Is ambulatory care a better way to go?

A bitter pill for patients, opponents say

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The tyranny of the postal code, a sow's ear or silk purse, the International Monetary Fund and Canada's bond rating.

These words came up in a spicy debate at a daylong symposium on the Shift to Ambulatory Care - which is code for medical services delivered on an outpatient basis.

Among the hottest trends in medicine globally, the shift to outpatient care in Quebec has been the product of a steady push over several years.

Who can forget the provincial Health Department's "virage ambulatoire" of the 1990s? Health critics and pundits have denounced it as the "mirage ambulatoire." That's because despite the closing of several acute-care hospitals, the funding that was supposed to be re-injected into home-care services never materialized. Similar problems arose when psychiatric patients were turfed out of hospitals and sent to be "taken care" of in the community.

Now the push is on for more hospital medical services to be taken on by the community.

At the symposium organized by St. Mary's Hospital, the topic for debate was quite clever - Virage Ambulatoire: Bitter or Better.

In just a few moments, speakers would begin to sum up what works and what doesn't work.

On the "better" side: nurse Carol Common, community outreach senior advisor at the McGill University Health Centres, and Zelda Freitas, a social worker at the CLSC N.D.G. and supervisor of the program for seniors who are losing autonomy.

On the "bitter" side: physician John Hughes, a McGill University faculty of medicine professor and former director of professional services during the 1996 closure of the Queen Elizabeth Hospital, and Isobel Cunningham who helped establish the CLSC Park Extension and has worked in social work for 30 years.

But first, before the arguments exploded, a quick show of hands in the room to gauge support. No surprise - the "better" side was in the clear majority.

Would a final show of hands following the debate upset popular opinion? BETTER: Common, who got to go first, acknowledged her bias, having worked for years at the MUHC establishing links to the community health clinics (CLSCs). Here are some of the points she made: S Technological and drug advances means people with various conditions can be supported in the community for longer periods of time, leaving highly specialized hospitals to provide highly specialized care to those who really need it.

S The virage ambulatoire led to the development of home-care services at the CLSCs - rehab for surgery, cancer, and heart patients. It's not perfect, but it contributed to "better comfort" and better outcomes for the patient.

"Can or should the hospital be all things to all people? No." S A recent meta-analysis of international ambulatory care programs, published in the Canadian Medical Association Journal, showed no increase in death rates and an improvement in patient depression, she said.

S Patient interviews have demonstrated that people really appreciate some care at home or close to home, "shorter travel time, reduced wait times, the whole experience. People are people first, not patients, and their lives have purpose and meaning beyond their illnesses." BITTER: Hughes went next and his position was that ambulatory care is a failure - especially when cost and outcomes are factored into the balance: S Most analyses do not consider the cost burden to the community caregiver, and social and psychological outcomes are hard to quantify. "There's no way to evaluate this." S Technological advances have always driven the "devolution of hospital care to the ambulatory setting." For example, the discovery of streptomycin emptied tuberculosis sanatoriums in the 1950s, anti-psychotic drugs emptied psychiatric asylums in the 1960s and '70s, then came scope surgery replacing more invasive techniques, artery stents replaced cardiac bypass surgery, the list goes on.

S Quebec's virage ambulatoire and the closure of 20 per cent of Canada's acute-care hospital beds in the 1990s, however, was the result of a threat by the International Monetary Fund to downgrade Canada's bond rating.

"I know that for a fact because (then finance minister) Paul Martin told me. The IMF threat translated into a $2 billion cut from the federal government to the provinces, which lead to hospital closures and the virage ambulatoire." S Former Quebec Health Minister Dr. Jean Rochon called it a natural outcome of medical advances, Hughes noted. Money was promised to cover outpatient care, but it never appeared.

S "If you close hospital beds due to budget cuts, don't try to pretend it's because of medical technological advances. Today we are still paying for the virage ambulatoire with substandard care, unacceptable waiting lists and human resources shortages. Hence, the need to call a sow's ear a silk purse." BETTER: Freitas touched on palliative and home-care programs that emphasize dignity and quality of life to the very end, thanks to coordination from case managers at CLSCs. It's an equitable system that provides for patient comfort while relieving pressure on the emergency room: S The fact is, Canada is an aging nation with increasing rates of chronic illnesses. Some 77 per cent of people over age 55 have chronic illnesses. These people live at home. Technological advances, including tele-health and computerized equipment "allow us to provide more care at home ... governments are trying to contain the health care budget and home care is generally perceived to be lower- cost care." S "But don't be mistaken, it's not simply a transfer of hospital services but a unique reconfiguration of these services that takes into account the intimate reality of the home environment, within a family and cultural context." S Home care is not the only solution, she said, but it is "the cornerstone of an integrated or efficient health care system." BITTER: The last speaker, Cunningham, called attention to the "tyranny of the postal code and the injustice of some patients getting more services than others simply because of where they live:" S Local community health services are dispensed according to

where patients live and some CLSCs are better equipped then others. Some must rely on private agencies for homemaker services.

S CLSC care is unpredictable, which makes discharging patients from the hospital difficult "when we are unable to know how much family or private help will be needed to supplement the CLSC," she said.

S The CLSCs cannot provide cooking, housecleaning or night services.

S Cunningham criticized the Montreal Health and Social Services Agency for closing hospital beds without first providing for the patients. She called this virage the biggest burden on the CLSCs.

S Now that the acute-care hospitals are emptying their long-term beds, people in the community getting home care while waiting their turn for spots in nursing homes, have fallen to the bottom of the waiting list.

"The hospital patients are now getting the priority," she said, adding that hospital and CLSC staff really do "know bitter." sss A final show of hands after the debate showed that the scales had tipped.

The "bitter" team won the debate by demonstrating that the shift was not about better patient care, but more about money, symposium organizer Dr. Todd McConnell said later.

But, he cautioned: "One shouldn't confuse the principle of good ambulatory care with the lack of resources to provide it." cfidelman@ thegazette.canwest.com

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