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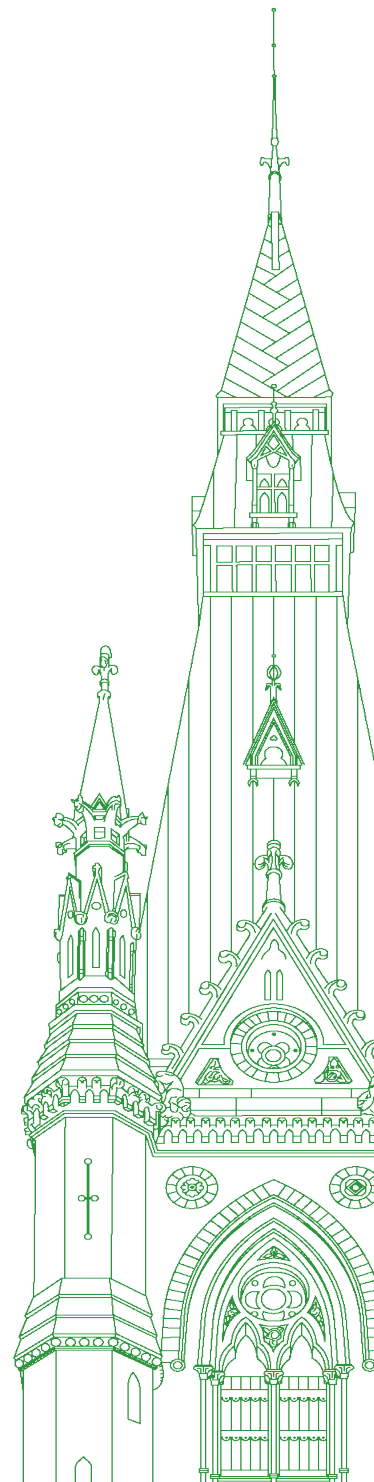
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Monday, March 9, 2020

Chair: Mr. Ron McKinnon



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• (1530)

[English]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call the meeting to order. This is meeting number seven of the House of Commons Standing Committee on Health.

There are two parts to this meeting.

The first part will be with our illustrious witnesses, who can tell us what we need to know, or give us a good start.

Then, for committee business, we'll go in camera for the last half.

I welcome, from the Canadian Institute for Health Information, Christina Lawand, senior researcher, health systems analysis and emerging issues.

As well, from the Department of Health, we have Marcel Saulnier, associate assistant deputy minister, strategic policy branch; and Sharon Harper, acting director general, health care programs and policy directorate, strategic policy branch.

I believe the Department of Health will begin with a 10-minute statement.

Please go ahead.

Mr. Marcel Saulnier (Associate Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Thank you very much. I want to begin by acknowledging that we are meeting today on land that is the traditional and unceded territory of the Algonquin Nation.

Thank you for the opportunity to appear in front of you on this very important issue.

[Translation]

Palliative care improves the quality of life of people facing life-limiting illness. It eases their suffering and supports their families. Though it is an essential part of health care, it is often overlooked, so I'm happy that the committee has decided to study palliative care in Canada.

[English]

Canadians approaching the end of their lives deserve to receive care in the setting of their choice and live out their final days in comfort and dignity.

As you'll hear from my colleague at the Canadian Institute for Health Information, the unfortunate reality is that three-quarters of

Canadians say they would prefer to spend their final days at home, yet 61% of Canadians still pass away in the hospital.

Access issues are complex and occur in all settings due to a number of factors.

[Translation]

Our society has a cultural tendency to deny the reality of death and this leads to a lack of planning, acceptance, and appropriate referrals. Meanwhile, our health system defaults to acute care when home care is usually preferred, and always more economical.

[English]

A lack of available providers, lack of understanding of the benefits of palliative care, and simple geography in the case of rural and remote communities are additional barriers to accessing quality palliative care.

