States of the Union

READ MY BLIPS

BY RICHARD J. MARGOLIS

IT'S A DELICATE subject but let's face it: In my eagerness to go on living, I may have become a millstone around the American taxpayer's neck. That's because, despite my age, I am now on Medicare, the Federal program with a big heart and an even bigger price-tag. This year the cost of Medicare will run upwards of $110 billion.

The reason I am eligible at age 61 for benefits otherwise vouchsafed to those 65 and over lies buried in the politics of renal failure—Washington's kidney politics and my kidney failure. The latter occurred last December (see "Make Me Whole," NL, August 6-20). Medicare has kept me alive ever since by footing much of the bill for my peritoneal dialysis, a do-it-yourself form of therapy that filters my waste. The treatment is unrelenting but painless. Among other things it features six-pound plastic bags filled with dextrose, which four times each day I let trickle through a tube and into my solar plexus.

Although peritoneal dialysis costs a bit less than the more widely used hemodialysis (where a machine periodically cleanses the patient's blood supply of accumulated poisons), neither treatment comes cheap. In my case, as with most other dialysis patients, it is not just the bags of dextrose that make the process expensive; to that must be added the salaries of the nurses and doctors at my local renal clinic, whose help I keep calling for. Their services, together with the dialysis supplies, come to $55 a day, or about $20,000 a year.

From the taxpayer's perspective, one of the things that makes my dialysis so costly is its cussed constancy: Dialysis is not a cure, it is a life-saving, lifelong expedient, a therapy only death or a kidney transplant can terminate. In effect, I am wait-listed for both, but of course I am counting on the transplant, which will cost about $40,000. Medicare will pay for that, too.

Meanwhile, the tab continues to pile up. To cite a few of the nondialysis items, there is my weekly Epogen shot (to fend off anemia) at $40 a vial, plus assorted blood tests, laboratory work, x-rays, echo scans, CT-scans, cardiac imagings, stress tests ... It all adds up to approximately $50,000 a year, and four-fifths of the sum will be paid by the Federal government.

Some of the tests, to be sure, may be one-shot events: They have been necessary in order to clear the way for my transplant. Aside from one's crippled kidneys, it seems, a transplant candidate must be in the pink.

Still, the astonishing and very expensive array of electronic machines that regularly probe my innards cannot be considered extraordinary in the current scheme of things. Modern medicine's ingenuity is matched by its avarice. Indeed, their combined force is mainly what has been driving health care prices sky-high. This year the cost of health care in the United States shot up to $606 billion, a rise of 164 per cent in a single decade.

Professors and pundits have long been fretting about medical inflation and its juggernaut tendencies. Here is Walter McClure back in 1976, in an article published by the *Journal of Health, Politics, Policy and Law*: "The quality, quantity and style of medical care are indefinitely expansible. The medical care system can legitimately absorb every dollar society will make available to it."

And here, 12 years later, is Robert H. Blank in *Rationing Medicine*: "Physicians have been trained in the technological imperative which holds that a technology should be used if it offers any possibility of benefit, despite its cost."

"Technology chasing technology" is how my doctor explains it. He seems apologetic, but then he orders more tests.

The other day I was lying flat on my back getting my heart photographed. The nurse and I watched my pulse, now transformed into a little white blip, flitting around the small monitor screen. "How much will this cost?" I asked the nurse.

"What do you care?" she said. "You're not paying for any of this, are you?"

Well, no, Medicare would cover most of the charges and Blue Cross would pay for the rest. Even so, how could I justify the expense to the American taxpayer? Read my blips?

You might say that Congress rushed to my rescue two decades before I needed rescuing. It was in 1972 that the lawmakers passed Public Law 92-603, known also as the End Stage Renal Disease Pro-

gram. An amendment to Medicare, the measure extended coverage to nearly all victims of kidney failure regardless of age.

Political pressure for such a law had been mounting for the better part of a decade. In the 1960s, as it happened, both hemodialysis and kidney transplants came of age. Up to then dialysis had been a stopgap measure at best. Its use was restricted by the fact that each time a patient was dialyzed he or she had to undergo surgery to insert tubes into an artery and a vein.

As Renee C. Fox and Judith P. Swazey tell us in their book on organ transplants and dialysis (*The Courage to Fail*, 1973), "Because each artery or vein could be used only once, the number of [tube insertions], and thus the number of possible runs on the machine was limited." For this reason dialysis "was not able to prolong the life of patients in the terminal renal failure stage...." As late as 1960, according to Fox and Swazey, kidney specialists "exulted because they had succeeded in dialyzing a patient for 181 days, at that point a new record.

