台灣基層透析協會

本會宗旨:

關懷透析病患，提升透析品質，維護透析診所與病患的權益，協助政府制定相關醫療政策及推行健康保險制度。

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最新消息：

☆各位基層同仁，我們基層透析週報出刊已經一年，如果只是在網路上寫一些批判文章，對整個基層透析現況不會有什麼幫助，一定要有具體的行動，才能產出成效。過去 7、8 年來，歷任腎臟醫學會理事長對爭取透析總額也是盡心盡力，提出健保署所要求的各種數據，並且全力配合所有政策，但是點值仍持續下降。最近看到一篇文章(如下原文)，雖然是評論美國單一保險人制度的可能性(想學台灣)，其中透露出一個訊息：美國醫療支出全年約三兆美元，而醫療界則花了 12 億美元對每一個國會議員進行遊說。正所謂天下沒有白吃的午餐，要維持這麼多的預算，就必需付出相對的代價。反觀我們台灣的洗腎總額，一年 330 億，也是不小的數目，我們自已付出多少在維護這個預算？答案是近乎“零”，我要呼籲各位夥伴，不能妄想坐等別人的善意施捨來維持自身的利益，每個人都必需要付出。以目前基層院所加上地區醫院共 600 多家院所，如果每年每家提供 2 萬元，就會

有 1200 萬，足夠以合法遊說方式來維護透析預算。每年 2 萬元對一家洗腎院所並非沉重負擔，只要點值回升 0.5，就大有價值。各位基層同仁，打嘴砲，寫筆仗於事無補，只有拿出行動才會有成果。

另一方面也要經營腎友會，讓他們清楚政府目前的透析政策，結合立委和腎友，才是我們未來的出路。6 月起全國分區座談，請大家務必參加。(日程如下)

地區	日期	時間	地　　點
新北市	6/8	10:00	國立台灣藝術大學 教學綜合大樓 10 樓演講廳(新北市板橋區大觀路一段 59 號)
台北市	6/8	15:00	台北馬偕醫院平安樓 15 樓階梯講堂(台北市中山區中山北路二段 92 號)
高屏區	6/22	10:00	高雄醫學大學附設醫院啟川大樓 6 樓第二講堂(高雄市三民區自由一路 100 號)
雲嘉區	6/22	15:00	聖馬爾定醫院 10 樓學術講堂(嘉義市東區大雅路二段 565 號)
桃竹苗	6/29	10:00	新竹市文化局圖書館 2 樓習齋教室(新竹市東大路二段 15 巷 1 號
中彰區	6/29	15:00	中山醫學大學正心樓 2 樓 0211 教室(台中市南區建國北路一段 110 號)

Would A Single Payer System Be Good For America?

Brian Klepper, Other, 07:21PM May 7, 2014

Brian Klepper

On Vox, the vivacious new topical news site, staffed in part by former writers at the Washington Post Wonk Blog, Sarah Kliff writes how Donald Berwick, MD, the recent former Administrator of the Centers for Medicare and Medicaid Services and the Founder of the prestigious Institute for Healthcare Improvement, has concluded that a single payer health system would answer many of the US' health care woes. Dr. Berwick is running for Governor of Massachusetts and this is an important plank of his platform. Of course, it is easy to show that single payer systems in other developed nations provide comparable or better quality care at about half the cost that we do in the US.

All else being equal, I might be inclined to agree with Dr. Berwick's assessment. But the US is special in two ways that make a single payer system unlikely to produce anything but even higher health care costs than we already have.

First, it is very clear that the health care industry dominates our regulatory environment, so that nearlyevery law and rule is spun to the special rather than the common interest. In 2009, the year the ACA was formulated, health care organizations deployed 8 lobbyists for every member of Congress, and contributed an unprecedented $1.2 billion in campaign contributions in exchange for influence over the shape of the law. This is largely why, while it sets out the path to some important goals, the ACA is so flawed.

Understood in terms of its probable returns on a nearly $3 trillion current annual health care spend over, say, 25 years. the lobbying investment was a drop in a very large bucket. The negligible opportunity cost will generate returns for the industry for many years to come.

Second, every health industry sector - brokers, health plans, physicians, health systems, drug and device firms, health IT firms - has demonstrated and continues to demonstrate a willingness to employ institutionalized mechanisms of excess, most of them variants on over-treatment and stratospheric unit pricing, that allow them to extract more money than they are entitled to. This is why US health care costs double what it does in other developed nations.

It's not that our people are sicker, but that we now accept distorted care and cost as normal. These practices unnecessarily expose patients to physical peril and cost purchasers double, displacing spending on other critical needs. Unfortunately, ACA does little to disrupt this waste.

Admittedly, employers and unions have so far failed to galvanize and mobilize their aggregated purchasing strength to demand greater health care value. But in a system in which the regulatory environment has been captured by health care, purchasers remain our most promising counterweight to the health care industry's unrelenting cost growth.

Imagine what might transpire if employers and unions were removed from the equation, except for their contribution through taxes. The purchase of health care coverage would move from groups, who have latent but considerable power, to individuals, who have little to no power against monolithic health care organizations.

In the curious dynamic that has evolved, non-health care business and labor leaders could work collaboratively, serving as a counterweight to the health care industry's excesses and holding their health care partners accountable. They could use their considerable purchasing leverage to reward organizations and professionals with good clinical and business practices and, frankly, punish those with bad ones.

But under single payer, we'd all be at the mercy of what occurs in the transactions between our Congressional Representatives and the health industry's lobbyists. If the past is prologue, there would be little opposition, and the industry would have open field running.

Brian Klepper *is a health care analyst and the new CEO of The National Business Coalition on Health.*

☆截至 4 月底，本會今年度以繳費會員共 241 名，尚未繳交者，協會將委託專員到院所收取，敬請配合。

學術專欄：

BUSINESS DAY

Cost of Treatment May Influence Doctors

By ANDREW POLLACKAPRIL 17, 2014

醫生在醫治患者時 ，是否需要幫患者考慮到醫療經濟學(Health economics)？在某些科的治療，可能會有保險不給付的項目，例如：風濕科免疫抑制制、血腫科的化療藥物或是心臟科的塗藥支架。然而，這些動輒幾萬元的自付額，每個患者都付得起嗎？醫師應該要每個患者都給一樣的建議嗎？若不給同樣的建議，醫師不是應該要不分貧富的醫治患者嗎？怎麼可以有差別待遇？

然而現在，社會上或是醫界上，慢慢地能接受經濟因素也是一項重要的考慮因子。

The cardiology societies say that the idea that doctors should ignore costs is unrealistic because they already have to consider the financial burden placed on the patient, if not society. "Protecting patients from financial ruin is fundamental to the precept of 'do no harm,' " the societies wrote in their paper outlining the new policy.

"We couldn't go on just ignoring costs," Dr. Heidenreich said.

在腎臟科，若是遇上上高血磷合併高血鈣的病人，最好的是非鈣非鋁的磷結合劑，然而，一個月 5-6 千元的藥費，也不是每人皆能負擔的。不能負擔昂貴藥物的患者，我們還要向他提這些治療選項嗎？另外，一些營養狀況差，白蛋白值低，有胺基酸點滴可用，不便宜也是要自費，要提起嗎？提這些自費的藥物，在傳統包山包海的健保海中，醫師告訴患者，有沒有可能讓患者心裡覺得是醫師個人的因素？而不是是為了患者好？這些因素都是我們要考慮的。