Dialysis Rationing and the Just Allocation of Resources: An Historical Primer

Background

• Approximately 571,000 people in the United States are affected by the chronic illness end-stage renal disease (ESRD) (USRDS, 2011)
  ▪ The prevalence of ESRD is rising
• Since 1972, Medicare covers the cost of dialysis for most eligible ESRD patients

(Savage & Browne, 2012)
Research Question

• Use the theory of distributive justice to examine the early allocation of kidney dialysis and discuss the federal government’s policy at that time
• What are the implications of a just allocation of dialysis?

(Savage & Browne, 2012)
Background: Theory of Distributive Justice

• How can health care resources, such as dialysis, be distributed justly if they become scarce?

• According to Roemer (1996), the theory of distributive justice is “the determination of how scarce resources are allocated among members of a society or group when such members have competing interests” (Savage & Browne, 2012, p. 38)
Social Work Ethical Considerations

- Social Justice ~ social workers must advocate for vulnerable clients when they are denied access to or are in danger of losing access to scarce medical resources (Savage & Browne, 2012, p.38)

- Dignity & Worth of a Person ~ when health care resources are scarce, social workers work to ensure that clients receive the resources to which they are entitled and that they require (Savage & Browne, 2012, p.38)
Methods

Literature review of the policies and practices for dialysis in the USA, discussing the just allocation of medical resources for ESRD patients

(Savage & Browne, 2012)
History of Dialysis Allocation

- 1940’s
  - First artificial kidney was invented in 1943
  - Patients with chronic kidney failure not eligible
  - Allocation decisions based on medical diagnosis
- 1950’s
  - Some patients with chronic kidney failure eligible
  - Artificial kidney units became more available but still expensive
  - Allocation decisions still up to individual doctors’ discretion
- 1960’s
  - Dialysis shunt revolutionized kidney dialysis allowing it to be available on outpatient basis
  - Dialysis still very expensive

(Savage & Browne, 2012)
Selection process devised for Seattle Artificial Kidney Center (SAKC) in 1962:

- “Patients had to be stable, emotionally mature, uremic adults under the age of 45, without long-standing hypertension and vascular complications, willing to cooperate with the dialysis regimen and low protein/low sodium dietary regimen, and with stable or slowly deteriorating renal function” (Blagg in Savage & Browne, 2012)

- Psychological assessment indicating they would be active in rehab and own well-being

- Financially able to support oneself

- Admissions and Policies Committee had to deem person important to community based on “social worth”
History of Dialysis Allocation (cont.)

- Public outrage at the biases in this selection process
- SAKC Dissolved the Admissions & Policies Committee
- Resulted in Federal funding & policies
  - Grants to SAKC & another Community Dialysis Center
  - Dialysis units established in VA hospitals
  - Established the Committee on Chronic Kidney Disease in 1966
  - 1972 ESRD Medicare Program established
    - All rationing of dialysis ended
    - All patients eligible despite inability to pay for services

(Savage & Browne, 2012)
Current Allocation of Resources

• Medicare pays for majority of dialysis expenses in the USA
• The cost of dialysis services in increasing
• Concern that rationing criteria may once again become exclusive and unfair

(Savage & Browne, 2012)
Implications for Practice

• Technology has not fixed problems of affordability or accessibility for kidney dialysis

• Rationing models need to:
  ▪ Be conscious of biases from values, norms, culture
  ▪ Involve stakeholders
  ▪ Be transparent process

• Ethical values are sometimes conflicting, can’t satisfy all values at all times

• Social workers must be present in dialogue about just allocation of dialysis for ESRD clients

(Savage & Browne, 2012)
References


(Savage & Browne, 2012)