

Signatories

JudyAnn Bigby, M.D.

*Harvard Medical School
Brigham & Women's Hospital*

William Butynski, Ph.D.

*National Association of State Alcohol and
Drug Abuse Directors, Executive Director*

Lloyd C. Elam, M.D.

*Meharry Medical School
Professor and Past President*

Anne Geller, M.D.

*College of Physicians and Surgeons of
Columbia University
Director, The Smithers Center*

Antonnette Graham, Ph.D.

*Case Western Reserve University
Medical School
Chair, Substance Abuse Committee,
Society for Teachers of Family Medicine*

Jean Kinney, M.S.W.

*Dartmouth Medical School
Project Cork Institute*

C. Everett Koop, M.D.

*Dartmouth Medical School
Senior Scholar, C. Everett Koop Institute*

David C. Lewis, M.D.

*Brown University Medical School,
Center for Alcohol and Addiction Studies*

Trevor R. P. Price, M.D.

*Medical College of Pennsylvania
Alleghany General Hospital*

Frederick Robbins, M.D.

*Nobel Laureate
Case Western Reserve University
Medical School*

David Satcher, M.D., Ph.D.

*Meharry Medical School
President*

Louis Sullivan, M.D.

*Moorehouse School of Medicine
President*

Anne Vance, R.N.

*The Betty Ford Center
Director of Training and
International Consultations*

George E. Vaillant, M.D.

Harvard Medical School

James West, M.D.

*Medical Director, Emeritus
The Betty Ford Center*

Peter C. Whybrow, M.D.

*Ruth Meltzer Professor and Chair
Department of Psychiatry
University of Pennsylvania*

**Statement
to**

**THE PRESIDENT'S
TASK FORCE
on
NATIONAL
HEALTH CARE REFORM**

**Alcohol, Nicotine
and
Other Drug Problems**

April 2, 1993

Alcohol, Nicotine, and Other Drug Problems

Alcohol, nicotine, and other drug problems constitute one of our nation's most significant health problems. Beyond the personal costs to individuals, their families, neighborhoods, and communities, undiagnosed and untreated substance abuse and dependence generate excessive and avoidable health care costs. Alcohol, smoking and other drug problems are estimated to account for 25% of the national health care budget.

Substance use problems are far more significant for licit drugs—alcohol and tobacco—than illicit substances. It is important to recognize also that while dependence (addiction) has a special toll, serious consequences can also arise from high-risk use, such as adolescent drinking and driving.

We recognize as well that substance use is tied to multiple social problems, interwoven through the fabric of virtually all of our nation's major social concerns—be it excess morbidity and mortality, especially among racial and ethnic minorities; the phenomenon of homelessness; adolescent suicide; accidents; traffic fatalities; homicide; domestic violence; school dropouts; the crisis of AIDS; unwanted pregnancy; sexually transmitted diseases; the disintegration of urban communities.

It has been clearly demonstrated that alcohol and other drug abuse treatments are cost effective. Treatment reduces health care costs not only for individuals but also for their families. It is imperative that any health care reform make provisions for treatment of alcohol and other drug problems to realize these health care savings.

It is especially important to provide for early identification, intervention, and risk reduction. Given the low rates of diagnosis of substance abuse and dependence in medical encounters, efforts must be directed to assure the needed provision of appropriate care. Thus, we propose that the following principles be incorporated in any health care reform, independent of the methods of payment adopted.

Health Care Benefits for Alcohol, Nicotine, and Other Drug Problems

1. *Include coverage of preventive services.*

The recently released AMA "Guidelines for Adolescent Preventive Services" recommends that health care coverage should include an annual preventive visit. Preventive counseling, personalized patient education, and risk reduction efforts must be similarly provided to all age groups, within the context of providing clinical care. The U.S. Preventive Services Task Force has identified the periodic health visit as an important opportunity to deliver such clinical preventive services, and emphasizes that alcohol, nicotine and other drug problems be specifically addressed.

2. *Include coverage for assessment, diagnosis and referral, and formal treatment.*

Screening and case finding are cost effective when prevalence of a disease is high, the cost of screening low, and early intervention is effective. Problems of substance use meet these criteria. These services are central to the optimal management of chronic illness.

3. *Assure a uniform standard of care for all health care delivery systems.*

This includes services and programs conducted by the Veterans Administration, the programs of the Public Health Service, the Department of Defense, CHAMPUS, and state and federal corrections systems.

