rehabilitation; *Prevention; *Public Agencies
IDENTIFIERS *Private Sector

ABSTRACT

Economic analysis of alcohol and drug treatment services usually focuses on understanding the private, profit-oriented, hospital-based setting. Professional publications of the alcoholism treatment field, as well as popular press and electronic media exposure, also focus heavily on the private system. Low cost, quality treatment services, however, are funded by all levels of government and are widely available. These public programs constitute a major national asset that parallels the private sector in scope and importance. The private and public sectors must work cooperatively to consolidate current gains in alcohol and drug treatment as groundwork for a permanent, integrated network of services. The network of community-based programs which comprise the public sector includes an eclectic array of providers that rely on the less costly, non-medical, social model approach to recovery. While the private sector focuses on treatment, the public sector targets significant resources at school-based and community prevention services. Such preventive activities can have a major impact on containing the progression of alcohol- and drug-related damages and, therefore, the costs to the health care system and society. The public treatment sector has provided substantial benefits to the public welfare. Careful planning and an appropriate commitment of funds are needed to continue the efforts of the public sector in alcohol and drug treatment. (NB)

THE PUBLIC SECTOR: A NATIONAL RESOURCE FOR ALCOHOL AND DRUG TREATMENT

John de Miranda, Ed. M.

While alcohol and drug treatment is available through either private or public sectors, economic analysis of treatment services usually focuses on understanding the private, profit-oriented, hospital-based setting. PPOs, HMOs, CONs and DRGs* comprise the alphabet soup commonly employed to discuss cost factors. The professional publications of the alcoholism treatment field focus heavily on private sector funding issues, and closely monitor third-party reimbursement developments.

Similarly, the private system garners the lion's share of attention from the popular press and electronic media. Hardly a week passes that we do not hear of yet another celebrity's rehabilitation at a private treatment center. Professionally developed advertisements dot the Sunday supplements, and television commercials promote attractive, costly treatment centers. While such extensive promotional advertising has done much to legitimize and destigmatize treatment of the alcoholic/

* PPO - preferred provider organization

HMO - health maintenance organization

CON - certificate of need

DRG - diagnosis related group

addict, it may also paint a distorted and one-sided picture of the recovery services available. The unsophisticated layperson could surmise from these sources that alcohol and drug rehabilitation is: (1) primarily available at private hospitals and expenseive free-standing centers, and (2) only available to individuals with superior health insurance or the ability to absorb treatment costs out-of-pocket. On the contrary, low cost, quality treatment services, funded by all levels of government, are widely available. These programs constitute a major national asset that parallels the private sector in scope and importance.

The health care marketplace is in massive flux and under enormous pressure to contain costs. Despite substantial gains in recent years, alcohol treatment is still only marginally accepted as an integral component of the health care continuum. The tenuousness of this position is evident in the current controversy over DRGs for alcohol treatment, as well as the erosion of treatment benefits for Federal employees. The public and private alcohol treatment sectors are at a crucial juncture, and must work cooperatively to consolidate current gains as groundwork for a permanent, integrated network that will last well into the 21st century. Leadership from both sectors must endeavor to develop a tiered, coordinated system of care that is planned and managed to incorporate the best elements of each sector.

Background

There is no doubt that current insurance reimbursement structures provide lucrative incentives for expansion of the private treatment system, and that chemical dependency treatment is a growth industry (Holden 1987; Weisner and Room 1984). As if to underscore the relationship between treatment and profitability, a current chemical dependency trade periodical carries a prominent display advertisement soliciting investment capital from "addiction professionals," including those "willing to invest skills against future earnings" (Alcoholism and Addictions Magazine 1987).

From its modest origins in Alcoholics Anonymous and other self-help/mutual aid organizations, alcohol treatment has mushroomed into a lucrative, multi-million dollar enterprise. Former director of the Berkeley, California-based Social Research Group, Don Cahalan, Ph.D., has observed the alcohol field's transformation for 25 years. He wryly concludes, "When there is major change at the State or Federal level, people naturally act to maximize what is in their best pecuniary interests. The early alcohol workers tended to be idealistic, much like the first preachers who went to Hawaii. They journeyed there to do good; their descendents stayed to do well!" Space does not permit a discussion of the increasing privatization of alcohol and drug treatment. Observers have commented on the adverse consequences of for-profit enterprises on the general health care system (Young 1984; Institute of Medicine 1986;

Califano 1986), as well as on the alcohol treatment system (Weisner 1983, 1986a, 1986b).

