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26 January 2007

Richard A. Berg, MD, FACS
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Dear Richard,

Amazingly I found my presidential address! Fortunately for me, the association with *American Surgeon* didn't occur until the next year, 1979, so I didn't have to submit it for publication.

We will be at the 50th annual meeting this year. I have invited my children (oldest just turned 50) and their families to the meeting as well. They, of course, came to the MSA meetings when they were little children.

Yours truly,

Bob

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ESRD: A Prototype for NHI?

Robert D. Allaben, M.D.

Shortly before the elections of 1972 an amendment was attached to what was to become PL 92-603. Less than 30 minutes were allotted by the Senate for discussion of this amendment and no hearings had been held previously by either the House Ways & Means Committee or the Senate Finance Committee. The Senate House Conference Committee deliberated on this section 299I only a few minutes. This amendment extending Medicare coverage for the treatment of almost all patients in the country with end-stage renal disease may well be the prototype for National Health Insurance.

Thirty years ago I wrote a paper in high school in opposition to the then proposed Murray-Wagoner-Dingell compulsory health insurance bill before Congress. Gradually, with the passage of Medicare-Medicaid and now ESRD legislation, we, as physicians, have had to accept forms of national health insurance. I would therefore like to outline some aspects of the current ESRD program.

In order to implement the 1972 action of Congress, a Notice of Proposed Rule Making was published in the Federal Register on July 1, 1975. This established 32 network Coordinating Councils. Inasmuch as the regulations were not in final form there was no funding mechanism. Many areas, however, did organize Coordinating Councils and some funds were obtained from Regional Medical Programs. These Councils and other interested groups formally responded to the Proposed Rules on March 25, 1976. The Commissioner on Social Security signed the final form of the Rules & Regulations as drawn up by the Secretary of Health, Education and Welfare and they became effective September 1, 1976. Some of the suggested changes were incorporated and others were not. These Rules & Regulations number twenty-two pages in the Federal Register.

Presidential address delivered at 20th Annual Meeting of the Midwest Surgical Association, September 2, 1978, Mackinac Island, Michigan.

In 1972 Congress was apprised that the annual cost of the ESRD program would be $250 million by 1976. It was actually $682 million. In 1975 the cost estimate for 1984 was $1 billion. This is now revised to an estimated $3.1 billion to treat 60,000 patients.

These inaccurate estimates may be blamed on government, physicians and patients alike. Governmental agencies did not accurately research the problem or consult all necessary individuals in order to reach valid conclusions. I am sure the estimates presented to Congress were on the conservative end of the scale. Inflation has an effect but certainly not a major one. Before enactment of this legislation nearly 40% of patients were being dialyzed at home. Now only 13% are.

Home dialysis costs are somewhat over $15,000 per year while center dialysis costs exceed this by more than $9,000. When center dialysis is utilized physicians receive greater income due to more frequent patient contacts and the families of patients find it easier to have someone else perform the dialysis. Patients are now being dialyzed who formerly were considered too poor risks because of their age and concomitant diseases. A lesser percentage of patients are being considered for transplantation, thereby further increasing the number of patients utilizing dialysis, the more expensive mode of therapy. Legislation has been passed this year in efforts to remove the disincentives to home dialysis and transplantation. Although transplantation has a first year cost slightly higher than one year of center dialysis the cost is not recurrent if a well functioning kidney results.

The ESRD regulations attempt to give physicians responsibility in the operation of the program but likewise place many restraints and restrictions. The minimum number of dialyses and transplants to be done by each center are clearly stated. The number of physician visits and tests which will be reimbursed are listed. Establishment of new programs is restricted.