In terms of Government of Canada measures, budget 2017 provided \$6 billion over 10 years in targeted funding for provinces and territories for home and community care, including palliative care. This was done through a series of bilateral funding agreements. This funding is being used right now by provinces and territories on activities identified in these bilateral agreements, which are posted publicly.

For example, British Columbia is working to provide 24-7 access by health care providers to consultations with experts on pain and symptom management. Prince Edward Island is implementing an integrated mobile health program, which uses community paramedics to support palliative patients at home. Saskatchewan is providing training to health care professionals in order to improve their ability to provide end-of-life care. Many other provinces are undertaking initiatives of that sort.

The current bilateral agreements are in place until 2021-22, and the government intends to negotiate renewal of these agreements for the next five years through to 2026-27. That means the whole five-year period.

[Translation]

We also have a number of other measures under way to enhance access to end-of-life care. In 2017, the government provided \$184.6 million over five years to improve home and palliative care for indigenous communities.

[English]

I'll now move to the framework and action plan on palliative care in Canada.

On December 4, 2018, the government tabled a framework on palliative care in Canada, based on consultations with a broad range of stakeholders, to bring focus to the benefits of palliative care and the access issues faced by Canadians. The framework gives Canadians, governments, stakeholders, individuals, caregivers and communities a common reference point to help us better collaborate and coordinate our efforts.

In August 2019, Health Canada released an action plan on palliative care, which builds on the framework. The action plan lays out Health Canada's five-year plan to tackle issues identified in the framework, using federal levers.

• (1535)

[Translation]

The federal action plan aims to help improve quality of life for people with life-limiting illness, address concerns of families and caregivers, and enhance access to quality palliative care, through improved health care system performance.

[English]

The action plan aligns with the framework on palliative care in Canada and focuses on five key goals.

The first is to raise awareness and understanding of how advance care planning and palliative care improve quality of life until the end of life. For example, Health Canada is developing awareness-raising initiatives to increase understanding of the benefits of palliative care and how to access it.

[Translation]

Secondly, we aim to support health system quality by improving palliative care skills and supports for health care providers, families, caregivers and communities.

To this end, Health Canada has been pleased to support Pallium Canada's efforts to scale up post-graduate inter-professional training that provides essential palliative care competencies to health care professionals, such as paramedics.

[English]

The third goal focuses on supporting health system quality improvement through enhanced data collection and research. Through the Canadian Institutes of Health Research, or CIHR, the federal government is supporting innovative research to address knowledge gaps and develop new models and approaches to palliative care based on scientific evidence. For example, CIHR is currently supporting a five-year research project to promote access to home-based palliative care for patients across Canada. This project will implement and test the effectiveness of palliative care training programs for 53 primary care teams across Ontario.

[Translation]

The Canadian Institutes of Health Research, or CIHR, is also supporting a Canada Research Chair in Palliative Care to examine ways of preserving dignity at the end of life through bedside and

clinical observations, and by tracking and examining large cohorts of Canadians at the end of life.

[English]

The fourth action plan goal is to improve access to palliative care for underserved populations, which include rural and remote communities, pediatrics and young adults, homeless people and LGBTQ2SI people. Furthermore, we know that some communities face cultural and linguistic barriers that prevent them from accessing palliative care in a timely way.

To address this, Health Canada is supporting projects such as an initiative to improve the uptake of advance care planning in the South Asian and Chinese populations in British Columbia. This project aims to decrease language and cultural barriers inherent in end-of-life care discussions so that members of these communities may access culturally sensitive palliative care.

The fifth and final goal focuses on the unique characteristics, needs and challenges faced by first nations, Métis and Inuit peoples, as well as urban indigenous people in accessing palliative care.

[Translation]

Health Canada is currently working with Indigenous Services Canada, national indigenous organizations and others on next steps to deliver indigenous-led consultations toward a separate distinctions-based framework on palliative care.

Meanwhile, we are supporting indigenous-led initiatives such as the Cree Board of Health and Social Services of James Bay project, which aims to inform culturally adapted care practice guidelines based on Cree beliefs and practices.

