Letter from . . . Chicago

Election year

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Everything in America takes place on a larger scale, and this includes the workings of the democratic process, so that the presidential electoral campaign is drawn out to a 12-months elimination series. This boosts the political industry, provides much-needed jobs for at least one year out of four, and tends to forestall serious legislative efforts—which is seen as an advantage by those who believe that the role of government in regulating human affairs should be as circumscribed as possible. In medicine, however, the laissez-faire approach is under attack, and with the average American spending 10% of his earned income on health the high cost of medical care is causing increasing concern. In April, this year, the President's Council on Wage and Price Stability reported that the increases in medical costs "have significantly outpaced" rises in other services, that they "increasingly contribute to the overall rate of inflation," and that a "more analytical attention to hospital costs, physician fees, drug prices, and the overall role of government in the health field" is needed. The report concluded that "these unusually large and persistent increases are having an increasingly significant impact upon the individual American as a family member, a worker, and a taxpayer, a much greater impact than he or she realises."

In 1975 the total expenditure on health care was reported as $118·5 billion. This included $46 billion in hospital bills and $22 billion in physician fees and amounted to 8·3% of the gross national product, to $547 a head, or to over $2000 for an average family of four. Hospital charges are rising, the cost of an average hospital stay has increased from $311 in 1965 to $1017 in 1975, an appendicectomy now costs more than $1000, a delivery $800, and a myocardial infarct $3000. Moreover, the inflation affects both the public and private sectors. In the last year, health insurance premiums have gone up by as much as 30%, and General Motors—with an annual health-care benefits bill of $825 m—recently announced it was spending more money on health than on steel. Nor are these rising costs likely to abate, and the Congressional Budget Office has predicted a further $100 billion increase between 1977 and 1982. These facts were greeted by many politicians with calls for more controls and regulations, and the daily press, increasingly critical of the medical profession, responded with editorials on "Runaway medical costs" and "Medicine's dark hour."

Yet, in truth, much of these medical cost increases result from inflation, high labour costs, an increase in the quantity and quality of services provided, the growth of new techniques and skills, and the need for new and expensive types of equipment. Nevertheless, with the government paying 42% of all health bills (through Social Security, Medicare, and Medicaid) it will also increasingly want to call the tune. Indeed, it has long been the common theme of government officials that this is the medical profession's last chance to put its house in order—or someone else will have to do it for them—meaning the government. "I would be less than honest," said Dr Charles C Edwards, former assistant secretary for health, "if I said I was really optimistic about the private sector regulating itself in a satisfactory way." Yet, he warned, "unless the leadership of the American health enterprise can summon the wisdom and the courage to act, the opportunity to lead will be lost because the United States will have no choice but to nationalise the health industry—not through ideological revolution, but out of sheer economic necessity."

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Getting their money's worth?

The question is also often asked whether the American people are getting their money's worth. This question, like beauty, is hard to judge. The American Medical Association claims that the "vast majority" of Americans receive good care; and they cite figures showing that 86% have a family doctor; that 60% report having visited a doctor at least once within the last six months; that medical school enrolments have increased; and that complaints about medical care ranked 12th in a 1974 consumer survey, far behind complaints about automobiles, furniture, and television repairs. Critics of the system, however, question the doctors' "monopoly" on health care, and emphasise that the system of third-party reimbursement (government and private insurance companies pay 92% of hospital bills and 65% of doctor fees) has little ability to control medical costs. They point to difficulties of access to care; to the geographical maldistribution of physicians and also to maldistribution within specialties; to the scarcity of medical resources in the inner city and in remote rural areas; and to the fact that, although the United States holds the undisputed world record for health spending, it comes 27th in male longevity, 11th in female longevity, and 15th in infant mortality. "We do not have a health care system in this country," recently declared the executive director of the Committee for National Health Insurance, "what we have is a disjoined, costly non-system."

Not surprisingly, Senator Kennedy, Mr Carter, and at least three other democratic presidential candidates continue to favour a comprehensive national health insurance bill. Yet other students of the health system increasingly doubt whether the country can afford the potentially enormous expenditure of such a programme. Instead, they have shifted the emphasis to controlling costs and maintaining fiscal responsibility, and they have warned that free services create unlimited demand. Some have once more questioned the assumption that more medical care will make the nation healthier and have called for increased attention to the environment, housing, education, nutrition, employment, the reduction of stress, and the provision of safer roads and cars. Others, still, have expressed doubts about the

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existence in the USA of sufficient managerial competence to administer a unitary, all-inclusive national health system of continental dimensions. And one witness at a recent congressional subcommittee hearing appealed that "whatever national health insurance programme is enacted, it should be capable of being administered by mere mortals."

Many solutions are currently being tried or considered to rationalise medical care and contain costs: professional services regional organisations to improve hospital use by physicians; a new planning law to prevent the uncontrolled proliferation and reduplication of hospital facilities; a health-manpower Bill to force young doctors into primary care and into medically underprivileged areas; a reduction of general medical beds in areas where too many are available; and a resolution of the lingering malpractice problem, which increases costs by passing the additional expenses on to the patient. There are calls for a more effective organisation of the country's health governance with possibly a separate department of health to unify various programmes, provide leadership and direction, and develop rational planning. Some hold the excessive and irrational federal spending as partially responsible for the present high cost of medical care; and they blame Congress for creating a multitude of isolated categorical programmes and then leaving the executive branch to deal with the nation's health needs in a piecemeal manner. Of these programmes, the one most frequently under fire is Medicaid, the ten-year-old state-administered welfare programme that provides medical care to more than 23 m indigent patients at an estimated cost of $14·7 billion a year and is frequently held up as a warning of what could happen under a universal free national health programme.

