

Medical Care Cost Offset Effects

Skip Robinson Ph.D.

Recent thought about mental health care cost-effectiveness, especially in conjunction with the healing of a physical condition or conditions

Some evidence that a healthy outpatient psychotherapy benefit can cost-effectively promote healing

And concluding with a list of categories of medical treatment in which outpatient psychotherapy has been reported to lower medical treatment costs

Introduction

Fuller (1995) says: "Untreated psychiatric and substance use disorders are responsible for a significant percentage of health care expenditures." Among its many virtues, good mental health treatment appears to significantly reduce medical care costs for the client. (Cummings & VandenBos (1981); Fries, Koop, Beadle, et al (1993); Goldberg, Krantz, & Locke, 1970; Hankin, Kessler, Goldberg, Steinwachs, & Starfield (1983); Jones & Vischi (1978); Mumford, et al, 1984, p. 1152)Mumford, Schlesinger, & Glass (1978); Vasquez-Barquero, Wilkinson, Williams, Diez-Manrique, & Pena (1990) As an example, "(e)ighty five percent (of 58 studies of effects of outpatient psychotherapy on subsequent medical care utilization chosen for a meta-analysis) reported a decrease in medical utilization following psychotherapy." (Rosen & Wiens, 1979)

Substantial studies have developed evidence that the reduction in costs stimulated by the cost offset effect may be substantially greater than the costs of outpatient psychotherapy treatment, presenting the plan as a whole with net savings. (Cummings (1981); Friedman, Sobel, Myers, Caudill & Benson (1995); Fuller (1995); Holder & Blose (1987); Sauber (1997, p. 24)

Antiquity

Galen over 2000 years ago pointed out that, as he understood matters, 60% of all persons visiting a doctor suffered from symptoms that were caused emotionally, rather than physically. (Shapiro, 1971)

Thought on offset in the recent years

I remember sitting in my office in downtown Oakland looking out my sunny morning window and being handed a copy of a new research article, "Reduce health care costs by reducing need and demand for the services" (1992?). Our consulting firm was aimed at fostering both humane case-management and cost containment. This method of "Reduction..." seemed a remarkably straightforward way to approach the problem. This appears to describe what happens in a variety of medical categories in the presence of appropriate outpatient mental health benefits.

The idea is to allow accessible and satisfying outpatient mental health treatment to facilitate a reduction in the need for physical services. To see whether we have a chance, we can take a look at the literature developing.

First, the paper looks at a recent reconfirmation of Galen. Then the paper traces other significant evidences of offset through recent years.

Galen's conclusion above was reconfirmed when Cummings & VandenBos (1981, p. 168) reported a 20 year study. Kaiser's early research experience on cost offset had found that 60% of primary care appointments of patients coming in to a Kaiser primary care clinic were for no physical purposes...(but were) for somaticized emotional distress." (They said the percentage was even higher when one counted in stress-related disease.) They described how "Kaiser-Permanente discovered it had to provide mental health services to prevent over-

utilization of medical facilities by otherwise healthy people who were somaticizing." (Shapiro, 1991; Slay & Glaser, 1995, p. 1119)

The idea would be to offer increasingly appropriate treatment in outpatient psychotherapy and therapeutic education in order to reduce the need and call for primary care physical visits. This reduction might emerge both from provision of the appropriate treatment (therapy) first and from patterns of stronger immune system and physical health engendered in the healing and integrating body over time.

A present threat

Consider this potential problem: This offset effect, often referred to as the medical care cost offset effect, may be being seriously hurt by the continuing array of managed care cost-cutting in outpatient therapy and may be losing its capacity to decrease costs of care. To understand this phenomenon, we probably need to know another aspect of how managed care came to take over outpatient mental health.

To start with its first mental health triumph, won on its own, managed care has made significant inroads in reducing psychiatric inpatient days of all types.

When managed care mental health came into health plans, it began to develop and contract for a continuum of potential intensive care for patients, partly in order to find the best place for the mental health client, partly to moderate costs.

Particularly through arranging alternative residential arrangements as options to full inpatient hospitalization, managed care saved the plan significant money, and one can argue that patients were, on the whole, served. The managed care systems made sense that it is often not necessary to use full hospital inpatient mental health services.

By exploring alternative residential mental health environments, managed care

systems were able to simultaneously lower costs by over 30% and increase the potential aptness to the specific client's residential mental health need. Savings and quality success on short order encouraged managed care mental health work and a more active and competitive market.

Bringing more formerly inpatient work to intense and transitional care settings, day or night treatment, and outpatient settings brought more intense cost to outpatient treatment . This in turn encouraged managed care plan case management to pay more attention to pro-actively managing treatment and saving money there, in the outpatient sector. Managed care companies, often with personnel from EAP services history, focused on managing the amount of treatment, using logic from that of short-term treatment, of managing and prioritizing scarce resources, of outcomes testing, of fairness to stockholders. Managers used to the thought patterns of EAP's monitor client care closely.

Consider this possibility: In their guidance from handbook protocols, case managers, executives, and consultants may be curtailing outpatient care to the point that it depresses the offset effect.