[English]

Some action plan projects are under way already. To date, Health Canada has invested almost \$13 million in projects to advance the objectives of the action plan and improve access to palliative care both at home and in the community. Through the action plan, we are striving to address access issues evidenced through current data and research, and reported by providers, people with lived experience and provincial and territorial representatives.

We know that most people with a life-limiting illness wish to remain independent and receive the care they need at home or in their community. Improving access to palliative care across all settings is critical to making this happen.

The current focus on medical assistance in dying, or MAID, is drawing attention to the need for improved access to palliative care. Palliative care stakeholders and MAID opponents have raised concerns that people may choose MAID as the only means to relieve their suffering because of inadequate access to palliative care.

However, preliminary data out of Ontario shows this not to be the case, and that the majority of recipients received or were offered palliative care prior to receiving MAID.

• (1540)

[*Translation*]

It should be clear—this does not negate the need to enhance access to palliative care and to continue to monitor and study the situation. Our vision is that all Canadians have access to quality palliative care from diagnosis to end of life, regardless of whether they choose medical assistance in dying in their final days.

To conclude, we will continue to press forward to implement our action plan, and to build on the many promising practices in providing excellent palliative care.

[*English*]

We all want to live out our lives in comfort and dignity. Appropriate care must be available when it's most needed. I believe our work will help to move the marker forward on this.

I thank you for the opportunity to make these remarks. Sharon Harper and I will be pleased to answer your questions when the time comes.

[*Translation*]

Thank you.

[*English*]

The Chair: Thank you, Mr. Saulnier.

We go now to Ms. Lawand, senior researcher, health system analysis and emerging issues, for 10 minutes, please.

[*Translation*]

Ms. Christina Lawand (Senior Researcher, Health System Analysis and Emerging Issues, Canadian Institute for Health Information): Good afternoon.

On behalf of the Canadian Institute for Health Information, CIHI, I would like to thank you for the opportunity to appear before the Standing Committee on Health.

Since 1994, CIHI has been an important organization in Canada's health sector. We are a not-for-profit, independent body funded by the federal government and all provinces and territories. Our board of directors is made up of deputy ministers of health and other health system leaders representing all regions of the country and the federal government.

CIHI has 28 databases and signed data-sharing agreements with every province and territory, Health Canada, Statistics Canada and the Public Health Agency of Canada. CIHI is a leader in health data methodologies and measurement of health system performance, and we are recognized internationally for our work.

[*English*]

At the Canadian Institute for Health Information, also known as CIHI, we are neutral and objective in fulfilling our mandate to deliver comparable and actionable information. Our aim is to give people, including policy-makers, the information they need to drive improvements in health care and health system performance and, ultimately, to improve the health of Canadians across the country.

The topic we are here to talk about today is palliative care. Canadians are living longer, but they are not always living better. Thanks to improved medical treatments, declines in health are now more gradual, but this can also draw out the process of dying. When this happens, palliative care can help improve quality of life for people with life-limiting illnesses by relieving symptoms, enabling a peaceful and dignified death and providing support to the family throughout the dying and bereavement process.

As Canada's population ages and rates of complex chronic conditions increase, the need for palliative care is expected to rise. Estimates suggest that up to nine out of 10 people who die might have benefited from palliative care.

[*Translation*]

In September 2018, CIHI released its first comprehensive pan-Canadian report on this topic: "Access to Palliative Care in Canada".

The goal of this report was to provide baseline information on palliative care in our country by using available data from CIHI and other sources. The report looks at what services Canadians received in their last year of life.

Specifically, it examines whether Canadians had access to palliative care in the community, whether they had equitable access to care and whether the services they received were effective and appropriate. It also looks at whether health professionals are prepared to provide palliative care and whether patients and their families are receiving the support they need to care for people at home.