Despite the increasing size and growing importance of the private treatment system, there exists a parallel network of recovery services fueled by millions of dollars and responsible for helping thousands of Americans recover. This system, often unrecognized and underappreciated by the general public, is, of course, the publicly-funded, national network of prevention and recovery services. The public sector of services exists as a flexible yet resilient national resource that has served as a major bulwark against our omnipresent alcohol and drug problems. This network of community-based programs includes an eclectic array of providers that rely heavily on the less costly, non-medical, social model approach to recovery.

This community-based system became firmly established with the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. With this groundbreaking legislation Congress found that:

> It is the policy of the United States and the purpose of this Act to (1) approach alcohol abuse and alcoholism from a comprehensive community care standpoint, and (2) meet the problems of alcohol abuse and alcoholism not only through Federal assistance to the States but also through direct Federal assistance to

> community-based programs meeting the urgent needs of special populations and developing methods for directing problem drinkers from criminal justice systems into prevention and treatment programs (quoted in Glaser et al. 1978, p. 258). Emphasis added.

Although the public system has to date weathered extersive fluctuations in financing, the quest for permanent and secure funding remains a major issue now and for the future. A dilemma in this quest is the extent to which public sector programs should pursue clients whose financial resources include private health insurance and/or the ability to self-pay treatment fees. From a public policy standpoint, should this pursuit of middle class clients be deplored as a retreat from the historical mandate to provide care regardless of the ability to pay, or welcomed as the natural evolution of a system that must survive in an increasingly competitive, larger health care structure.

For example, according to Robert Reynolds, Alcohol Program Administrator for San Diego County, California (a leader in social model programming), the county has prohibited service providers from pursuing or accepting third-party health insurance payments for alcohol treatment. "These decisions were not made lightly, but were made recognizing that the current requirements of health insurance and credentialing systems will certainly destroy the efficiency, and perhaps the effectiveness, of our recovery service systems (Reynolds 1987, p. 1)." On the other hand, Carolina Jane', the Alcohol and Drug Program Manager for San Mateo

County, California, pioneered development of a project to increase the number of insured clients in county-supported programs "to offset some of the costs of the partial pay or no pay clients as well as to help upgrade facilities and staff salaries (Jane 1983, p. 3)." Before turning to this issue in more detail, a few observations about the public sector are in order.

The exact parameters of the public sector vary with the perspective of each observer. For present purposes, however, the public sector will be viewed as the formal and informal network of programs, agencies, and institutions that receive a substantial amount of operating revenue from Federal, State and/or local governmental sources. According to a recent report, allocations to programs that received "at least some funds administered by the State alcohol/drug agency" in fiscal year 1985 for treatment and prevention services totalled over $1.3 billion. Fully half of these monies are allocated from State general tax revenue. According to the National Association of State Alconol and Drug Abuse Directors, these funds were distributed to a total of 5,901 treatment units that admitted over 1.1 million alcohol and 305,360 drug clients (Butynski et al. 1986). More recently the same source estimated that in the year ending September 30, 1986, $1.6 billion was spent for publicly-funded alcohol and drug treatment and prevention services (Lewis 1987). These public sector programs are operated either directly by Federal, State, or local public health agencies, or through contract with private, community-based, largely non-profit agencies. Many of these agencies are

are direct descendents of the early volunteer and religious efforts which served alcoholics and public inebriates before government funding for such services became widespread in the 1970's.

Despite the size and importance of the public sector, little ongoing formal attention is paid to researching and analyzing its overall functioning as a major national resource. Robin Room, Ph.D., Director of the federally-funded Alcohol Research Group, says that a multitude of factors account for this omission:

- The increase in public sector alcohol funding came relatively late in the development of the modern welfare state. As a result, the system is "very entrepreneurial" and lacks the "systems consciousness" of more evolved structures such as mental health and criminal justice.

- Because of the nature of alcohol problems, the treatment system has always been a "marginal system" that has not coexisted comfortably with other systems. Room cites the statement of fellow researcher Ron Roizen that, "Alcoholics are too good to be in jail, but not bad enough to be in the hospital."

- The responsibility for alcohol funding is so diffused among different strata of government that no one level has ultimate authority for system-tending.

- The organization of State systems varies enormously from the highly integrated type evident in South Carolina, to the largely Balkanized system in California where local county government plays a major role in creating, defining and managing the alcohol and drug services system for its particular community.