Medicaid

Recently characterised as a "jungle" and as a "mess," Medicaid is not only inefficient but also much abused. Welfare recipients receive a card that entitles them to free and uncontrolled access to medical care. They are not required to register with any particular doctor, and consequently they wander from surgery to surgery, from hospital to hospital, often as the whim seizes them, often merely shopping around for a second opinion. For a patient to have been in several hospitals and under the care of multiple physicians is almost the rule rather than the exception. Expensive diagnostic procedures are frequently reduplicated, and some patients are known to have undergone intravenous pyelography as many as three times—in different hospitals and under different doctors—for investigation for their hypertension. Some patients attend two outpatient clinics concurrently; some receive their medication from one clinic but follow the instructions of the other; and some end up by collecting twice the amount of medication required. Only feeble attempts are made to limit the amount of drugs dispensed; and a determined patient can obtain a practically unlimited amount of life-saving or symptomatic medications.

There is also a constant hassle about money. To be paid by Medicaid for services rendered requires a certain skill and know-how; and those uninitiated in the inexplicable mysteries of the billing procedure find that they are paid inadequately, late, or not at all. Furthermore, the States are always running out of money. Within the last year problems have arisen in New York, Ohio, Pennsylvania, New Jersey, and Georgia. In Illinois the governor cut $50 m from a $750 m annual budget by reducing payments to doctors, pharmacists, and hospitals; but the hospitals responded with a law-suit, refused to accept Medicaid patients, and referred an increasing number of people to the already overcrowded but free county hospital.

In addition, it seems that some doctors also abuse the Medicaid system. Some conduct their office on a mass-production basis, overprescribe, or overtreat, and it is reported that Medicaid patients have twice as much surgery as the rest of the population. Within the last year there has been a spate of investigations and newspaper exposés of fraud and unlawful practices. These include unnecessary operations, gross overprescribing, inflating costs, "kickbacks" from laboratories to physicians ordering tests, double billing, and billing for services that were not rendered. It is reported that one optometrist charged the State for eyeglasses but provided sunglasses; another ordered eyeglasses for an entire family which he had never examined; and a dentist apparently charged a patient $100 for dentures and then also sent a bill to Medicaid for the same services. One nursing home charged yacht and country-club dues, trips to Hawaii, and expensive automobiles as part of patient care; and a conspiracy was reported between factoring (billing) companies and Medicaid officials to deliberately slow down payments to those physicians who did not use these firms to do their billing.

As a result of these exposés, several pharmacists, physicians, and nursing home operators have been suspended or criminally charged. The Health, Education, and Welfare Department estimates possible losses exceeding $750 m a year from fraud and abuse. Said secretary Mathews: "We recognise that the overwhelming majority of health care providers are ethical and professional," but he also pointed to the need to develop efficient programmes and better management, and to prevent abuse.

Yet better management and more efficient programmes may require the type of initiative unlikely to emanate from Congress in an election year. As for the executive branch, it currently has more than its share of problems, and its main impact on health care this year seems to have been the recommendation to immunise the entire nation against the swine influenza virus—an issue which I wish to defer to a later date. This brings us to some interesting decisions of the judiciary branch: in New Jersey the Supreme Court overruled by 7 to 0 an earlier lower-court decision in the case of Karen Quinlan, who had been unconscious for a year, and appointed her father legal guardian, with the understanding that he was free to instruct her doctor to discontinue the respirator or find some physicians who would do so. The Illinois Supreme Court has exacerbated the local malpractice crisis by declaring unconstitutional the legislative's last year's laws that set limits on insurance premiums and awards to patients and established review panels to sift out frivolous claims. In Pennsylvania a jury acquitted the state's first physician ever charged with involuntary murder—the case resulted from the accidental death of a 5-year-old child after the doctor punctured the liver during thoracocentesis. The National Labor Relations Board dealt a blow to the rising trend towards house-staff unionisation by deciding that interns and residents are students, not employees of their hospitals. And finally, the United States Supreme Court ruled that hospitals had the right to ban husbands from the delivery room while their wives were giving birth, which confirms the observation of David Hume—the philosopher whose 200th anniversary of his death we commemorate on 25 August of this year—that "there is nothing which is not the subject of debate" and "that the most trivial questions escape not our controversy."

What is an argon laser photocoagulator and what are the main clinical indications for its use?

An argon laser consists of a laser containing argon gas which emits a very bright beam of blue light linked by a delivery system to a slit-lamp microscope. The beam can be focused on to structures in the anterior segment of the eye and with the aid of a contact lens can also be used on the fundus. The main clinical indications for its use are to obliterate blood vessels in conditions such as diabetic retinopathy and some types of exudative macular disease. The laser may also be used to perforate the iris in cases of closed-angle glaucoma and some types of secondary glaucoma.

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