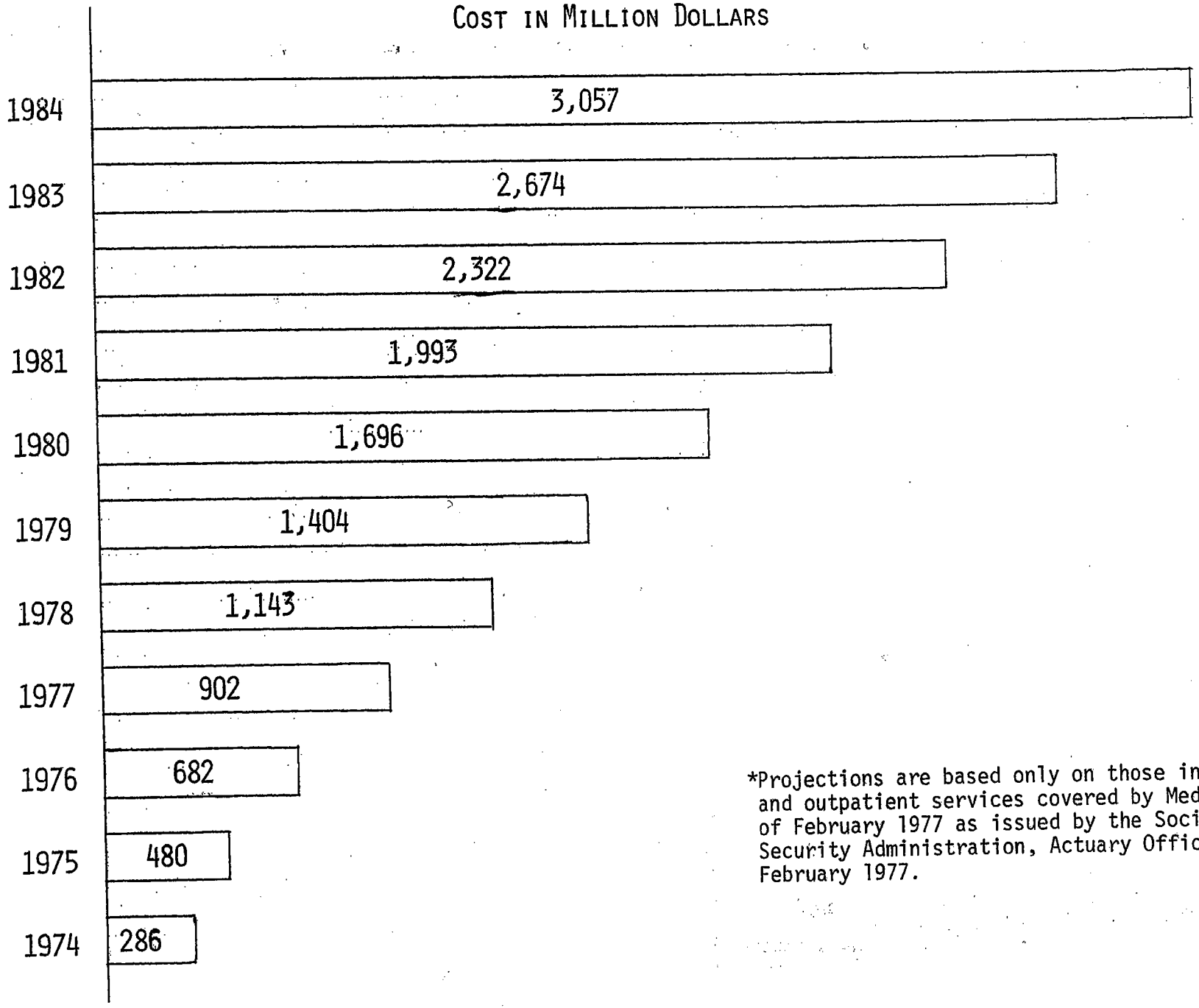
The overall control of the program is through the Department of Health, Education and Welfare. It has various regional offices to which each network reports. There are thirty-two networks; some include portions of states and others include many states. Network 14 includes the lower peninsula of Michigan and a few counties just across the Straits of

Mackinaw. Within each network a Coordinating Council and Medical Review Board are established. In Michigan each discipline of each ESRD program appoints a representative and alternate to serve on the Coordinating Council. Also represented are associated organizations such as State Departments of Health and third party carriers. In addition, at least three consumers and alternates must be elected. From 1975 to September 1, 1977, no specific funds were available to finance these Councils. Innumerable hours were spend in council and committee meetings by physicians and others in attempts to fulfill the requirements of the Federal Rules & Regulations, all without reimbursement. After September 1, 1977, funds became available to obtain necessary supplies and office space and to hire necessary personnel. Council members now are reimbursed $.17/mile for transportation to attend meetings which last from three to eight hours. The consumers on the Council also receive a per diem rate.

The Coordinating Council has various committees which approve individual membership on the Council and forward recommendations concerning approval of new programs within its network to the regional office of the Department of Health, Education and Welfare. The Coordinating Council also elects a Medical Review Board consisting of seven members and alternates as specifically defined within the Federal Rules & Regulations. This Board reviews the appropriateness of care annually for all programs within the network. These recommendations may be forwarded to the Coordinating Council but must be reported to the Secretary of Health, Education and Welfare who controls payments to all ESRD centers.

With this brief overview of the ESRD program within this country, I have attempted to provide some ideas as to what National Health Insurance may be in the future. Many aspects certainly will improve patient care; however, is the expense of this governmentally regulated program indicated for the treatment of such a small percentage of our population? A comprehensive National Health Insurance would likewise benefit only a small percentage of our population. I believe the costs of the present ESRD program when examined by Congress will be the greatest deterrent to implementation of comprehensive National Health Insurance as currently being introduced in Congress.

ANNUAL PROJECTED COSTS OF MEDICAL SERVICES*
MEDICARE DIALYSIS AND TRANSPLANT PATIENTS
UNITED STATES, 1974-1984



*Projections are based only on those inpatient and outpatient services covered by Medicare as of February 1977 as issued by the Social Security Administration, Actuary Office, February 1977.