[English]

In discussing our findings, let me start with access to palliative care in the setting many patients prefer: their home. While many people could benefit from palliative care at the end of life, only a few are receiving formal palliative home care outside of hospitals. In provinces where this could be measured, we found that only one in six people who died received publicly funded palliative home care. Our study shows that receiving palliative home care increases the chance that you will die at home. This is important, because surveys have shown that most Canadians would prefer to die at home, provided the appropriate supports are in place. Our study found that people who received palliative home care were two and a half times more likely to die at home than Canadians who received regular home care in the last year of life.

Friends and family members play an essential role in palliative home care, although more support for caregivers may be needed. Our report found that 99% of palliative home care clients had family or friends helping to care for them, and almost one in three of these unpaid caregivers experienced distress.

The timing of palliative care can also make a difference. Our findings show that Canadians who received palliative care earlier in their care journey, before the last 30 days of life, were less likely to make frequent visits to emergency rooms or to receive aggressive treatment at the end of life. This provides evidence that access to early palliative care in the community can help reduce poor outcomes for patients at the end of life. However, we found that most people received palliative care only very late in their care journey. In fact, 62% received palliative care only in the last month of life and only in a hospital setting.

• (1545)

For residents of long-term care facilities, palliative care also made a measurable difference at the end of life. We found that long-term care residents who had a record of receiving palliative care in their nursing homes were far less likely to be transferred to hospital to die. These transfers can be stressful for both patients and their families.

We also set out to understand whether Canadians had equitable access to palliative care and whether some patients were more likely to receive it than others. We found the biggest differences were based on the type of disease a person had. Patients with cancer were up to three times more likely to receive palliative care than patients with other illnesses who could also have benefited from palliative care in the last year of life. Age was also a determining factor. Patients between 45 and 74 were more likely than younger adults and older seniors to receive palliative care across most care settings.

The issue of health care provider training and communication with patients is an area of great interest to palliative care patients and their families. We examined whether health care providers felt prepared to provide palliative care to patients in Canada. Results from the Commonwealth Fund international survey of primary care physicians show that while most Canadian family doctors often see patients with palliative care needs, three out of five of these physicians say they do not feel well prepared to manage the care of pal-

liative patients. This finding is below the international average of their peers in 11 developed countries.

Our findings also identified significant variation across the country in policies and programs that influence access to palliative care in the community, including access to residential hospices. At the time CIHI's report was published, residential palliative care hospices operated in only seven out of 13 jurisdictions. Public funding models also varied across the country, from 30% to 100%, depending on the hospice.

[Translation]

Finally, we looked at whether patients who chose medical assistance in dying accessed palliative care. Of those patients who received medical assistance in dying in hospital settings after June 2016, the first year data was available, we found that 65% received some palliative care during their final hospital stay. However, only about one in five of these patients had a palliative treatment plan prior to their final hospital admission.

[English]

CIHI's palliative care report represents a collaborative effort with our national, provincial and territorial partners to provide the most comprehensive picture to date of access to palliative care in Canada. Our findings highlight opportunities to improve transitions of care and to initiate palliative care earlier in a patient's journey.

However, data and information gaps remain. This report identified the need for more pan-Canadian information on home care, hospice care and primary care. It also identified the need for more patient- and family-reported data, or using the voice of patients to understand whether their needs are being met and whether palliative care is making a difference in improving their quality of life.

The lack of a common definition of palliative care across the country was also identified as a gap in the report. A clearer definition and some guiding principles have since been provided in the national framework on palliative care in Canada, which Health Canada has talked about.

CIHI continues to work collaboratively with provinces and territories to improve data collection and measurement of palliative care in Canada. For example, we're improving our emergency room data; we're expanding home care data coverage; and we are continuing to work with our national and international partners, such as the Commonwealth Fund, the OECD, the Canadian Partnership Against Cancer, and Statistics Canada, all of which play a vital role in collecting and reporting information on palliative care.

We are also working with the federal, provincial and territorial governments to measure access to community services as part of the “Common Statement of Principles on Shared Health Priorities”. One indicator scheduled for release in 2022 will measure death at home and is aimed at enhancing access to palliative care at home or in hospices.