4. *Adopt procedures to assure provision of appropriate care.*

To date the health care system has failed to adopt easily administered, low cost, non-technologically based procedures to screen for alcohol and other drug problems. Nor have there been effective referrals for treatment when such a problem is identified. At best, it is estimated that only 30% of alcoholics are diagnosed. Of these only one-quarter are referred for treatment. Thus, appropriate care is provided to less than 10% of those seen. There is no other major medical condition for which there is a comparable absence of diagnosis and failure to initiate care.

We recognize that we are entering an era of managed care and cost containment. Discussions to date have focused largely upon the need to limit access to care, and to eliminate inappropriate and unwarranted care. Absent from this discussion is using these same mechanisms to *promote* provision of services with a demonstrated ability to prevent future medical problems, thereby reducing future health care costs. Such services are exemplified by childhood immunizations and prenatal care. Alcohol, nicotine, and other drug abuse screening, risk reduction efforts, early diagnosis and referral, and treatment have a similar beneficial impact.

5. *Reimburse alcohol, nicotine, and other drug abuse treatment in a manner consistent with other chronic medical illnesses.*

Limits on reimbursement for care of alcohol, nicotine, and other drug dependence are no more appropriate than are limits for care of other chronic medical conditions, such as diabetes, hypertension, or renal disease. If caps are placed upon treatment benefits, there is the clear likelihood that the result will not be cost savings, but a transfer of costs—whether for coverage of the inevitable associated illnesses and trauma—or a transfer of costs to the criminal justice and human services systems.

Rise in Health-Care Costs is Linked to Social Behavior

Chicago, Feb 22 (Reuters). Of the \$666 billion that Americans spend each year on health care, nearly one dollar in four goes to treat victims of drug abuse, violence and other kinds of social behavior that can be changed, the American Medical Association said in a study released today.

Such behavior, including alcohol and tobacco use, is adding \$171 billion a year to the nation's health-care bill, the report concluded. . . .

'We cannot successfully resolve our current health care crisis unless we are willing to alter damaging patterns of behavior,' said Daniel Johnson speaker of the Association's House of Delegates. . . . 'President Clinton is absolutely correct that our health-care system must become cost effective,' Mr. Johnson said. 'Every person can make a difference in battling run-away costs by adopting a healthier life style.'

New York Times

Sect. C, p 3. Feb 23, 1993

— Upon release of AMA Report —

Factors Contributing to the Health Care Cost Problem

Alcohol, nicotine, or other drug dependence is not a bad habit. It is a chronic disease.

The figures cited in the above referenced AMA report may be the most current and up-to-date. However, the report is grossly deficient in its understanding of the nature of the phenomenon responsible for virtually one-quarter of health care costs. These health care costs are not the result of thoughtless citizens who are not *choosing* or *adopting* a healthier lifestyle" and who are not *willing* to alter damaging behavior."

On the contrary, reduction in health care costs will only be realized when the medical community begins to address alcohol, nicotine, and other drug use from a perspective suitable to management of chronic illness.

A few relevant facts.

- 20% of the total U.S. population consumes 80% of all alcohol. More significantly, 7% of the population consumes 50% of all alcoholic beverages. [1]¹
The majority of these individuals are not "social drinkers" nor persons with "poor" health habits. This represents those with dependence or abuse as well as high-risk use, all of which warrant intervention.
- The adolescent who smokes from 4-5 cigarettes is at very substantial risk of embarking upon several decades of smoking. [2]²
There are exceedingly few "social" or "recreational" smokers.
- Alcohol abuse and dependence is the most common chronic illness between the ages of 18-44; drug abuse and dependence is the second. They are three and two times more common than arthritis, which is third.
After age 44, the prevalence for alcohol or drug abuse and dependence is less than that for arthritis, heart disease, and hypertension. However, both chronic alcohol use and smoking are significant contributing factors to these conditions. [3-6]³⁴⁵⁶

Current Standards of Medical Care

Care of those with alcohol or other drug dependence is sorely inadequate as outlined below. The diagnosis of dependence is made in a minority of cases seen by physicians. Of those diagnosed only a fraction are referred for treatment. When a diagnosis is made it is generally after dependence is well established, and symptoms of late stage alcohol or drug dependence are present.

Care for Substance Abuse Problems "too little, too late, by too few"

Absence of Health Care Education, Preventive Counseling and Risk Reduction

Because 80% of the U.S. population visits a physician each year, physicians have a unique opportunity to engage in efforts to modify the health-risk behavior of their patients. A survey in one state (North Carolina) explored the frequency of physicians' engaging in education, counsel and referral of patients who smoke, abuse drugs or alcohol, or have diet and nutritional problems.

