Yes, we can lower health-care costs

JIM MEEK, Halifax Herald
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Canada's health-care debate is stranded in the 1980s, the last decade in which universal access was a public policy rather than a political slogan. Today, even though we've left Shangri-La far behind, we're stuck there in our minds.

No wonder we're going broke — financially and intellectually.

Just this week, the Canadian Medical Association tried to move the debate forward, but old language kept popping up in the CMA's new report — entitled "Health Care Transformation in Canada: Change that Works. Care that Lasts."

What the report does, in the end, is sweep some old crumbs off the kitchen floor, and try to serve them at the dining-room table as fare fit to fuel a health-care revolution.

On the menu are the old favourites: patient-centred care, proper staffing, improved use of technology, and universal access to prescription drugs. Minds wiser than mine may have compiled this list, and it may even be the right list. But the old themes still keep coming back at us with the soporific impact of a CSI rerun.

In Canada, we've rewritten the screed a dozen times, and we keep bringing it down from the mountaintop as if it were a set of commandments borne by Moses. This means the great national debate seems to centre on articles of faith, not rules of scientific evidence that might produce better outcomes in clinical practice.

For a more satisfying public conversation, Canadians can look to the U.S., where health care outcomes are worse but the public debate is more instructive. I cite, in defence of this view, not the inchoate rambling of U.S. senators but the work of a singular journalist, Atul Gawande, who moonlights as a Boston-based, Harvard-educated surgeon.

In "Letting Go," an article published in the New Yorker (Aug. 2 edition), Gawande bears compassionate witness to the death of a young woman who had been diagnosed with terminal lung cancer just as she was about to deliver her only child.

It is understandable that no one in her family (or on her medical team) can give up on "Sara." She cannot beat the odds, however, and Sara finally dies — wasted in spirit and frame — after undergoing successive bouts of chemotherapy that only seem to weaken her. And after her husband has given her permission to die: "It's OK to let go."

Her husband's words seem moving rather than telling; in fact, they are both. For what emerges in the research that forms the subtext to this story is the power of real conversation — that is, actually talking with patients about their wishes.

This takes me to the article's central question: "What should medicine do when it can't save your life?" The answer seems to be to talk to patients and families — that is, to figure out end-of-life wishes before the terminally ill are taken captive by illness and the best-intentioned interventions of medical teams.

Gawande makes his point by referring to an unintended medical experiment conducted in La Crosse, Wis., where elderly patients "spend half as many days in hospital as the national average, and there's no sign that doctors or patients are halting care prematurely."

The secret of La Crosse's success is that medical teams have (since 1991) asked patients to describe their end-of-life wishes before they were in crisis.

It turns out that conversations about dying are more useful than the living wills themselves. The key in La Crosse is that people are willing and able to talk about death. "The discussion, not the list, was what mattered most. Discussion had brought La Crosse's end-of-life costs down to just over half the national average." (We spend a huge proportion of our health-care dollars on end-of-life care. In the U.S., 25 per cent of all Medicare expenditures are made in the last year of life.)

Gawande typically describes successful health-care models (like La Crosse) rather than just criticizing failures. In short, he charts a way forward. What's frustrating, as health-care costs cripple both nations financially, is our failure to put better, more affordable care models in place. It's not that we don't know what to do. The problem is our failure to do it.

Instead, we rewrite reports, documenting old failures rather than acting to overcome them.

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