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行政院衛生署一〇一年度委託研究計畫

101 年度『透析服務支付政策之評估』研究計畫

研究報告

計畫執行機構：台灣腎臟醫學會

計 畫 主持人：楊五常

協 同 主持人：黃尚志、許志成、謝慧敏

研 究 人 員：劉佳鑫、李宛諭、林慧美

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中文摘要

一、研究背景：

世界各國末期腎臟疾病(End-Stage Renal Diseases, ESRD)發生率與盛行率逐年增加。台灣從 2001 年開始在全球 ESRD 盛行率和發生率居首位。由於透析病患持續增加，我國自 1995 年全民健保開辦以來，健保支出費用中透析的總花費不斷攀升。透析患者只佔總保險人口的 0.18%，但卻佔健保總醫療費用支出約 7.17%。因此健保局於 2003 年 1 月全面將西醫基層及醫院之門診透析部門預算合併為單一透析總額，以進行醫療費用的管控。

二、研究目的：

本研究從病患和透析醫療院所層面評估透析總額支付制度前後對醫療效率、醫療資源分布、以及健康結果的趨勢變化。另外本研究亦深入瞭解透析支付制度對於醫師、學者的意見與看法。

三、研究方法：

研究方法主要為利用次級資料庫分析量性研究，搭配焦點團體訪談等質性研究以補充量性研究的不足和限制。量性研究利用病患及醫療院所 2000 到 2010 年間健保資料庫，來瞭解門診透析總額支付制度實施前後的醫療效率（如醫療資源利用）、醫療結果、和醫療資源分布的變化趨勢分析。

四、研究結果：

總額支付制度是有效控制醫療費用的方法，但是醫療院所是否會因此改變病患的醫療品質和服務是政策實施最大的疑慮。本研究結果發現在總額支付制度限制費用下，對於病患的存活率、生化檢驗指標、以及平均醫療費用並無顯著增加。從醫療院所層級分析醫療院所效率表現，發現基層診所家數增加幅度相當大，另外，院所醫師獨自經營的比率下降，轉為聯合醫療模式比率增加。從縣市層級分析醫療資源供給分佈狀況，每萬人口的透析醫療院所數、透析病床數等醫療資源分布逐年均衡。

五、政策建議：

綜合研究的結果和討論，對於政策上的建議包括：(A)透析治療模式的合理占率；(B) PD 與 HD 的透析支付方式；(C)門診透析總額的運作模式；(D)門診透析總額的合理成長率；(E)減少慢性腎衰竭/透析病患發生率之對策；(F)透析經營集團化的行政管理與醫療品質的管控

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關鍵詞：門診透析總額支付；末期腎臟疾病；醫療效率；醫療利用；醫療費用；醫療品質；醫療資源分布

Abstract

Background and Introduction:

The number of treated end-stage renal disease (ESRD) patients worldwide has continued to grow annually. Taiwan is the country with an incidence and prevalence rates for ESRD that had been ranked at the top internationally since 2001. The number of ESRD patients takes account for only 0.18% of entire health insurance enrollees. However, there is about 7.17% total healthcare spending of Taiwan's National Health Insurance (NHI) was used for the care of ESRD patients. In response to the rapid growth of outpatient dialysis spending, the NHI program implemented global budget caps for some outpatient dialysis clinics facilities in 2001and was expanded as outpatient dialysis global budget (ODGB) cap to cover all NHI's outpatient dialysis facilities in 2003.

Objectives:

The purpose of this study is to examine the effect of ODGB cap on the trend change of the aspects in terms of health efficiency, health outcomes and distribution of health resources. In addition, this study investigated the opinions from clinicians and scholars regarding the ODGB cap policy.

Methods:

Secondary data analysis using National Health Insurance Medical Claim data for entire insured population from 2000 to 2010 and Taiwan Society of Nephrology (TSN) Dialysis Registry data were used as the major data sources to do trend analysis. In addition, qualitative research method using focus group interview data were also used as supplementary information when evaluating the effect of ODGB policy.

Results and Contribution:

Implementation of global budgeting has shown effectively in controlling the increase in medical expenses. However, policy makers may concern whether the cost containment policy affects health services and healthcare access when their profit margin shrank. Our study findings indicated that patients' unadjusted survival rate, biochemical test and average health expenditure did not significantly change. From health organizational level analysis, we found the number of clinics increased substantially. In addition, number of facilities with solo practice model decreased and turned to group practices. From county level analysis, we found the health resources (e.g., number of dialysis facilities and beds) were gradually and equally distributed during study years.

Policy Implications:

Given the study results from focus group interviews and secondary analysis, several policy implications were listed. First, policy makers shall consider the advantage and disadvantages of changing current dialysis global budget system from "virtual" global budget to "formal" global budget in order to effectively control health expenses and decide growth rate reasonably. Second, the payment method for PD and HD need to be further evaluated. Third, given the fact that rate of PD for dialysis patients in a dialysis

facility was listed in hospital accreditation criteria, this study suggested this would leave health professionals the flexibility to determine. Forth, policy makers shall encourage the renal disease prevention and hospice care. Fifth, the quality of care and financial statements among industrial operated facilities were needed to be continuously monitored.

Keywords： Outpatient dialysis global budget(ODGB); End-stage renal disease; Healthcare efficiency; healthcare utilization; healthcare costs; healthcare quality; equity; Distribution of health resources