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# Editorial

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This issue considers cost-of-illness studies in depression (Berto *et al.* p.), cost–benefit analyses of drug treatment services (Cartwright p.), the economic impact of comorbidities in schizophrenia (Dickey *et al.* p.), financial implications of applying capitation models for the reimbursement of the services provided by the US Department of Veterans Affairs (Leslie *et al.*, p.), and the consequences of changes in geographic location and use of psychiatric services in Norway (Pedersen and Lilleeng p.). A Commentary by Godfrey p. refers to the Cartwright article on cost-benefit analyses of drug treatment services.

The article by Berto *et al.* (p.) reviews a number of studies published on the international literature after 1970 and analyses the social and economic costs of depression in various countries. Authors consider the relevance of the burden of depression in the examined studies, related both to the costs of services used and to the earnings losses due to the illness, and underline the relevance of hospitalization in driving direct costs while other sources of costs, such as drug treatment, account for small percentages of the economic resources allocated to the care of depression.

Cartwright (p.) examines the cost/benefit literature focused on drug services. These studies have been performed in the United States since the early 1970s, when the public drug treatment system was founded in the United States. They fall into a variety of categories: planning models for delivery systems in states and cities, short term follow-up studies of individuals, individual programs and state systems' monitoring of outcomes.

The author highlights the challenges and difficulties of a comprehensive economic analysis of drug treatment services. He refers to the extensive impact of drug addiction and its co-morbidities and the frequent multiple use of various services (services for drug addiction, other psychiatric services, medical services and the judiciary system), the importance and need for long-term data collection in this population, the variety of outcomes measures considered (for example, number of drug-free days, relapses, quality of life of addicted subjects and annual addiction related crime episodes) and the analysis of the perspective to be used in the economic analysis (i.e. taxpayers, society).

The author claims that in spite of the variety of the methods used in performing cost-benefit analysis of services for addictive disorders, a persistent finding is that the benefits of providing these services exceed the costs, in consideration of the reduction in external costs created by the behavioral consequences of addiction and drug use. Further research is to be addressed to the standardization of methodology in this area and to the analysis of the socioeconomic consequences of addiction in particular groups such as women and adolescents, until now not sufficiently studied. Godfrey (00) provides a Commentary to the article.

The article by Dickey *et al.* (p. 00) focuses on the consequences of the co-morbidity of schizophrenia and substance use disorder (SUD) on services use and cost. The study considered all disabled Medicaid beneficiaries (aged 18–64) treated for schizophrenia during one year in a managed care carve-out programme in Massachusetts. About one-fifth of these individuals had a diagnosis of substance use (60% alcohol related diagnosis). A 12 months point prevalence treatment rate of eight common medical disorders (diabetes, hypertension, heart disease, asthma, disorders of the digestive system, skin infection, malignant neoplasms and acute respiratory disorders) was analysed in subjects affected by schizophrenia with or without substance use comorbidity. In those with substance use disorder there were higher rates of treatment for five of the eight medical disorders, higher treatment costs for two of the medical disorders and much higher costs for psychiatric treatment among those with co-morbid substance use disorders. The authors claim that greater attention should be given to substance use and medical comorbidities in the treatment of subjects affected by schizophrenia, and that the availability of continuity of care among professionals of different specialties is expected to alleviate health and economic consequences of these co-morbidities.

The study of Leslie *et al.* (p. 00) analyses the hypothetical financial implications of using capitation reimbursement schemes in the US Department of Veterans Affairs (VA).

Unlike in traditional cost-based reimbursement, in capitation providers receive a fixed amount per patient based on the patient's characteristics and the cost of caring for this type of patient system-wide. If the actual costs of treating the patient are less than the capitated amount the provider keeps the difference. If treatment costs are higher than the capitated amount, the provider incurs a loss. The risk of financial loss for providers can arise from differences in case-mix, differences in costs of units of services provided (labour is more expensive in some areas than others) and differences in treatment styles (inpatient-outpatient care).

The study considered all veterans treated in VA outpatient settings during the first two weeks of the fiscal year 1991. Total utilization and costs for this sample during the

remainder of 1991 were calculated using VA administrative databases, and the hypothetical distribution of funds based on seven alternative capitation models was simulated. In contrast to the Diagnosis Related Groups (DRG) system which addresses inpatient care only for specific episodes, this study applies an empirically based capitation system to all services (inpatient and outpatient, mental health and general medical) used by public sector mental health patients in a fixed period of time. The analysis shows that approximately 8% of overall VA budget was redistributed under a simple capitated scheme, and some individual networks and facility types experienced changes in funding of over 30%. While substantial variation is shown to be related to the different styles in treatment provided, the authors claim that further research is needed in order to analyse the impact of capitation and of the development of standards of care on providers behavior and on the patients' wellbeing.

Pedersen and Lilleeng (p. 00) consider the effects, analysed between 1979 and 1994, of the policy aimed at achieving a more equal geographical distribution of health services in Norway and at providing an easier access to the population. The study examines two aspects of the variations in distribution: the distribution of personnel (physicians and psychologists) by location of services, and the distribution by consumption of services. The authors claim that the main result seems to have been relocations in the production of services more than re-distributions in the consumption of services.

We would like to underline the importance of developing further research aimed at analysing the following: the consequences of the co-morbidities between mental disorders; substance use and addiction and medical disorders; the value of the coordination of interventions and services in the co-morbid patient; the value of financing mechanisms in taking into account comprehensively this issue.