The Daily Dish

Advancing American Kidney Health

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Eakinomics: Advancing American Kidney Health

Wednesday the president signed an executive order (EO) — the Advancing American Kidney Health (AAKH) order — that seeks to reduce the number of Americans developing end-stage renal disease (ESRD) by 25 percent (by 2030), to have 80 percent of new ESRD patients receiving either dialysis in the home or receiving a transplant (by 2025), and to double the number of kidneys available for transplant (by 2030).

The EO seemingly came out of nowhere. But I think we should always be open to a hearty renal policy discussion. After all, the kidney is the only organ that has a bean named after it. Given the number of full-time foodies masquerading as policy experts, they should be all in. Personally, I'm open to all things kidney because I only have one kidney. Well, actually, I have two, but they are both on the left side of my body (which is obviously why I lean left) since I am the recipient/victim of a right renal autotransplant in which I donated my native right kidney for transplantation to the lower, left front abdominal cavity. It was a lot of fun, but unfortunately the kidney subsequently failed. Anyway, I'm game for any kidney discussion, whether dialysis, transplant, chili … you name it.

But the real reason for the discussion is that kidney disease is pervasive — about 37 million, or 15 percent, of Americans are afflicted — and deadly — the 5-year mortality rate for those with ESRD is 50 percent. Given that, it is not surprising that it is also expensive. Everyone with ESRD is eligible for Medicare coverage regardless of age. The Department of Health and Human Services (HHS) reports that "Total Medicare spending for beneficiaries with chronic kidney disease (CKD) and ESRD, including spending on comorbidities and other health care services that may be unrelated to ESRD, was over $114 billion in 2016, representing 23 percent of total Medicare fee-for-service (FFS) spending."

Unfortunately, the current care for renal disease too much reflects the fee-for-service model. What the EO proposes that HHS do is move to paying providers for outcomes, specifically in order to slow the progression of renal disease to prevent kidney failure. It also proposes, in the event of kidney failure, to move dialysis out of a center and into the home, where it is cheaper and more comfortable. Even better, it hopes to incentivize preventive transplants that preempt the need for dialysis — hence the goal of doubling the number of kidneys available for transplant.

The changes in financial incentives to induce better care are a bit arcane, and the mechanics of being more efficient in the use of donated kidneys are comparably complex. But it was surprising to see that roughly 20 percent of kidneys for transplant go unused — fixing this seems like low-hanging fruit. I think the really interesting part is the HHS demonstration project that will pay up to $5,000 in lost wages (plus transportation and family costs) for living donors (who make up about 30 percent of the pool). This is not quite paying for kidneys, but it is tiptoeing closer to the line.

The AAKH is the kind of initiative that often goes unnoticed. But it addresses a real health issue and attempts to improve a health care policy that is in clear need of reform.