While virtually all physicians indicated that physicians should assist asymptomatic patients in reducing risks of future problems, in practice this was not the case. Among physicians who routinely provide risk-reduction interventions in 80% of their patients, their interventions in these areas were significantly lower. [7]⁷

Discussion of:	Smoking	50%
	Drug use	50%
	Alcohol use	31%
	Diet & nutrition	20%

The rate is substantially below that targeted by the National Health Promotion and Disease Prevention Objectives for the Year 2000.

Failure to Take or Record an Alcohol/Drug Use History

Physicians frequently fail to take an alcohol/drug use history or to record it in the medical chart. This is not only required to assess a potential substance abuse problem. It is essential for provision of good medical care.

- Chart reviews of hospitalized patients indicate that the percentages of records without an alcohol/drug use history ranged from 63% to 54% to 22%. [8,9]⁸⁹
- In ambulatory care an alcohol/drug use history is even less common. Among patients seen for physical examinations, 59% were not asked about alcohol or other drug use. Of patients seen for limited visits, only 4% were asked. [10]
- Although only 17% of the population, those over age 60 account for 51% of all deaths from drug reactions. A significant portion are attributed to drug mismanagement. [11] The ten most commonly prescribed medications interact with alcohol, as do one-half of the 100 most commonly prescribed. [12]¹⁰

Rates of Detection

- Multiple studies have shown that, at best, physicians diagnose alcohol and other drug dependence in less than 30% of cases that present to them. [13]¹¹

Rates of Referral for Formal Treatment and to AA

- Physicians make an effort to initiate treatment in only 25% of patients diagnosed with an alcohol or other drug problem. [13]

- Among AA members only 7% credit their physicians as having been responsible for the initial contact with AA.
36% credit another AA member; 36% cite counseling or "rehab"; 27% report "On my own"; 19% identify the family; and last is "my doctor," 7%. [14-15]¹²¹³

Proportion of Cases Entering Treatment

The low rate of detection combined with the low rate of referral means that in all likelihood fewer than 10% of all cases of alcohol or drug abuse seen by a physician receive adequate care.

Absence of Early Diagnosis

Diagnosis, if and when it occurs, is generally delayed until the condition is well established. [16, 17]

- A major study found that after the point of having had four life-time problems related to alcohol use, virtually all patients meet criteria for diagnosis of alcohol dependence. However, the diagnosis was typically made by their physicians only after 8-11 alcohol-related problems had occurred. [16]
- Among referrals for treatment generated by an employee assistance program, of those who had seen their physicians in the preceding year, only 22% recalled any warnings or discussion about their drug and/or alcohol use. [17]
- Those who recalled a physician's discussion were those with obvious medical complications, such as liver disease or a history of major withdrawal. [17]¹⁴
- A score of 5 on a common screening test is indicative of alcohol dependence. Physicians, however, were most likely to make a diagnosis for patients who score 29 or higher. [18]¹⁵
- By way of comparison, when an alcohol or drug problem is suspected, a family member, friend, or acquaintance is more likely to address it than is the physician. [19]

The Consequences of Late Diagnosis

The failure to discuss and attempt to intervene is unfortunate. The potential for early treatment, which is less costly and has a better prognosis, is lost. Also, physician interventions can be a major impetus to entering care, and may be an important factor in treatment outcome.

- Of employee assistance referrals for treatment, those who recalled a physician's warning had better treatment outcomes. [17]
- Among a group of patients with prescription drug abuse, 25% terminated use on the basis of a brief discussion or a letter from their physician instructing them to do so. [18]¹⁹[20]
- Several studies have examined what prompts heavy drinkers to cease alcohol use without benefit of formal treatment. Serious illnesses or accidents are mentioned by one-third as instrumental. [21, 22]¹⁷¹⁸

A Basis for Optimism

- There is no other chronic disease more responsive to treatment than alcohol and drug dependence. The prognosis is far brighter for treated alcohol and other drug problems than is the prognosis, for example, for those with juvenile diabetes or renal disease.
- There are many effective interventions; we are not forced to await a "scientific breakthrough" to improve care.
- We are not dependent upon sophisticated and expensive technology to treat these problems.
- We need only apply what we know is effective.

Resources.

Over the past two decades a strong foundation has been laid to educate providers and to improve clinical care. Clinical research and educational initiatives have been mounted by The National Institute on Alcohol Abuse and Alcoholism and The National Institute on Drug Abuse in concert

with private foundations and professional associations. Model curricula have been developed for a variety of health care professionals. Clinical guidelines and minimum standards have been articulated.

