

Prospective Direction of Palliative Care in Canada

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Palliative care (PC) is one form of health services for patients diagnosed with a life-threatening illness (Vautier & Mann, 2018). It has both holistic and clinical approaches to assist pain and symptom management, provide social, emotional, and spiritual support, and protect the dignity and quality of life of patients (Vautier & Mann, 2018). In Canada, PC is offered at hospitals, long-term care homes, community care support centers, and primary health care providers (Government of Ontario, n.d.).

Arguably, PC has a greater role than ever before as more Canadians suffer from chronic conditions, co-morbidities, and slow deterioration of health (Arnup, 2013). The number of individuals who need PC is only projected to grow with Canada's aging population. The Canadian Institute for Health Information estimates that Canada will see a 68% growth (up to 10.4 million) in the number of older adults in 20 years (Canadian Institute for Health Information, n.d.). Despite the significant role of PC in patients' quality of life and the continuous increase in demand, PC is excluded from the Canada Health Act (CHA), making it difficult for the service to be equitably accessible to all Canadians (McNeil et al., 2012).

Moreover, limited research has been conducted to explore the factors associated with this exclusion and the future projections of PC and CHA in Canada (Lyzwinski, 2013; Roulston, 2018; Williams et al., 2010). Therefore, this paper aims to discuss the advantages of incorporating PC into the CHA as well as the potential challenges Canada may face when implementing this change.

Background

In 1984, parliament passed the CHA which practices the principal intent of the Canadian Health Care Policy (Canada, 2018; Deber, 2017). Despite its aim to allow reasonable access to insured healthcare services for all eligible Canadians, PC is still excluded from the legislation,

and there are no clear documentations that justify or disclose projected amendments (Canada, 2018).

Advantages of Including PC in the Canada Health Act

1: Equitable Accessibility

Geographical Location

Currently, the literature suggests significant inequalities in accessing PC across Canada. For instance, a 2013 study found that older cancer patients were 60% less likely to enroll in PC than younger cancer patients (Burge et al., 2008). Several potential reasons were suggested, including seniors residing farther away from PC facilities than the younger population (Burge et al., 2008). Several studies have found significant correlations between the geographical locations of patient homes and their enrollment in PC (Conlon et al., 2019). In addition, promising correlations between access to PC in rural regions and better management of serious illnesses amongst patients have been discovered (Bakitas et al., 2020). Unfortunately, even if rural patients received PC, they were less likely to be supervised on a 24-hour basis by trained community nurses compared to facilities in urban regions. Thus, resulting in greater risks of symptom-related crises and visits (BC Centre for Palliative Care, n.d.).

Race and Ethnicity

Race and ethnicity of patients have been found as significant factors in influencing access to the healthcare system and PC is no exception (Fuhr et al., 2018; Johnson, 2013; Nielsen et al., 2015). This is a substantial challenge as Canada is racially a diverse nation. Statistics Canada stated that over 250 ethnic groups reside in the country, with European ancestry (20 million) being the largest ethnic group, followed by Chinese (1.8 million), and East Indian (1.4 million) ancestries (Government of Canada, 2017). If PC were to be incorporated into the CHA, we may

see a decrease in inequity of access since there would be stable and continuous financial support to establish interconnected and coherent PC in Canada (Vautier & Mann, 2018).

2: Burden of Costs

Patients and Caregivers

Due to the patchwork of PC funding and delivery, patients and their caregivers are often faced with an overwhelming amount of cost-related distress. According to Gardiner et al (2014), costs can be broken down into three categories: 1) work-related costs; 2) out-of-pocket expenses; and 3) carer time costs. Regarding work-related costs, research suggests that caregivers often forfeit their work, and increase leave or sick days to meet the demands of caretaking (Gardiner et al., 2014). Further, several avenues of out-of-pocket expenses were identified, such as medical equipment, prescription drugs, and travel fees (Gardiner et al., 2014). Finally, a varying amount of time was estimated to be spent by caregivers supporting patients (Dumont et al., 2009). Cost burdens were suggested to differ based on geographical location, with the total cost in rural regions being 1.5 times more expensive than in urban regions (Dumont et al., 2015). If PC was to be protected under the CHA, patients and caregivers could experience a reduced burden as the government would be responsible for the costs involved.