• (1550)

[Translation]

In closing, as our data and information improve, we will continue to have a clearer picture to enable the sharing of best practices and to identify areas for improvement. This will help to provide better experiences for patients and their families at all stages of life. More broadly as a society, there is also a recognized need for more frank and open discussions about death and the dying process, to ensure that Canadians have an opportunity to express their wishes and have advanced care plans in place to ensure these wishes are respected.

Thank you for giving us the opportunity to speak today.

[English]

I would be pleased to answer questions from members of the committee.

The Chair: Thank you for your statements.

We will start with questions from Mrs. Jansen for six minutes.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): First of all, thank you very much for your presentations.

I wonder if I could ask Mr. Saulnier this. Is palliative care considered an essential health service in Canada, as MAID is?

Mr. Marcel Saulnier: I think we could say that palliative care is an important part of a well-functioning and high-performing health care system. It is not an insured service under the Canada Health Act, unless it is delivered in a hospital setting or provided by a medical practitioner covered by that insurance plan.

Mrs. Tamara Jansen: Since we know that a request for MAID can't truly be considered voluntary if there is no access to palliative care, do you think palliative care should actually be considered an essential service in Canada?

Mr. Marcel Saulnier: There are a lot of discussions taking place in our system with provinces and territories about how to improve health care delivery. Traditionally, for services that are not delivered in hospitals or in physicians' clinics—and that is increasingly the case for services such as mental health services in the home and community-based services—there's an ongoing debate about how to appropriately fund and deliver those services and how to adequately meet public expectations about access to those services.

Mrs. Tamara Jansen: Okay.

Ms. Lawand, how has the legalization of MAID affected the delivery of palliative care in Canada? I'm thinking specifically of my own home province, where Fraser Health actually implemented MAID in hospice, which is obviously against the concept that a hospice neither postpones nor hastens death. I wonder if you can tell me, if you know, how much it has changed since its legalization.

Ms. Christina Lawand: Once again, the report we did was considered a baseline report. It was our very first report on access to palliative care in Canada. Because MAID had been in effect for only a very short amount of time, I would say that there's not yet enough data to be able to do that analysis properly, although it is something we can look at.

I would also say that at CIHI we only capture MAID events in hospital settings, so we're missing what's happening in the community piece. We know that Health Canada has a registry for MAID and other researchers are accessing that data in other ways.

• (1555)

Mrs. Tamara Jansen: Then my next question would be regarding what percentage of medical professionals are trained to provide palliative care. I noticed you talked about that in the report.

Ms. Christina Lawand: Yes. Once again, on the total number, we know there are a lot of different types of health professionals who can work in palliative care. For ideal palliative care, you would see a very interdisciplinary team bringing in many different types of health professionals.

With the data we have, we were able to look at doctors in certain provinces and found that a small number specialize in palliative care. About 2% of licensed practical nurses had a specialty in palliative care, although many more practised in palliative care for at least part of their—

Mrs. Tamara Jansen: I was actually asking more about the training. I understand that what little training was being done at university and so forth is not even being done now. Instead, MAID is being taught.

Is that correct? Have you heard of that?

Ms. Christina Lawand: No, I haven't heard that in relation to MAID.

With respect to the gap in medical training for palliative care, based on a survey done by the Canadian Partnership Against Cancer, they did find that there was some room for improvement in terms of medical training. However, I think there's an understanding in the system that it's better to broaden the training as much as possible. Primary care physicians, for example, all have a basic understanding of palliative care.

Mrs. Tamara Jansen: Right.

Maybe I can ask Mr. Saulnier a question. I was looking at the numbers from the CIHI report that there were 23,000 palliative care patients in Quebec and Ontario, 16,000 in B.C. and 7,000 in Alberta. Those were the numbers in 2005. Yet, when I look at the federal funding allocation, Quebec and Ontario get 10 times as much money as B.C. and Alberta.