In various ways, costs of care have been reduced. Unfortunately, little study has been done to adjust 1980's offset numbers to post-managed care treatment cost profiles.

While we may be less sure about some effect sizes in the post-managed-care-takeover, there is no obvious reason to believe that categories of savings are fundamentally different from what has been observed so far. Reasonably established categories of savings may be put in a chart of potential savings categories (to be found at the end of this commentary).

We read about the development of managed care mental healthcare and about four losses developing in its wake. If we have some responsibility for managed care mental health plan design in conjunction with one or more of the main stakeholder groups, we may want to think about how the first three losses (loss of client choice of clinician,

clinician choice of client's plan, both parties' choice of treatment methods) can be, in some measure, improved for and with them, within current resources, agreements, and understandings. Improvement around the fourth loss, about clinician-client loss of control over choice of treatment duration, may depend in part on re-proving outpatient treatment's important financial effects (if there are any, of course) on the costs of the overall health plan. Fuller (1995, p. 1015) says that "by limiting access to treatment, ... organizations may actually increase their overall health care costs by increasing the likelihood that patients will become inefficient users of the health care system."

If, on the other hand, good outpatient psychotherapy contributes significantly to keeping medical costs down, then designers will be moved to be sure to provide adequate plan resources to outpatient psychotherapy, not only because it is right and because outpatient psychotherapy is a very successful healing tradition, but also because, through operation of the offset effect, outpatient therapy acts as a "profit center" for the plan. If the offset effect were wider understood, its maintenance, "care and feeding" could become a high and standard priority to all primary stakeholders around the plan -- and perhaps the offset effect might be strengthened -- certainly a win-win development. (Studies are called for.)

Medical care cost offset studies arose from experience and assertions that if good mental health care is provided to those plan participants who have a number of physical problems, the medical care cost expense for those individuals will with reasonable predictability demonstrate significant declines. If one thinks about this, it becomes obvious that if mental health services become increasingly inaccessible, the medical care costs related to mental health process may become artificially high.

Since offset thinking is not now part of our central planning, study is required.

Offset savings in the workplace

Interestingly enough, and as a re-inforcement to the focus of our inquiry, the potential net

savings are not only in the health plan.

In the words of Fuller as he studied Hoffman, et al (1992): "Significant improvements were also seen in (work) absenteeism, work mistakes, tardiness, work completion, and conflicts with supervisors."

Employers can look for savings both in their health plan costs and in their cost of doing business. Savitz tells us: "The good news is, according to (a number of studies) that when behavioral problems are treated, the cost of medical care drops. ...Evidence is convincing corporate managers that employees with (untreated) personal problems are a drag on corporate culture, costs and profits....An untreated worker is a hidden cost, a slow leak in a barrel that escapes attention day by day but eventually drains a company's strength." (1995, p. 1)

1016)

In conclusion

Substantial evidence has been developed indicating that outpatient mental health benefits and psychoeducation have had the effect of causing the affected clients' medical costs to go down. Just how much overall remains for research needed now.

We can study more how to understand and stimulate apparently better treatment and savings in such areas as depression, anxiety, headache, and exhaustion are among the most common reasons for seeking help (Kelleher, Holmes, & Williams, 1994), treatment refractory depression, PTSD, medication and treatment non-compliant patients, repeated inpatient admissions, borderline acting out, and somatizing patients (Schwartz (1997); Pollack (1994))

Perhaps we can learn about how this offset effects works, what volume of savings may still there after the managed care systems changes of the last years. Perhaps we can restudy the best of those earlier studies, as practical, to cast light on

current margins. Perhaps, just possibly, we can encourage study which may be of benefit to the next generation of outpatient mental health plan design.

Note: 10-3-02:

This is a text draft. The citation section will be added later.

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Examples of reported medical cost-offset categories

(somatic, somatiform, psychosomatic, ambulatory-care-sensitive conditions reported in the literature)

Alcoholism

- hospital use
- medical services
- emergency medical admissions
- psychiatric admissions
- detoxification admissions

Anorexia nervosa

Asthma

Back pain

Burn patients, serious

Cellulitis

Chemical dependency (and other substances than alcoholism)

- outpatient and residential treatment programs
- overdose hospitalizations

Colitis

Dehydration

Depression accompanying medical procedures

Diabetes mellitus

Gastrointestinal tract

- Gastritis, generalized
- Hemorrhage

Heart disease

- angina

ischemic
post-myocardial infarction
cardiac surgery
congestive heart failure

Hypertension

Hypoglycemia

Kidney dialysis

Mental health hospitalizations

Pneumonia, bacterial

Pulmonary disease, chronic, obstructive

Skingrafting

Surgery

Ulcers

Urinary tract infection

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Other miscellaneous draft categories:

emergency room visits

hospitalizations in general

Work productivity

Worker's Compensation

Work-related illnesses

Personal/family/workplace growth

Relief of suffering

Medical utilization overall, high

Mental illness

 hospitalization rate and duration
 high utilization

Disability, early return to work