Curing and Caring in Older Adults

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How can I best illustrate the difference? I think with examples.

I received the following memo recently:

"Health Sciences North is commencing a Trans Aortic Valve Initiative (TAVI). This program will address the needs of patients that are considered too high risk for aortic valve replacement. We invite all physicians to make referrals to our centralized Coordinator for consideration of a trans aortic valve replacement."

Whereas the traditional treatment for critical narrowing of the aortic valve is open-heart surgery, TAVI means inserting a catheter through the skin in the groin, guiding it up an artery and into the heart - a much less invasive procedure than splitting the chest. The initial cost of the procedure is around $38,000 U.S. TAVI is a new example of curing. The early results are good.

Dr. Natalie Dupuis is our chronic pain specialist at Health Sciences North (HSN). She has been negotiating for funding to support a new Chronic Pain Service. She is getting close, which is encouraging because the lack of support led another colleague to leave Sudbury years ago. She is asking for $500,000 to start a bare bones program.

Chronic pain sufferers report the lowest health related quality of life when compared to others with chronic health conditions including advanced heart disease. Twenty one per cent of Canadians who experience chronic pain have to wait more than two years for diagnosis and treatment of their condition. Large parts of Canada have no treatment programs whatsoever even though chronic pain is not an uncommon disorder. Treatment is complicated. It is much more than pills. It involves the use of multidisciplinary teams, each member specializing in a different aspect of pain. Chronic pain programs are an example of caring.

For me, caring is the bedrock, the initial step in building a high quality health care system. It means decent economic and home support for our poor and fragile elderly, decent home and institutional care for the chronically ill, the disabled, the cognitively impaired, and the mentally ill. It means access to rehabilitation to restore function and it means the relief of pain; and at the end of life it means access to hospice and palliative care in a supportive setting.

Ontario's budget indicates that future increases in the health care sector will be limited to 2.5%. This will be a big drop from many years of 6% increases. How will this work when the province is already having difficulties meeting its health mandate? How will the province find the funds to make the necessary investments in the community sector? The government's assumption is that improvements in the community sector and primary care, together with other managerial measures will decrease hospital utilization and create the necessary savings. This is wishful thinking. A recent Canadian study concluded:

"Even if a national, integrated primary care system were established, it would not necessarily end cost escalation, because other cost drivers would still be factors. It is therefore imperative that issues such as increased technological and pharmaceutical interventions and increased service provision –also be tackled."

If we cannot afford everything, what should we do?

Let me quote Daniel Callahan. He is President Emeritus of the Hastings Institute, an American institute devoted to medical ethics.

How about a health care system that began with decent caring; it also guaranteed good pediatric and maternal care, public-health measures, and primary care. Do common operations and procedures. Thereafter, with whatever funds remained, which would be significant, expensive technological curing-medicine could be pursued."

This paradigm, if adopted, would be the exact opposite of what we currently do in Canada. We begin with high tech medicine and then with whatever is left over….