I'm wondering if you could explain to me the discrepancies in that funding.

Mr. Marcel Saulnier: Are you referring to the funding under the targeted investments for home care and palliative care through the common statement of principles, or other specific targeted funding from Health Canada?

Mrs. Tamara Jansen: It was specifically in regard to palliative care. I asked the Library of Parliament to give me a bit of a run-down.

Mr. Marcel Saulnier: I'm not sure I've seen those numbers, Mr. Chair.

I can make a general comment about the allocations—

Mrs. Tamara Jansen: Sorry, do you mind if I ask the next question?

What accountability measures exist for the federal government to evaluate the performance of the funding it transfers regarding palliative care?

Mr. Marcel Saulnier: I can comment on that.

In the common statement of principles, as Ms. Lawand indicated, there is a common set of metrics that has been adopted by federal and provincial governments to assess progress against the objectives that were set out in the common statement of principles. That applies to home, palliative and community care, as well as mental health and addiction services.

Some of those indicators are pertinent to home care and palliative care and—

Mrs. Tamara Jansen: I'm asking specifically about accountability measures. What sort of accountability measures are in place?

Mr. Marcel Saulnier: In addition to the indicators, there is a requirement for provinces and territories to report annually to Health Canada on how they have used the funding, to verify that the allocations they have directed to palliative care or home care or mental health have in fact been made to those areas—

Mrs. Tamara Jansen: And what—

The Chair: Thank you, Mrs. Jansen.

Ms. Sidhu, you have six minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, panel, for your presentations.

My question is for Health Canada.

You said that 62% of end-of-life patients receive palliative care, so there must be barriers. What kind of approach are you taking to remove those barriers?

Ms. Sharon Harper (Acting Director General, Health Care Programs and Policy Directorate, Strategic Policy Branch, Department of Health): Thank you for your question.

The action plan on palliative care, which was mentioned by Marcel, sets out Health Canada's approach to addressing those barriers. It includes activities to raise awareness about palliative care and end-of-life care planning. It includes activities to look at training for health care providers as well as supports for caregivers. It also includes activities to look at research and data to improve those across Canada. As well, it looks at underserved populations, areas of population that may not receive as much palliative care, for a va-

riety of reasons. It also looks at palliative care received by indigenous groups and populations, including first nations, Inuit and Métis.

• (1600)

Ms. Sonia Sidhu: You said that we know that some communities face cultural and language barriers that prevent them from accessing timely palliative care. To address this, Health Canada is supporting projects like an initiative to improve advance care planning to South Asian and Chinese populations in British Columbia.

Do you have any projects in Ontario as well?

Ms. Sharon Harper: At this time, we have projects that are being planned but we do not have any other projects in Ontario to address populations like those in B.C. I can't say anything further at this point.

Ms. Sonia Sidhu: How much funding will be provided to stakeholders to support the implementation of the framework on palliative care in Canada?

Ms. Sharon Harper: The \$13 million that Marcel mentioned in his remarks is targeted funding that goes to national stakeholders across the country to implement palliative care activities.

Ms. Sonia Sidhu: What role do public awareness and education play in improving access to palliative care in Canada?

Ms. Sharon Harper: Could you repeat the question?

Ms. Sonia Sidhu: What indicator will be used to measure progress towards the implementation of the framework on palliative care in Canada and Health Canada's action plan on palliative care?

Ms. Sharon Harper: We are planning a series of indicators to address the action plan and how it's being implemented. We expect those to be available in fall 2020. There is also a parliamentary review that will require a report on palliative care in June 2020. Also Bill C-277 requires the minister to provide a follow-up report on palliative care in December 2023.

Ms. Sonia Sidhu: Can you elaborate on how this money is being used by provinces and territories to improve access to palliative care in Canada? I know that, through budget 2017, the Government of Canada is investing \$6 billion over 10 years for home care. As you said, 15% of people don't have access.

How are we doing this to support palliative care in Canada?