Barriers.

A number of barriers to physician involvement with substance abuse problems have been identified. [23] These range from the lack of adequate training for many physicians now in practice, to physician pessimism about the benefits of treatment, to the nature of medical training, which continues to focus upon treatment of complications rather than early intervention, as well as the failure of the health care system to reimburse physicians adequately for clinical counseling, risk reduction and early interventions.

Setting Standards.

Beyond adequate reimbursement it is essential that health care institutions adopt standards for care, monitor the quality of the care provided to patients, and have qualified treatment personnel available to assist staff.

Despite the obstacles noted, relatively modest *changes in the systems of health care delivery* in which the physician practices can make a significant difference. A small community hospital adopted a 4-question alcoholism screening test as part of its standard procedures; the rate of detection and diagnosis increased markedly. [24] Hospitals with substance abuse teams or consultation services available to assist staff diagnosis and make appropriate referrals for care have a similar impact. [25, 26]

While health care teams are common in management of chronic diseases, analogous resources are not widely available to assist in the care of patients with substance abuse problems. For example, for a diabetic patient, the physician has access to a nutritionist, a patient educator, a podiatrist, as well as medical specialists. For management of substance abuse, physicians are, too often, left to their own devices.

As we embark upon health care reform, we cannot afford continuing to treat smokers, or individuals with alcohol or other drug problems as the "undeserving ill." We cannot afford continuing to ignore early detection and treatment. We cannot afford delaying diagnosis until problems of substance abuse are long-standing and accompanied by major medical complications. The costs to our society are too great.

Table 1

Prevalence of Drug Use¹⁹

Alcohol and tobacco are the most widely used drugs in America; two-thirds of the population drink and one-third are smokers. While the rates of smoking are declining, alcohol use remains stable. These licit drugs represent our major drug use problem. In comparison, only 6% of the population uses drugs other than nicotine and alcohol. [27]

Type of Drug	Millions of People	% of Population
Alcohol	105.8	53.4
Nicotine	57.1	28.3
Marijuana	11.6	5.9
Cocaine	5.8	4.1
Crack	.5	.2
Stimulants	1.7	.9
Analgesics	1.1	.6
Tranquilizers	1.2	.6
Inhalants	1.2	.6

Sedatives	.8	.4
Hallucinogens	.8	.4

Table 2

Lifetime Prevalence of Abuse and Dependence

It is commonly estimated that among drinkers, one out of ten persons will develop alcohol abuse or dependence. For smokers, smoking beyond 4-5 cigarettes as teenagers places individuals at substantial risk for addiction and being smokers for several decades. [2]²⁰

Alcohol and Other Drug Abuse/Dependence by Age Groups [5,6]²¹

	Prevalence	Age groups
Alcohol	Other Drugs	
13.60 %	13.5 %	18-24 years
17.80 %	8.2 %	25-44 years
12.10 %	.6 %	45-64 years
6.50 %	.075	65 years +

Dependence upon any single drug substantially increases the likelihood of dependence upon another drug. Smokers are estimated to be 10 times more likely to also be alcohol dependent than are non-smokers. Conversely, alcoholics smoke significantly more than non-alcohol dependent persons. Most descriptive studies of alcohol abusers published in the past 20 years have reported tobacco use rates of at least 90%. [28] Seven times fewer alcoholic smokers (7%) are successful in attempts to quit smoking compared to 49% of the nonalcoholic smokers. [29]²²

Use of illicit drugs is generally accompanied by alcohol and nicotine dependence. For example, among heroin addicts, smoking and drinking is found in two-thirds of the cases. Marijuana is the next most commonly drug used, with use of benzodiazepines more common in the later stages of chronic drug use. [30]²³

Table 3

Prevalence of Chronic Illnesses

Alcohol Abuse/Dependence and Other Chronic Conditions [5, 6]^{24,25,26,27}

Chronic Condition	Total	Rate per 1,000 Persons	
		18-44 yrs	45-64 yrs
<i>Alcohol abuse/dependence</i>	136.0	164.5	122.0
<i>Drug abuse/dependence</i>	74.6	108.5	33.6
Arthritis	127.3	48.9	253.8
Hypertension	113.6	56.0	229.1
Heart conditions	75.9	36.1	118.9
Chronic bronchitis	49.2	44.5	53.7
Asthma	47.2	41.3	41.8
Diseases of urinary system	28.5	30.1	38.1
Diabetes	26.6	10.7	58.2

