Letter from . . . Chicago

Hard times in intensive care

GEORGE DUNEA

During most of 1982 the economy languished in intensive care, anxiously watched by specialists unable to agree on whether to transfuse, apply leeches, or administer vasodilators to reduce economic impedance. Some of the monitors surrounding the patient indicated that inflation was reasonably under control, but others flashed and buzzed and sent warnings that interest rates were catastrophic, business stagnant, and the unemployment rate dangerously high. Not surprisingly, the supply siders and trickle down economists recommended further surgery and wanted to cut out more taxes and eliminate more social programmes. But operations of this type are not always easily undertaken, especially as further haemorrhages in defence spending threatened to increase the federal deficit to astronomic proportions. At last everybody agreed that some of the tax cutting of the previous year had to be undone. So in September, 10 weeks before the election, a large tax increase was passed, relished perhaps more by liberal Democrats than by conservative Republicans, yet hailed as a triumph for the president's lobbying and persuading efforts.

The 1983 budget imposes new taxes on cigarettes, telephone bills, airline tickets, and petrol. It has a new withholding procedure on dividends, increases corporate taxes, and repeals certain tax advantages for business. It strengthens tax collecting procedures, decreases the amount of medical expenses deductible from gross earnings, and establishes a 20% minimum tax on high incomes. Less money may be sheltered in tax deferred pension plans and less may be borrowed back. All in all, the government expects to raise $93 billion in the next three years—$18·3 billion in 1983.

Included in the new budget were cuts of more than $12 billion for Medicare and $1·4 billion for public aid (Medicaid) over the next three years. The new regulations are extensive and complex, and their application will have profound effects on the practice of medicine and especially on the hospitals. They will affect medical, laboratory, and nursing services, providing for lower ceilings on reimbursements, higher compulsory copayments by patients, and incentives designed to cut costs. A whole host of new controls and financial restrictions will force hospitals to tighten their belts, and this time the cuts will be felt throughout the nation, unlike earlier changes that affected mainly the programmes for the indigents and had their greatest impact in the inner city.

So the prognosis remains uncertain, for medicine and for the economy in general. Meanwhile, in September, perhaps in anticipation of the budget cutting operation, the sickly economy astounded the intensive care staff with a convulsive change for the better. The stock market rallied, the Dow Jones index rose above 1000, and interest rates fell. With the government experts pronouncing that soon the economy will be strong again, all would have been well but for those nasty October headlines indicating that the unemployment rate was 10-11%, the highest since the depression, and that 10 million Americans were out of work. Nor did the argument that 100 million Americans were working, many at two jobs, and that the labour force was larger than ever, sound convincing. On television, experts argued about who was responsible for the recession and blamed variously the high interest rates, the spending by previous administrations, the unions' demands for higher wages, the Reagan tax cut, or the excessive spending on defence. So as the elections drew close one had the spectacle of economists differing so radically as to make metereology or medical therapeutics look like "hard" sciences.

Midcourse mandate

Perhaps the least confused in this debate were the voters. On 4 November they exhibited what editorials called an instinct for the centre, giving a "midcourse mandate" and suggesting they would "stay the course" with Mr Reagan if he tempered his politics with more sensitivity for those suffering economic hardship. As the Republicans retained their 54 to 46 control of the senate it was thought remarkable that the economic situation had not caused a greater swing against the government. But the Democrats gained some 24 seats in the house, increasing their majority to 268 to 165 and gaining some seven governorships. In Illinois the Republican incumbent governor was re-elected by a majority of only 5074 votes out of 3·6 million, "a miracle" as he declared later, willing also to concede that he had been greatly humbled. For the future there were hints of more compromise and less cutting of social programmes, perhaps some reassessment of defence spending, and a new emphasis on creating jobs. A bipartisan measure to increase the federal petrol tax by four cents was accepted even by supply siders as a "users fee," especially as the estimated budget deficit was now projected at $180 billion for next year and at $250 billion by 1985. So amid warnings that interest rates would rise, business confidence would sag, and the unemployment scene would suffer unless federal borrowing was restrained, the "lame duck" congress met in December to pass the petrol tax and to use that money to create some jobs for fixing highways and bridges, while leaving the more momentous decisions for the new congress in the new year.

For it is jobs that remain the main concern, elsewhere as well as here in Illinois, where the unemployment rate is 13% and over 700 000 people remain out of work, enough people to fill the whole city of Boston, as the newspapers pointed out to emphasise that unemployment here is second only to the auto dependent states of Michigan and Ohio. Furthermore, the recession now affects everybody, not only the inner city blacks and Latinos but also the suburbanites, many of whom have lost their jobs and exhausted their unemployment benefits, so that some have moved to the sunbelt, to Texas and Arizona, living in cars and caravans on camping grounds while trying to restore their shattered fortunes. Amid an all time high of business failures and foreclosures, bankruptcy lawyers are reported to be

Cook County Hospital, Chicago, Illinois, USA
GEORGE DUNEA, FRCP, FRCPED, attending physician

experiencing somewhat of a boom, while other lawyers meanwhile are cutting fees, trimming overheads, or are even reduced to suing their clients for owed fees. Other professionals, such as architects and engineers, are also reporting sharp declines in income; many dentists are suffering from the empty chair syndrome; and primary care doctors have seen their practices reduced by half and are talking about marketing, making house calls, or going out of their way to make themselves known to potential patients.