Ms. Sharon Harper: Can I turn that to you?

Mr. Marcel Saulnier: Sure.

As part of the “Common Statement of Principles on Shared Health Priorities”, provinces and territories were given a menu of potential areas they could invest in, in the area of home and continuing care, to improve the integration of home care with primary health care, to better support caregivers in terms of caring for people who are in the home, to strengthen the delivery and access to palliative care delivered in the home or the community, and also to address infrastructure challenges for home and continuing care, including hospices.

Provinces and territories are using federal monies for home care. It's \$6 billion for projects in each of those areas. They had the choice about which of those four areas—or all four of them if they would like—to invest federal dollars in, and they're doing that. They have submitted to Health Canada their action plans, which detail exactly how that money is being allocated.

The Chair: You have one minute.

Ms. Sonia Sidhu: If someone wants information, I think having 24-7 access to health care is the best thing. We heard that Prince Edward Island is doing something, and B.C. is doing something. Why isn't the same thing happening in every province? Why are there differences?

Mr. Marcel Saulnier: As in any area like this, where there's tremendous potential to expand service delivery and often inadequate resources generally to go as far as everyone would like them to go, you see really innovative projects and initiatives being started in different parts of the country and being scaled up elsewhere. I think this is what's happening here. Jurisdictions are starting up new projects. They are evaluating them carefully, and when they are shown to have a lot of value in improving access or efficiency in care delivery, then they are taken up by other jurisdictions and scaled up across the country.

We have national organizations that help to do that work with jurisdictions, including the Canadian Foundation for Healthcare Improvement, the Canadian Partnership Against Cancer, and others that are really trying to facilitate that scaling and spreading of good initiatives.

• (1605)

[Translation]

The Chair: Mr. Thériault, you have six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

Ladies, Mr. Saulnier, welcome.

In the 2015 report “Access to Palliative Care in Canada”, an insert states that Canada ranks 11th in the international quality of death index.

First, could you explain to me what the quality of death index is?

Ms. Christina Lawand: Actually, this index was not created by the Institute, but by researchers at the Economist Intelligence Unit. The researchers used available data and developed a series of indicators to rank countries in terms of palliative care. They looked at whether countries had a national policy framework on palliative care. When they created the index in 2015, there were none.

They also looked at such factors as government investment in health care, resources for targeted training in palliative care, the

availability of subsidies to support families and reduce the burden on informal caregivers, as well as access to opioid analgesics.

Various measures were available at the time. Since 2015, the situation has changed somewhat. As regards international comparison, I know that the OECD is interested in it. All developed countries have aging populations and palliative care is becoming an increasingly important issue.

I think there will be work to do in the future to improve international comparisons in palliative care.

Mr. Luc Thériault: What makes Australia and New Zealand stand out? What are their practices?

Ms. Christina Lawand: A number of the countries that stood out had placed a great deal of emphasis on a national strategy. Canada is a more decentralized country in terms of care delivery. Having a national strategy earned those countries many points.

Mr. Luc Thériault: It doesn't necessarily mean the care is better or worse. The quality of life of a dying person criterion is not related to this. Action taken and care delivery are not fully measured. They are very difficult to measure, aren't they?

Ms. Christina Lawand: International comparison is always a challenge. Again, this is a report from the Economist Intelligence Unit. I am not very familiar with the methodology that was used, but it provides a starting point.

Mr. Luc Thériault: Your report is quite complete and contains some very surprising data. For the past 50 years, palliative care has been identified as the gold standard for dying with dignity. Many industrialized or wealthy countries have not been able to provide access to palliative care, generally speaking.

What are your main recommendations? What needs to be done to ensure that, in 2020, we are at the forefront of making palliative care more accessible?

• (1610)

Ms. Christina Lawand: Is the question for me or for Health Canada?

Mr. Luc Thériault: It is for you, because I have a feeling you have the scientific data we need.

Mr. Saulnier, if you want to add something, you can.

