Reflections on the Boston Meeting from across the 49th Parallel

David C. Mendelssohn

Humber River Regional Hospital and University of Toronto, Toronto, Ontario, Canada


As a Canadian observer and participant, I offer the following opinions about the recently concluded Boston meeting concerning the morbidity and mortality of dialysis in the United States of America.

First, I congratulate Americans for having the courage to execute a meeting that catalyzed a disturbing discussion about imperfect technologies and poor patient outcomes in their country. Thank you Drs. Steinman, Parker, and Hull and members of the steering committee. Canada has never had such a meeting. Although our mortality rates are lower than the United States (1), key intermediate outcomes show signs of getting worse over time (2). In a setting with universal health insurance, our central venous catheter (CVC) rate has reached an appalling 45% in prevalent patients, and we have no fistula-first initiative (3,4). This is our national tragedy. There is much for America to be commended about.

The conference concluded with the assertion that the science is clear and that the next steps are fairly obvious. As stated by the giants of the field and supported by the rank and file, it appears there is a pragmatic consensus about the major thrusts that are required. These include longer and/or more frequent hemodialysis, a focus on left ventricular mass regression, a focus on less inflammation and infection (linked to fewer CVCs), and a focus on better care before dialysis is initiated. Certainly, in my opinion, all this is laudable and is based on the basic and clinical data as best we understand it, and it is reasonable to conclude that many lives could be extended and/or improved with this strategy. However, the quality and quality of evidence, upon which most of this is based, would not satisfy the strictly applied rules of evidence-based medicine and comparative evaluation research as presently defined. Policy makers may still reject the mixed evidence and opinion-based recommendations of nephrologists, no matter how sensible they seem to us. This pivotal evidence gap in nephrology is a critical problem for the community and is impeding the implementation of advances in our discipline.

This brings me to the fundamental challenge, which was not articulated at the conference. However, the meeting encouraged the audience to think outside the box, and so I offer this wild idea as food for thought. Many of the fundamental flaws of the US dialysis system are exacerbated or caused by the funding and reimbursement system, which under Medicare is managed by the Center for Medicare and Medicaid (CMS). There are perverse incentives and disincentives, and misalignment of goals of the multiple stakeholder groups. Systemwide reform is virtually impossible, especially since CMS has only a limited and biased view of how modern dialysis should be delivered in the United States. Until the stakeholders are empowered to manage the funding and reimbursement mechanisms (or share the management), it seems unlikely that constructive change will occur at more than a snails pace.

Such a system of co-management is in place in British Columbia, Canada, where a multi-stakeholder BC Renal Agency (BCRA) is empowered to manage the kidney care system (www.bcrenalagency.ca). Founded in 1997, it coordinates all aspects of kidney care related to service delivery, funding, research and education, patient support, and government liaison. The executive director is a nephrologist, Dr. Adeera Levin. The BCRA vision is an innovative, integrated health system resulting in outstanding care for patients living with kidney disease.

As an example of the kind of bold public policy shifts that are possible under this model, BCRA has created a funding envelope and is now expanding a daily home hemodialysis program. While a model that works in a Canadian province with less than 5 million inhabitants cannot be copied exactly in the much more complex US environment, the principle is what should be focused on.

The economy of North America is in turmoil, and the powerful wave of health care reform that is sweeping America is a unique opportunity for the renal community. Clearly, the current system is not working and may be under threat. Given the critical and already unique place of the ESRD entitlement program within Medicare, might there be an opportunity to convince the Obama administration and Congress that Medicare should take dramatic and immediate steps to protect and improve the ESRD program? The mechanism would be to contract out the ESRD program to a third party, multi-stakeholder agency, perhaps on a 5 yr pilot project basis. Of course, CMS must be part of such an agency, but other voices must be at the main table.

Would it be easy to create such an agency, and would it be supported by the renal community to affect change? Given the diverse interests and power of various stakeholder groups, it is a given that it will not be easy at all. However, America does have many senior, credible and balanced leaders in nephrology...
who might enjoy sufficient respect to carry this to fruition. Nonetheless, an opportunity like this may not come again for 20 more years. In my opinion, the outcome is uncertain, but it is worth discussing the agency approach at the highest levels of American nephrology stakeholder groups.

The US renal community beat the odds in the early 1970s when it convinced Congress to create the Medicare ESRD entitlement program. That energy must be harnessed again. Without an ability to influence service delivery, innovation and cost management, the US ESRD system will continue to tinker around the edges. I fear that it would then reconvene a Dallas/Boston-like conference in 20 yr time to once again bemoan the lack of progress since 2009. It is time to seize the moment.

Disclosures

None.

References