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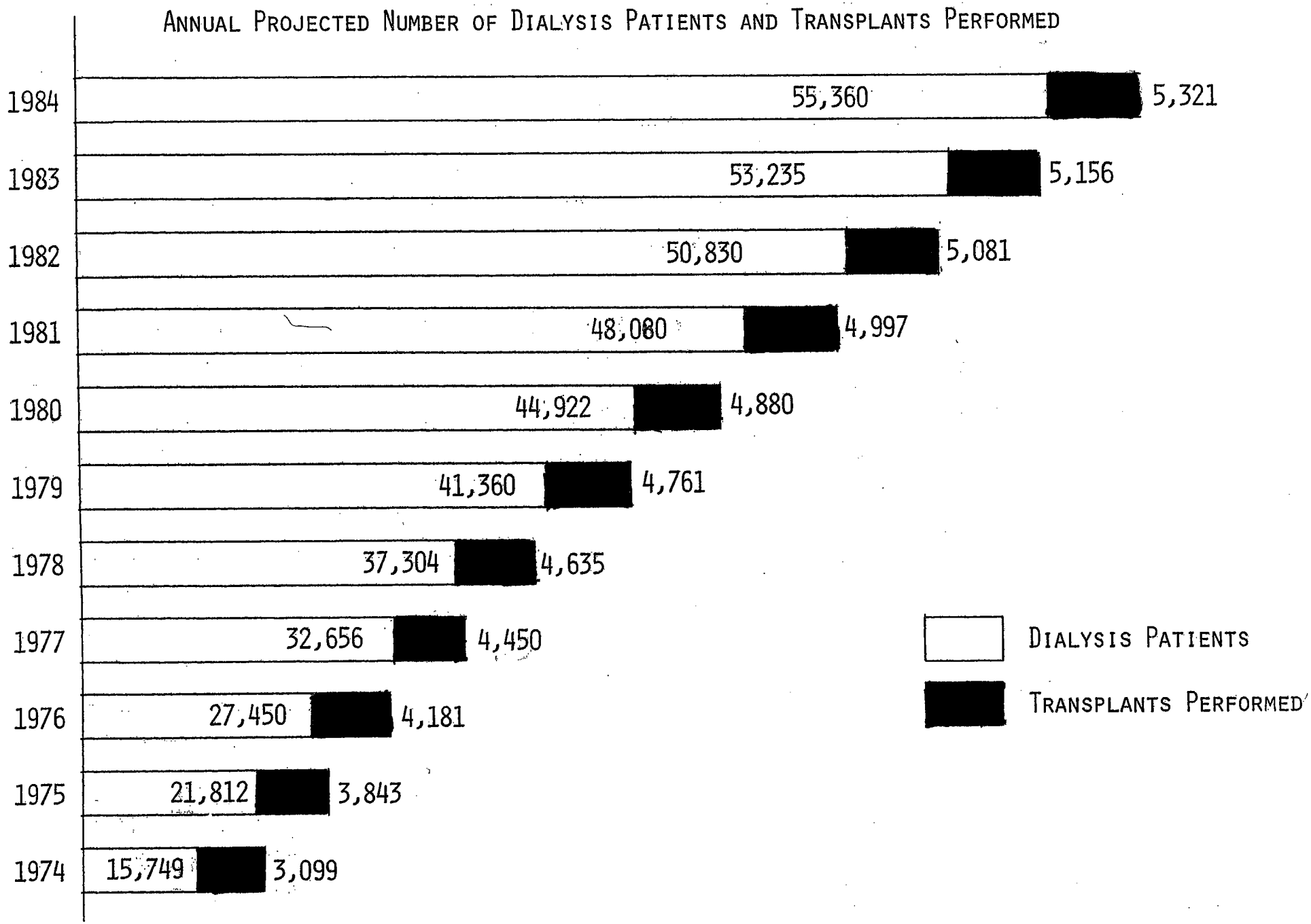

ESTIMATED ANNUAL PATIENT COSTS ACCORDING TO METHOD OF TREATMENT (CURRENT DOLLARS)

Method	Yr 1	Yr 2	Yr 3	Yr 4-10
Facility Dialysis	24,500	24,500	24,500	24,500
Home Dialysis+	17,000	15,400	15,400	15,400
Cadaveric Transplantation‡:				
1st Yr Costs	25,000	—	—	—
Follow-up Costs:				
For Patients With				
Successful Grafts:				
Stable Success:				
% Of Surviving Patients	—	75%	92%	92%
Follow-up Costs	@	3,000	2,000	1,500
Unstable Success:				
% of Surviving Patients	—	25%	8%	8%
Follow-up Costs	@	9,000	9,000	9,000
Rejection Costs*	@	10,000	10,000	10,000
Dialysis Costs:				
For Patients Surviving And				
Returning to:				
Facility Dialysis	24,500	24,500	24,500	24,500
Home Dialysis	15,400	15,400	15,400	15,400

+Costs of Home-Dialysis Equipment & Supplies Reflect 1976 Catalog Prices of Major Suppliers. Costs of Those Who Assist Patients With The Operation of Home-Dialysis Equipment Excluded.

‡Applicable to 1st & 2nd Transplants (1st-yr Costs For 2nd Transplants Are Estimated At $20,000).

@Included in 1st-yr Costs.

*1-Time Additional Costs in Yr of Rejection Incurred By All Patients With Rejection of Transplants.

SOURCE: Internal Management Reports Assessing the National Cost & Charges Experience (Chronic Renal Disease Branch, Medicare Bureau, Health Care Financing Administration).