Government

Studies suggest that PC can save the government a considerable amount of money by reducing the number of patients admitted to acute healthcare services. For instance, it was suggested in 2008 that patients who obtained PC consultations correlated with more than a \$5,000 reduction in direct hospital costs compared to those who never received consultations (Morrison et al., 2008). In Canada, the Ontario Ministry of Finance projected that PC could provide a significant increase in savings for the government with total savings ranging from \$247

million to as much as \$2.1 billion by 2036 (Miedema, 2013). Nationally, this would mean that Canada could spend 11% less on its high-cost populations by improving access to PC (Gans et al., 2012). Further, the growth of PC in Canada could allow efficient use of funding by reducing admission costs. A study found that PC services within the initial 48 hours of hospital admission can lead to a shorter patient length of stay in a hospital facility which is equivalent to a reduction of total cost by 40%. It is worth noting that this is approximately \$2,300 per day (Bharadwaj et al., 2016).

Challenges of Including PC in the Canada Health Act

1: PC Research

Due to the nature of PC and its patients, conducting PC research is often difficult and has left some experts questioning its efficacy. Decato et al.'s (2013) study found that in comparison to other means of research, PC research faces further complications when obtaining approval from the Institutional Review Board, recruiting adequate research staff, and accruing participants. In particular, participant recruitment is a well-known challenge due to the serious nature of patients' illnesses, symptom burdens, and proximity to death (O'Mara et al., 2009). Moreover, as health commonly declines at a rapid rate in PC patients, there is often a noticeable amount of missing data (O'Mara et al., 2009). Many of these challenges further contribute to the ethical dilemmas of PC research such as inadequate informed consent of patients and difficulty assessing the risks and benefits (Casarett & Karlawish, 2000).

In addition, observational study designs are frequently used in PC research, which puts research findings at risk of selection bias (Ernst et al., 2003; Starks et al., 2009). Selection bias is a type of bias in which the enrollment of patients is prompted by non-random influences, such as referral to a PC facility (Starks et al., 2009). Furthermore, confounding variables often arise as

some variables are related to the predisposing selection as well as the outcome (Starks et al., 2009). Drawing conclusions from research studies that embody bias and confounding variables can be risky as an interpretation of results could be distorted (Šimundić, 2013).

2: Collaboration of Stakeholders

Since the inception of PC in the 1980s, it has gone through several political milestones, including the creation of a Canadian PC Framework in 2017. Despite these efforts, studies suggest a lack of implementation and minimal presence of PC in the healthcare system due to varying levels of key stakeholder engagements (Xiao et al., 2022b). Specifically for Canada, which involves the federal, provincial, and territorial governments as well as the private sector in the operation of the healthcare system (Deber, 2017), a clear understanding of the level of responsibilities of stakeholders is crucial. In the case of PC, which not only requires intricate engagement from the governments, health care providers, caregivers, and community organizations (Xiao et al., 2022a), but also mitigation of ethical and research dilemmas, it can be even more challenging to advocate for the inclusion of PC in the CHA.

Conclusion

As the Canadian demographic shifts to an aging population with an increasing number of noncommunicable diseases, having a well-established PC protected under the legislation is important. Not only does PC improve the equity of health care access irrespective of geographical location, race and ethnicity, but it also reduces the financial burdens for patients, caregivers and the Canadian government. However, PC is not protected under the CHA and several factors may be influencing this such as unreliable PC research findings and the lack of collaborative engagement and understanding of stakeholders. The present discussion validates

the need for further systematic analysis to assess whether the advantages of PC rationalize its protection under the CHA.

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