References

1. National Institute on Alcohol Abuse and Alcoholism. *The Public Health Approach To Problems Associated With Alcohol Consumption: A Briefing*. Rockville MD: NIAAA, 1980.
2. Russell MAH. The nicotine addiction trap: A 40-year sentence for four cigarettes. *British Journal of Addiction* 85(2): 293-300, 1990.
3. National Institute on Alcohol Abuse and Alcoholism. *Seventh Special Report to the U.S. Congress on Alcohol and Health*. Rockville MD: NIAAA, 1990.
4. National Institute on Alcohol Abuse and Alcoholism. *Toward a National Plan to Combat Alcohol Abuse and Alcoholism: A Report to the U.S. Congress*. Rockville MD: NIAAA, 1986.
5. Robins LN; Helzer JE; et al. Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry* 41: 949-958, 1984.
6. *Statistical Abstract of the United States, 110th Ed.* Washington DC: Bureau of the Census, 1992.
7. Dever J; Kalsbeek W; et al. Counseling practices of primary care physicians: North Carolina, 1991. *Morbidity and Mortality Weekly Report* 41(31): 565-568, 1992.
8. Hamilton MR; Menkes DB. How alert are hospital doctors to alcohol misuse among acute orthopaedic patients. *New Zealand Medical Journal* 105(33): 167-169, 1992.
9. Mitchell WD; Thompson TL; et al. Underconsultation and lack of follow-up for alcohol abusers in a university hospital. *Psychosomatics* 26(6): 431-437, 1986.
10. Woodall HE. Alcoholics remaining anonymous: Resident diagnosis of alcoholism in a family practice center. *Journal of Family Practice* 26(3): 293-296, 1988.
11. Office of the Inspector General. *Drug Utilization Review*. Washington DC: Department of Health and Human Services, 1989.
12. Scott RB; Mitchell MC. Aging, alcohol and the liver. *Journal of the American Gerontology Society* 36(3): 225-265, 1988.
13. A review of the literature was conducted and results summarized. Citations available upon request.
14. Alcoholics Anonymous World Services, Inc. *Comments on A.A.'s Triennial Surveys*. New York: Alcoholics Anonymous World Services, Inc., 1990.
15. General Services Office of Alcoholics Anonymous. AA Surveys Its Membership: A Demographic Report. *About AA: A Newsletter for Professional Men and Women*. Fall, 1987.
16. Vaillant GE. *The Natural History of Alcoholism*. Cambridge MA: Harvard University Press, 1983.
17. Walsh DC; Hingson RW, et al. The impact of a physician's warning on recovery after alcoholism treatment. *Journal of the American Medical Association* 267(5): 663-667, 1992.
18. Dawson NV; Dadheech G; et al. The effect of patient gender on the prevalence and recognition of alcoholism on a general medicine inpatient service. *Journal of General Internal Medicine* 7(1): 38-45, 1992.
19. Room R. The U. S. general population's experiences of responding to alcohol problems. *British Journal of Addiction* 84(11): 1291-1304, 1989.
20. Cormack MA, Owens RG, et. al. The effect of minimal interventions by general practitioners on long-term benzodiazepine use. *Journal of the Royal College of General Practice* 39(327): 408-411, 1989.
21. Ludwig AM. Cognitive processes associated with spontaneous remission. *Journal of Studies on Alcohol* 46(1): 53-58, 1985.
22. Tuchfield BS. Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol* 42(7): 626-641, 1981.
23. Lewis DC; Faggett WL. *Policy Report of the Physician Consortium on Substance Abuse Education*. Rockville MD: Department of Health and Human Services, 1991.
24. Graham AW. Screening for alcoholism by life-style risk assessment in a community hospital. *Archives of Internal Medicine* 151(5): 958-964, 1991.
25. Lewis DC; Gordon AJ. Alcoholism and the general hospital: The Roger Williams Intervention Program. *Bulletin of the New York Academy of Medicine* 59(2): 181-197, 1983.
26. JudyAnn Bigby, M.D., Boston MA. Personal Communication.
27. National Institute on Drug Abuse. *The national household survey of drug abuse: Populations Estimates 1988*. Rockville MD: NIDA, 1991.

28. Bobo JK. Nicotine dependence and alcoholism epidemiology and treatment. *Journal of Psychoactive Drugs* 21(3): 323-329, 1989.
 29. DiFranza JR; Guerrera MP. Alcoholism and smoking. *Journal of Studies on Alcohol* 51(2): 130-135, 1990.
 30. Navaratnam V; Foong K. Adjunctive drug use among opiate addicts. *Current Medical Research Opinion* 11(10): 611-619, 1990.
-