- The shift to block grant funding at the Federal level in 1981 reduced the importance of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as an overarching, national presence. This concomitantly reduced the system-building capabiltiy of NIAAA that had been so vital in the public sector expansion of the 1970s.

Room also notes, "Funding research into developments within the public alcohol system usually carries a low priority for funding sources. Rarely is money forthcoming except in reaction to a social problem. The investigations that do occur tend to take place at the edges of the work for which researchers are funded" (Room 1987).

Prevention as Cost Containment

Any discussion of the economic costs of alcohol and drug problems or containing the actual costs of treatment must highlight the importance of prevention and early intervention activities. Unlike the private sector, the public sector targets significant resources at school-based and community prevention services. Major campaigns to create public

awareness of problems such as alcohol-related birth defects and adolescent drinking driving are for the most part launched and maintained with public dollars. In addition, progressive public policy prevention initiatives (i.e., alcohol server intervention, curbs on marketing and promotion, and increased taxes on alcoholic beverages, etc.) are usually advocated by leadership from the public sector. Such activities have a major impact on containing the progression of alcohol and drug-related damages, and, therefore, the costs to the health care system and society as a whole.

Cooperation or Competition

The public and private systems are inextricably linked, and partake of a complex symbiosis that both nourishes and at times threatens each. The public sector system has historically provided the infrastructure that underpins the more visible and glamorous private network of services. Ironically, the private system of the 1980s owes much of its economic robustness to Federal strategies during the 1970s designed to "mainstream" alcohol treatment into the traditional health care system. This activity was intended to legitimize the disease concept of alcoholism and pave the way for access to third-party reimbursement (Rodwin 1982). This effort, initiated by NIAAA not long after its inception as a result of passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention and Treatment Rehabilitation Act, has been so successful that

currently at least 37 states either mandate provision of alcoholism treatment benefits and/or require insurance providers to offer such benefits for purchase. Similarly, research by Gail A. Jensen of the University of Illinois attests that 68.5% of private sector employees are covered by an alcoholism benefit, compared to 36.2% in 1982 (Jensen 1987).

Although often viewed as secondary or inferior, the public system regularly provides major benefits to the private system. For example, the career ladder of many addictions professionals often begins with entry-level employment at a drinking driver program or community-based recovery home. A period of apprenticeship or "dues paying" ensues, during which the individual accrues direct experience, a network of colleagues, and perhaps additional formal education. Finally, armed with sufficient credibility and credentials, the upwardly mobile professional is able to secure a position in the private system at a higher salary level with substantially improved finge benefits and "perks."

Our systems of triage often serve to maintain a dual track treatment structure, in which public programs are viewed as largely the choice of last resort for those without financial means. Conversely, private sector programs are often seen as the treatment-of-choice even by public sector workers. Publicly funded information/referral services and school-based prevention/education porgrams have traditionally served as a major, no-cost referral source for the private system. Callers to

public sector "help lines" in need of treatment are routinely screened to determine levels of insurance coverage before a decision is made regarding optimal referral. While there may be a natural tendency to refer clients to the most expensive level of service for which they are financially qualified, this process of automatically directing paying clients to private programs is ultimately not in the best interest of the larger public system, since fee-paying clients are increasingly necessary to the fiscal stabilty of public programs. Also, an assumption that private, profit-driven treatment programs are better or more effective carries the correlative judgment that public programs are somehow inferior. In recent years, some public systems have ceased referring to private hospitals unless specifically requested. This policy of enlightened self-interest and referral of paying clients to other public programs further requires that referral seekers and the larger community be educated as to the quality, availability, and cost of the community-based, publicly-funded services that are offered as an alternative to the private system. To this end aggressive marketing and self-promotion have become important elements of many public programs. Accessing paying clients also necessitates that public programs develop the capability of accessing third-party reimbursement, a complex and controversial undertaking.

In recent years there has been increasing direct competition between public and private programs for self-pay and third-party insured clients (de Miranda and Lampe 1985; Jacob 1985; Weisner 1986a, 1986b;

Weisner and Room 1984). Public sector funding has decreased at the Federal level due to the shift to block grants, and at the State and local levels because of politically-driven austerity budgeting. To make up for the shortfall, some public regulatory agencies have encouraged and/or required public programs to access third party reimbursement (California Department of Alcohol and Drug Programs 1982; State of New York 1987). Common sense survival also dictates movement in this direction, since without a diversified revenue base that includes substantial private pay or third-party fees, these community-based services become increasingly subject to the political and fiscal whims of their governmental funding agencies.