Then along came Dr. Belding Scribner of the University of Washington School of Medicine in Seattle. He solved the problem of the tube sites by inventing a semipermanent shunt. Surgery prior to every exchange of blood was no longer required. From that moment on, it became possible to keep patients with nonfunctioning kidneys alive. (My brand of *peritoneal* dialysis did not become widely accepted for another two decades.)

That kidney transplantation evolved from its experimental stage into a semilegitimate cure in the '60s, too, was largely due to the development of immunosuppressive drugs that could stave off the body's rejection of an alien organ. The new surgery, in turn, encouraged the use of dialysis, for as the renal scholar Richard A. Rettig has pointed out, "transplanters realized that the [dialysis] machine could be used to maintain the lives of potential transplant recipients," while they were waiting for an available kidney.

Dramatic as these medical breakthroughs were, they had their instant economic downside. The trouble was, few renal victims could afford the price of either dialysis or transplantation. Once again science had confronted society with a sticky moral dilemma: We now possessed the technological means to save thousands of lives, but could we summon the requisite will and generosity?

For a time the answer appeared to be No. Typical of that period was the response of a New York State official to Dr. Norman Schupak, who ran a dialysis center in Queens, when he came hat in hand to a state agency. "Society," said the official, "has not yet made the determination these people [dialysis patients] should be saved."

In truth, for lack of ready cash "these people" were dying in droves. According to a 1970 report by the National Institute of Health, out of an estimated 7,500 people suffering from end-stage renal disease that year, 1,250 were getting dialysis treatment, 917 had received transplants and 5,333 had been permitted to die.

MATTERS approached a head in November 1971, when members of a new interest group, the National Association of Patients on Hemodialysis (NAPH), traveled to Washington to testify before Wilbur D. Mills (D.-Ark.) and his House Ways and Means Committee. Shep Glazer, the NAPH's vice-president, testified while attached to a hemodialysis machine, with his wife at the controls. Forty-three years old and the father of two schoolchildren, Glazer explained to a rapt committee why he was no longer working: "I was a salesman until a couple of months ago, when it became necessary for me to supplement my income to pay for the dialysis supplies. I tried to sell a noncompetitive line, was found out, and was fired.

"Gentlemen," Glazer pleaded, "what should I do? End it all and die? Sell my house for which I worked so hard, and go on welfare? ... Please tell me. If your kidneys failed tomorrow, wouldn't you want the opportunity to live? Wouldn't you want to see your children grow up?"

This time, in effect, the answer was Yes. On September 30, 1972—a Saturday morning—Vance Hartke (D.-Ind.) stood up in the Senate and proposed that the Social Security bill for that year be amended to extend Medicare coverage to victims of end-stage renal disease. Hartke argued that the nation spent billions of dollars for transportation, outer space, defense, cosmetics, and appliances, "but when it comes to maintaining our health, we revert to the primitive values and attitudes of the distant past."

The fundamental question, declared the Senator, was this: "How do we explain that the difference between life and death is a matter of dollars? How do we explain that those who are wealthy have a greater chance to enjoy a longer life than those who are not?" He went on to urge that we "begin to set our national priorities straight by undertaking a national effort to bring kidney disease treatment within the reach of all those in need."

Debate lasted only 30 minutes, according to Richard A. Rettig's detailed 1976 retrospective article in *Law and Contemporary Problems*, and only Senator Wallace Bennett (R.-Utah) rose to speak against the provision. "With nearly half the Senate members absent," Rettig writes, "the measure was adopted by a vote of 52 'Yeas' and three 'Nays.'"

Thus Congress committed the nation to a future of saving the lives of hundreds of thousands of renal patients. For my part, I am delighted to be numbered in the saved remnant.

A landmark act of compassion, to be sure—but was it fiscally prudent? Maybe not. Last year Medicare shelled out more than $3 billion to 144,000 renal beneficiaries. Rational economists like Robert H. Blank think we should scrap the program and reap the financial benefit. But even Blank is aware of society's irrational elements—for instance, people with failed kidneys.

As he justly complains, "What might be logical from an economic standpoint on the aggregate level often is unattractive from the emotional perspective of the individual."