Why support the kidney care quality and improvement act

Health & Medicine, Healthcare

For the past years, healthand health care have transformed to become the dominant economic and political issues in the United States and many other countries. Because most nations have experienced rapid rises in health care spending over the past 30 years, governments have assisted patients in their countries because the cost is simply becoming unaffordable for them.

During the earlier times, provision of health care was a relatively simple matter. Doctors carried most of the equipment they used in a black bag and the samedoctorwas likely to attend a patient for most, or all, of her or his life. During those days the range of medical and surgical interventions was quite modest. Today, sophisticateddiagnostictechnologycomplements an extensive array of medical and surgical options making medical care a very complex, highly specialized, and costly commodity.

One of the most alarming diseases that had burdened American people is kidneyfailure. According to a U. S. Newswire report (16 March 2005), approximately 400, 000 Americans currently suffer from kidney failure and of those, around 300, 000 require dialysis several times a week, for an average of 3. 5 hours per session. At the current rate of new cases -- many the results ofdiabetes, obesityand hypertension -- the number of patients is expected to quadruple to more than 2. 2 million by the year 2030. Many experts recommended that early detection and better disease management is regarded as the best means to delay the onset of kidney failure.

Definitely, kidney function is essential for life. Once a person’s own kidneys fail, some form of treatment is necessary if they are to go on living. Currently, there are two forms of treatment – dialysis (in which the kidney

function is taken over by artificial means) and transplantation (in which another person’s kidney is used instead). Successful treatment – by dialysis or a transplant – now gives people with kidney failure a new lease of life, sometimes for many years (Stein 2002, p. 122).

However, death can be inevitable. Patients and families usually want to know how long a person can survive with untreated end-stage kidney failure. This too is variable, depending on the extent to which their old kidneys are working – and therefore the amount of urine that they pass. The kidneys may be able to get rid of some excess fluid, but unable to process waste products such as creatinine and urea, or salts such as potassium. It is the build-up of these substances in the blood (especially the potassium) that usually leads to death. This is why dialysis represents the success of our knowledge and skill in conquering a kidney illness. Dialysis is all about life. And, it could cost an insurmountable amount ofmoneywhen someone goes to dialysis three times a week for the rest of his or her life

Indeed, there is an immediate need to improve the government’s program that provides dialysis care for those with kidney failure. This is why the members of the U. S. House and U. S. Senate introduced bipartisan legislation to update the End Stage Renal Disease (ESRD) program, which 75 percent of the nation's dialysis patients rely on to live.

This is called The Kidney Care Quality and Improvement Act of 2005, sponsored by Senators Rick Santorum and Kent Conrad, and Representatives William Jefferson and Dave Camp. This legislation would update Medicare's composite rate for ESRD -- which does not automatically adjust for

inflationary increases -- as well as provide for importanteducationand preventative programs to help stem the rising tide of kidney failure in the United States (U. S. Newswire, 16 March 2005).

The primary reason for health care is to prevent or cure diseases or attend to people with chronic or terminal illnesses. It may be possible, however, for health care costs to undermine the soundness of what our pockets can afford, and such an eventuality would be undesirable. Hence, a pressing issue entails how to achieve a situation in which expensive medical care can continue to be available while, at the same time, the total cost of health care is scaled back so as to keep this cost in line with the overall rate of skyrocketing prices.

For instance, Talladega in Alabama has only two dialysis units and there are almost 100 patients that cramp the two units. With The Kidney Care Quality and Improvement Act of 2005 patients will be assured for better care among patients stricken with kidney disease through improvements in Medicare and enhanced education programs, which would prevent numbers in Talladega County from growing any more. Although the act currently sits in a Senate committee awaiting approval, that’s not stopping local doctors from offering warnings to at-risk patients.

Ghayas Habash, a nephrologist, said that the main thing people need is to get the message across to people at risk for kidney failure, those with diabetes, hypertension, black people and those with afamilyhistory. If only we address these people aggressively, we can prevent a lot of kidney failure (Casciaro, 18 August 2005).

True enough, medical costs have more than doubled over the last decade, and health insurance premiums have risen nearly five times faster than wages. Americans are spending far more on health care than residents of any other industrialized country while receiving lower-quality care overall. Meanwhile, big U. S. businesses that provide health coverage to workers complain that the high costs are crippling their ability to compete with companies abroad whose workers get government-subsidized care.

The Bush administration is encouraging consumers to switch to consumer-directed health plans, whose high co-payments would force them to shop for more cost-effective care. But critics argue that individuals can do little to control costs. Instead, they argue, the plans would primarily benefit the wealthy and that society must make hard choices about which care should be paid for by public and private dollars (Clemmit, 7 April 2006).

The overwhelming amount of health care purchased in the United States is paid for by the government through Medicare and Medicaid or by privately owned health-insurance companies. Both Medicare-Medicaid and health insurance firms employ personnel, process claims, and issue payments. Their procedures and personnel are expensive and add to the cost of health care without actual medical benefit to anyone.

Proposals have been made to dismantle the so-called third party infrastructure and change to a single-payer system in which government would provide and pay for health care. Taxes would be adjusted to cover the costs and administrative bureaucracy would be kept to a minimum so as to maximize efficiency. While a single-payer system has obvious merits, a

national consensus in favor of such a system has not emerged. Thus, the problem of health care dollars paying for administrative infrastructure remains, and there is no clear indication as to how to resolve it.

For kidney patients, The Kidney Care Quality and Improvement Act of 2005 is long overdue because dialysis is not an option but a necessity for them to continue living. This legislation modernizes the Medicare ESRD program by:

· creating public and patient education initiatives to increase awareness about Chronic Kidney Disease (CKD) and to help patients learn self-management skills;

· ensuring patient quality through improvements in the ESRD payment system, including establishing an annual update framework and evaluating the effect of the new Physician Fee Schedule G-code visit requirements;

· providing Medicare coverage for CKD education services for Medicare-eligible patients;

· establishing an outcomes-based ESRD reimbursement demonstration project;

· aligning incentives for physician surgical reimbursement for dialysis access to promote quality and lower costs;

· establishing a uniform training for patient care dialysis technicians; and

· improving ESRD coverage by removing barriers to home dialysis and creating an ESRD Advisory Committee (RPA Website, 2006).

Some critics have argue about the use of CKD education. In deeper analysis, CKD education is very crucial because people need to know the things about it prior to developing kidney failure but there is no funding for education that could have helped prolong your kidney function. This Act will be beneficial not only for CKD patients, but also for people who may be at risk. This act will definitely enable people that you (or your loved one) can get more treatments. With the current policy, most people cannot avail the dialysis they need because Medicare doesn't pay for more than 3 treatments a week

As quality of care is everyone’s privilege, Medicare reimbursement should be updated annually for dialysis clinics just like it is for other providers. Medicare's low reimbursement could result to employer health plans paying more than their share and private companies have to pay higher. This would be a heavy burden for people with CKF because they need to pay higher premiums or their health coverage is reduced, or sometimes employees with CKF or employees that have dependents with CKF have the risk to lose their jobs because of the high costs on their part.

Kidney patients need life-saving treatments that need to be improved because their lives are on the line and it is sapping them out of their funds because of the costs. Enacting Kidney Care Quality and Improvement Act of 2005 should therefore be prioritized and Congress should not think twice. Everything should be done to help CKF patients combat this lethal disease, and support them with all our efforts to get better treatments before it is too late

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