It is difficult to determine how successfully public programs have accessed third-party reimbursement. One report suggests that third-party collection for State systems with early mandate legislation (i.e., legislation requiring alcohol treatment benefits) is as high as 30 to 40 percent of all funding (Jacob 1985). This is a substantial increase from 1978 when NIAAA reported that "private reimbursements accounted for only 3.2 percent of total expenditures for public sector treatment centers (Regan 1981)." Arguably, the permanent security of the public sector alcohol and drug treatment system may be dependent on its ability to access third-party reimbursement.

Barriers to Third-Party Reimbursement for Public Sector Programs

Efforts to gain reimbursement for public programs are hindered by a variety of factors. Employers, insurers and public sector providers maintain different concerns about the desirability and practicality of third-party reimbursement.

EMPLOYERS & INSURERS. Although attracted by the possibility of substantial cost savings (a residential treatment regimen at a community-based program can be one-half to one-third the cost of a private program), occupational referral sources sometimes view community-based programs as qualitatively inferior. They are concerned that staff experience and qualifications do not measure up to the private sector, and that poorly maintained physical facilities will dissuade clients from participation. Similarly, they fear that public sector programs will not adequately comply with the often complex information reporting needs of the referring organization or insurance company. Employee assistance professionals are also wary that the non-medical and self-help approaches of many community providers will hamper ongoing efforts to convince their corporate superiors of the disease concept of addiction. In addition, referral sources and potential clients are cautious, since public sector programs are viewed as primarily oriented towards indigent clients and the public inebriate.

A natural affiliation is developing between community-based recovery programs and some labor union-based member assistance programs. Union officials find that social model oriented public sector programs are both cost effective and idealogically compatible with the orientation of their "blue collar" and middle class members. In addressing a national conferernce on alcohol treatment and cost containment Bill Healy, Director of the Member Assistance Program of the United Food and Commercial Workers Union stated, "We prefer to use, and actively seek out social model programs for our members in need of treatment. We are getting away from alcohol and drug treatment in acute care hospitals, because we are tired of paying for other beds on other floors (Healy 1987)."

Insurance carriers are likewise concerned about issues of program quality, and lack familiarity with alternatives to hospital-based treatment. Long accustomed to the quality assurance procedures of the Joint Commission on the Accreditation of Hospitals (JCAH) and the Commission on Accreditation of Rehabilitation Facilities, insurance companies that wish to pay for public sector programs must learn the regulatory and credentialing processes of State and local government. Finally, as is the case with most attempts to expand insurance benefits, carriers are concerned that utilization of community-based providers will ultimately result in increased costs unless offset by additional premiums.

PROGRAM PROVIDERS. Community-based agencies often assume that third-party reimbursement is patently impossible, and the sole preserve of the private treatment sector. Similarly, they fear that pursuit of occupational referrals and conversion to a fee-for-service model will require major program revisions including excessively burdensome record-keeping requirements. Some insurance companies require that claims include documentation that medical professionals are directly involved in treatment. Such medicalization of the recovery process is often viewed as antithetical by social model practitioners, who emphasize self-help principles and experiential knowledge in the recovery process. In addition, public sector programs often lack the business acumen and marketing savvy to negotiate successfully with employers and insurers. Finally, there is legitimate concern that aggressive pursuit of a middle-income clientele will deflect from their historic mission to serve all without regard for ability to pay and to meet the needs of court-mandated clients. Indeed, Cahalan's distinction between "doing good" and "doing well" presents a serious conflict for many public sector programs.

To compound the matter, regulatory agencies have sometimes provided contradictory directives by both requiring public programs to pursue private fees, while demanding that full attention be paid to indigent and low income clients (Jacob 1985; Weisner and Room 1984).

Conclusion

The future role of the public sector will be shaped as the alcohol and drug fields wrestle with several important public policy considerations:

- Is the public interest served by allowing, and indeed stimulating, direct competition between public and private sector treatment systems?

- Is revenue generation through third-party reimbursement a legitimate method of stabilizing the fiscal base of public sector programs, or should government sources provide additional permanent funding to increase the level and quality of services targeted at poor and low income clients?

- How can the public and private sectors begin working towards creation of fully integrated and purposefully coordinated treatment systems at the community, State, and Federal levels?

