Medical Concerns and the National Budget Allocations

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Nephrologists throughout the world have been bombarded for many years with various messages from prominent government financial authorities about the excessively high expense of regular dialysis and the need for cost containment. Of late, the will to resist this false but fashionable doctrine seems to have become less and some of us are apparently beginning to agree with this view. Let me point out the facts from the vantage point of an editor who comes into contact with nephrologists from all over the world. Unwillingness to spend the taxpayer's money on treating dialysis patients is not new. Several years ago, I was obliged to write an editorial about the UK policy of excluding the elderly and those with complicating disease from dialysis [1]. Fortunately, the British government relented under pressure from its nephrologists and the timely advent of CAPD [2]. Other countries have been generous in their attitude to dialysis in the past including most West European democracies, Japan, and Israel. With the recent economic crisis, the problem has been simmering, but in the USA this is part of a greater health economic crisis. Now that the USA has emerged from its economic depression, somewhat earlier than the European countries and Japan, there is still little firm policy on health care in general or dialysis in particular, other than vague and ill-formed balloons floated against a National Health Service, and a generally accepted wish to change the system without knowing if any of the proposed new systems will be an improvement on the old. The proposed strengthening of vast Health Management Organizations run on state lines has temporarily been dropped in the USA, but the suggestion of a government-run cost-efficient health service is still anathema to the majority of elected representatives in the US Congress. Looking at Europe one sees the various health systems in different degrees of disarray and it is hardly surprising that politicians get the feeling that a health system is too massive a burden to fund from taxes in a time of increasingly complex and therefore costly technical developments. Regular dialysis services are a small part of the health budget in all democracies, but they bestow a reasonably good quality of life in the majority of recipients of regular dialysis, whether it be peritoneal dialysis or hemodialysis. A sine qua non of democracy is that pressure that public opinion can bring to bear on the government can succeed in molding policies of the government. Nephrologists should have an active part in the struggle to persuade our elected representatives to fund dialysis more generously. As nephrologists looking back on the 34 years since Scribner's famous telegram was sent to renal centers announcing the possibility of regular dialysis through an AV shunt, we can have some satisfaction from the fact that over 300,000 people on this planet are being kept alive with regular dialysis. This is largely due to the lobbying

work of a handful of dedicated physicians in each country, many years ago, in advising both politicians and public of the benefits of dialysis.

Nephrologists, often those with the best records in the struggle for determination to get regular dialysis financially backed by government funding, are now beginning to listen a little too much to the Pied Piper coming out of the various Treasury Departments of the countries' governments. It is true that there is only a finite amount of tax income to go round, that there has been a recession, and that there are additional new burdens for the Health Care Services of all democracies not known 15 years ago -AIDS, massive drug addiction problems, hepatitis C, etc. It is clear that regular dialysis services, like those of other essential requirements in the health services of European, American and Japanese/Asian countries, will have to compete for funds. Should we as doctors accept the various half-baked kites flown by the politicians and refrain

from pointing out what we think will be best for the sick? If there is a public outcry in a democracy, whether it is USA, UK, France, Germany, Italy, Japan or Israel, then the kite is quietly pulled out of the sky and packed away. This is a certainty in a democracy because the incumbents in the government buildings wish to be re-elected, thus they will usually not violently erode their supporting voter base.

We can certainly agree that demented patients should not be on regular dialysis because they cannot understand that the procedure of painful insertion of needles is for their own good [3]; we should remember Trousseau's axiom, 'guérir quelquefois, soulager souvent, consoler toujours'. In the US the situation is complicated by medicolegal action which relatives can initiate if they want their demented next of kin to be regularly dialyzed. One can try and persuade them against it, but must comply with their wishes otherwise. Other democracies with different legal systems may not be required to dialyze these unfortunate patients.

As nephrologists we must bring to the knowledge of our elected representatives the facts about the best of other countries' dialysis services. An example is the enlightened Japanese system of paying more money for longer dialysis; and also the more realistic sums paid for dialysis in Europe, which are 2V3 times or more than paid in the US. These factors may be partly responsible for the higher mortality rate in the US dialysis patients when compared to the European Registry and Japanese figures.

There are certain rules to which nephrologists should adhere, and which are self-evident. At the very least, in the richer countries there should be no automatic age exclusion to dialysis, nor should concurrent disease be an automatic bar to regular dialysis. The problems with government attempts to prevent free and equal access to dialysis seem to be worldwide, so far with the notable exception of the USA. Sometimes the restriction is denied but possibly present, as in New Zealand, where the question arose as to whether a man of 75 was rejected for dialysis because of his age or because of intercurrent disease, said to be coronary artery disease and prostate cancer [4]. This is a clear indication of the cumulative effect of misinformation about dialysis. Coronary artery disease is commonplace in the elderly and does not automatically imply that the patient is unfit for dialysis or will not benefit from regular dialysis. Similarly, prostate carcinoma is not necessarily rapidly fatal. Indeed the majority live up to 10 years and may benefit from dialysis for several years after diagnosis of carcinoma of the prostate. The UK policy was initially similarly tough and unbending [1], but has

improved very considerably, partly due to the pressure of nephrologists. The tendency to ration medical treatment is an increasing problem throughout the world for the nephrologist, and, as far as dialysis services are concerned, requires rigorous but measured political counter-pressure by the nephrology community to prevent the otherwise inevitable erosion of the present acceptance criteria for regular dialysis. It should be stressed that this need for watchfulness and defense of the right of patients for dialysis is not applicable in just one or two countries, but is common to all the democratic world. Dialysis should be provided without reference to the wealth of the patient. The other side of the coin must be mentioned. Governments should keep a careful watch on dialysis units' methods to be sure that they are providing adequate, safe and efficient dialysis. In countries with private dialysis units, those with excessive profits caused by excessive repeated reuse or undue shortening of dialysis time should be penalized. In countries providing transport of patients to dialysis units care should be taken to make sure that the service is not abused either by the patients or the transport companies [3]. Artificial kidney manufacturers and drug companies should be pressured to keep their profits to a bare minimum in the care of dialysis. There is already a major problem with a price differential between the USA and other countries for medications which are much more expensive in the USA. This needs correcting for the benefit of medicine as a whole and nephrology in particular. If we as nephrologists press these matters, we may be able to influence the elected legislators to see the national dialysis programs in a different light, – not just as an expense but as a life-giving efficient and altogether praiseworthy therapy. This may help prevent the financial cut off of funding for dialysis which cannot but have fatal consequences for many innocent and deserving patients.

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