Meanwhile the newspapers abound with stories about the psychological trauma of people losing their old jobs and being unable to find new ones, till they are driven to despair and just lounge around the house watching television. Other items emphasise the need to readjust and the painful humiliation of once independent middle class people having to apply for unemployment compensation or welfare cheques. There are stories about people losing their jobs, their houses, their families (as the divorce rate rises), and their savings; but it has also been noted that some three to six million aliens work in the United States because the natives disdain certain jobs that are considered to be too menial, too hard, dead end, or underpaid. Several unions, however, faced with the prospect of further lay offs, have renegotiated labour contracts and agreed to reduced benefits and pay in order to save jobs and avert closure of plants. Whether the economy will recover and the industry regain its efficiency and competitiveness on world markets remains to be seen. But meanwhile managers have noticed a trend for people in many industries, including the health occupations, to come to work on time, to take less time off for minor illnesses, to stay longer in a given job, and not to walk out at the first trivial dissatisfaction. And indeed, economic puritans have long preached that only increased discipline and efficiency, combined with some tightening of the belt, can lead to an effective recovery with low unemployment and low inflation.

No more blank cheques

It remains to be seen how the hospitals will fare in this changed economic environment. For many years, while the government and the insurance companies provided virtually a blank cheque, the hospitals had expanded at an enormous rate. Subsidised by government funds and tax advantages, they built facilities, embarked on ambitious programmes, and operated with enormous overheads, relying on a good measure of creative accounting and shifting costs with great skill from one book to another, so that the charge for a chest radiograph or haemoglobin estimation bore little relation to the actual cost. But now, as the government is cutting back and the insurance companies are also becoming refractory, many hospitals are having a bad time. Last year I described how hospitals were closing wards and wings, and the trend has continued to the point where one is left wondering where all the sick people have gone. In Chicago many hospitals report 60% occupancy rates, and some are in real trouble, victims of the times but also of their own efficiency as the impact of years of audit is catching up and more people are having tests as outpatients, especially before surgery. In times of recession, furthermore, many people tend to defer elective procedures for fear of losing their jobs or of having to make expensive copayments they can ill afford.

To all this must now be added the government's increasing determination to cut health care costs. Already many state Medicaid programmes have been paying the hospitals reluctantly and inadequately, while giving the doctors little more than a nominal fee, often for services needing considerable time and effort. But now the federal Medicare programme is also about to change. In September Secretary Schweiker, acting under a congressional mandate, proposed a new system of "prospective reimbursement," to replace the previous method of paying for incurred costs. Under the new scheme hospitals would be paid for some 467 "disease related groups" (DRG) according to a set amount for each category, so that efficient hospitals would be allowed to make a profit and less efficient ones would lose. By instituting these changes the government hopes to contain costs and save $38 billion in the first year, as well as abolishing pronounced disparities between hospital charges, such as from $1500 to $9000 for a myocardial infarct and from $2100 to $8200 for a hip replacement. But while some have expressed the hope that the system will increase efficiency, that, for instance, some hospitals will specialise and do "volume business" in what has been called "economic specialisation," others have criticised the proposals as providing incentives for hospitals to undertreat, skimp services, take short cuts, jeopardise patient comfort and even safety, avoid treating certain expensive diseases, and shift even more costs on to other payers. The American Hospital Association thought the proposals were too rigid and "exactly the wrong way to go." The American Medical Association urged caution and warned against radical changes without further study of their possible impact. Others thought that the scheme would penalise the elderly with multiple diagnoses, or that doctors and hospitals would work around the system by putting down the most reimbursable disease. Others still thought the method would be unworkable and pointed out that the results of the three years' pilot trial in New Jersey had not yet been published. One newspaper thought that the proposals were "reasonable surgery for Medicare" and that costs had to be contained, but others were less sanguine about what could be "an unhealthy experiment in financing health care." There were also concerns about straining relations between hospitals and doctors or about reducing the doctor's freedom to choose what is best for the patient; and someone asked how the patients would like being told that they could not have a certain test because it was too expensive.

Already the public hospitals are arguing that within disease related groups payment should be tied to the severity of illness, because their patients are generally sicker. And a recent report released by congress's office of technology assessment has found that increased competition could reduce the use of hospital beds and laboratory tests but would harm medical care by discouraging patients from seeking help and by giving doctors and hospitals an incentive to limit costs at the expense of quality. Further constraints on medical care could also emerge from a recent government proposal to tax a part of the health insurance premiums paid by employers, which so far have been part of the fringe benefits package, and, being free, have been deemed to cause "extra inflationary strains on health facilities." On the same lines, the Blue Cross—Blue Shield insurance companies recently announced new guidelines for respiratory care, designed to save some $1·25 billion by limiting the indications for intermittent positive pressure therapy, spirometry, arterial blood gases, postural drainage, pulmonary function tests, and oxygen therapy. As the insurance companies are next moving to address the indications for cardiac diagnostic and therapeutic procedures, one is left with a distinct feeling of hard times in the intensive care unit and one can only hope that the patient will survive.

It has been reported that beta-blocking drugs aggravate the loss of myocardial reserve in many patients with coronary heart diseases.[1] Lately, propranolol has been widely promoted for treatment of hypertension with or without associated coronary heart diseases. How far is such routine use of propranolol advisable, particularly if there is evidence of loss of myocardial reserve?

Propranolol is useful in angina and lowers the blood pressure. Patients on the brink of heart failure may be tipped into failure by the reduced cardiac output that results from beta-blockers, but the vast majority of patients with hypertension and ischaemic heart disease are not on the brink of heart failure and for them beta-blockade is an eminently satisfactory form of treatment.—R E IRVINE, consultant physician, Hastings.

[1] Taylor SH, Silke B, Nelson GIC, Cokoli RC, Ahuja RC. Haemodynamic advantages of combined alpha-blockade and beta-blockade over beta-blockade alone in patients with coronary heart disease. *Br Med J* 1982;**285**:325-7.