- Should research priorities be expanded to include significant examinations of the functioning and interrelationship of the public and private systems?

Throughout its short history, the public treatment sector has provided substantial benefits to the public welfare. As with all valuable, national resources efforts to conserve, preserve, and strengthen must be ongoing. With foresight, careful planning and an appropriate commitment of funds, this resource should continue to serve us well into the 21st century.

References

Alcoholism and Addictions Magazine, March/April 1987, p. 48.

Butynski, W., Record, N. and Yates, J. State Resources and Services Related to Alcohol and Drug Abuse Problems: Fiscal Year 1985. A Report for the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, Washington: National Association of State Alcohol and Drug Abuse Directors, May, 1986.

Calahan, D. Personal interview, May 5, 1987.

Calahan, D. Understanding America's Drinking Problem: How to Combat the Hazards of Alcohol. San Francisco: Jossey-Bass, forthcoming.

Califano, J. America's Health Care Revolution. New York: Random House, 1986.

California Department of Alcohol and Drug Programs. Alcohol Program Certification and Third Party Payments. Publication No. ADP 82-13. Sacramento, CA: Health and Welfare Agency, 1982.

de Miranda, 17, and Lampe, M. Employee assistance cost containment through utilization of community-based social model treatment providers. Paper presented at the 1985 National Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism, Boston, MA, 1985.

Glaser, F.; Greenberg, S.; and Barrett, M. A Systems Approach to Alcohol Treatment. Toronto: Addiction Research Foundation, 1978.

Healy, B. Presentation at national conference. "The Alcohol Piece in the Health Care Cost Containment Puzzle." University of California-San Diego. Feb. 22 - 24, 1987.

Holden, C. Is alcoholism treatment effective? Science. Vol. 236: 20 - 22, April 3, 1987.

Institute of Medicine. For Profit Enterprises in Health Care. Washington: National Academy Press, 1986. Cited in: Gray, B. and McNerny, W. "The Institute of Medicine Study." New England Journal of Medicine, 314, No. 23, 1523 - 1528, June 6, 1986.

Jacob, Olive. Public and Private Sector Issues on Alcohol and Other Drug Abuse: A Special Report with Recommendations. Rockville, MD: Alcohol, Drug Abuse and Mental Health Administration, October 1985.

Jane, C.R. Third party project. San Mateo, CA: Department of Health Services, 1983.

Jensen, G. "Employers' initiatives to control health benefit costs." Presentation at national conference "The Alcohol Piece in the Health Care Cost Containment Puzzle." University of California-San Diego. February 22-24, 1987.

Lewis, J. The Alcoholism Report, Vol. 15, No. 14, May 12, 1987.

Regan, R.W. The role of Federal, State, local and voluntary sectors in expanding health insurance coverage for alcoholism. Alcohol Health and Research World 5(4): 22 - 26, 1981

Reynolds, R.I. Opening remarks. The Alcohol Piece in the Health Care Cost Containment Puzzle, Proceedings. La Jolla, CA: University of California-San Diego, 1987.

Rodwin, V. "Health insurance and alcohol treatment services: A strategy for change or a buttress for the status quo?" Working paper, Berkeley, CA; Alcohol Research Group, 1982.

Room, R. Personal interview, May 4, 1987.

State of New York, Guidelines for Development of Alcoholism and Alcohol Abuse Programs 1987 - 88. Albany: N.Y.: Division of Alcoholism and Alcohol Abuse, March 1987.

Weisner, C. The social ecology of alcohol treatment in the United States. In Galanter, M., ed., Recent Developments in Alcoholism, Volume 5. New York: Plenum, 1986a. pp. 203 - 243.

Weisner, C. The transformation of alcohol treatment: Access to care and the response to drinking-driving. Journal of Public Health Policy. 78 - 92, Spring 1986b.

Weisner, C. The alcohol treatment system and social control: a study in institutional change. Journal of Drug Issues 117 - 133, Winter 1983.

Weisner, C., and Room, R. Financing and idealogy in alcohol treatment. Social Problems, 32(2): 167 - 183, 1984.

Young, Q. Impact of for-profit enterprises on health care. Journal of Public Health Policy. 449 - 452, December 1984.

John de Miranda, Ed. M., is a consultant to the San Mateo County Alcohol and Drug Program, San Mateo, CA, and Director of Peninsula Health Concepts, 382 Forest View Drive, South San Francisco, CA 94080.