Ms. Christina Lawand: Okay.

Making recommendations is not part of the Institute's mandate.

Mr. Luc Thériault: I know.

Ms. Christina Lawand: However, our data does point to areas where improvements could be made. With this in mind, we could look more specifically at the early identification of patients in need of palliative care and the early introduction of such care. This would greatly improve the situation of end-of-life patients and their families. The problem is that the patients' need for palliative care is established only when their curative treatments are finished. Their situation can deteriorate very quickly and it is then too late to implement palliative care in the community.

That's why we see a lot of emergency room visits and hospitalizations. It is very stressful for families and patients, and it is costly for the health care system. So early detection at the time of diagnosis of a life-limiting illness, for example, would be a good start. This would allow for the gradual introduction of palliative care to support patients and their families.

We have also noticed that there is more community support. Our data indicate that few people receive publicly funded palliative home care. Some provinces have launched promising programs to provide paramedical services at home, for example, as Mr. Saulnier said. This reduces unnecessary emergency room visits for patients receiving care at home.

It was also noted that better training could be provided to health care professionals. Three out of five family physicians do not feel they are truly ready, while 80% of them often see patients who need palliative care. This shows that there is still work to be done in educating health professionals.

The Chair: Thank you.

[English]

Mr. Davies, go ahead; you have six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Thank you to the witnesses for being here.

This is a question for Health Canada. We know the federal government announced commitment in the 2017 budget to provide \$6 billion over 10 years to the provinces and territories for home and community care. That was through the bilateral health agreements with the respective jurisdictions. Forgive me if I missed this, but what proportion of that \$6 billion in federal funding for home and community care will be used by the provinces and territories specifically to improve access to palliative care, either at home or in hospices?

Mr. Marcel Saulnier: No designated proportion of that funding was set aside for palliative care or for more traditional forms of home care or other community-based services. Provinces negotiated a menu of potential areas of interest of investment with the federal government. The federal government made a strong case to make sure that palliative care was on that menu. Part of the process of completing and finalizing the bilateral agreements with provinces was for them to clearly articulate in their action plans to the government which of those four areas—all four, if possible—they would be investing federal money in, with what objectives in mind, and to have clarity and transparency to Canadians about that.

Mr. Don Davies: We're about to begin year four of a 10-year plan. Do we have a sense yet of how much of the money the provinces are getting is allocated to palliative care?

Mr. Marcel Saulnier: In some cases, this information is all public information available on the Health Canada website. The action plans are all posted. In some cases, the jurisdictions in their action plan identified an explicit allocation of funding that was designated for palliative care services. In other cases, there was a mention of palliative care access as one of the objectives of a broader investment in home and community care. It's difficult to come down on what the specific amount allocated to palliative care would be. You could surmise a certain number from looking at the action plans, but it's probably greater, because palliative care investments are embedded in some of the other—

• (1615)

Mr. Don Davies: Thanks, I will check the website.

Would it be fair to say there's a fair bit of variation among the provinces? Some may be allocating a significant amount of the money they got to palliative care and others may not be.

Mr. Marcel Saulnier: In terms of what they stated publicly as amounts that are specifically allocated to palliative care, yes, there is some variation across jurisdictions.

Mr. Don Davies: When the framework on palliative care was published in 2018, Health Canada agreed to re-establish an office of palliative care to provide high-level coordination on activities going forward.

Could you inform this committee whether that office has been set up yet? If not, when will it be operational?

Ms. Sharon Harper: Thank you for the question.

As part of the development of the framework and the action plan, Health Canada did consider re-establishing the office of palliative care. It took into account stakeholder views, work that had already been done to consult provinces, territories, experts and Canadians, and networks that already exist to organize the excellent work being undertaken by stakeholders and other organizations. Health Canada decided to use its end-of-life care unit within the strategic policy branch as a focal point for palliative care policy and programs. Resources, then, have been targeted to supporting action plan activities.

Mr. Don Davies: It sounds like the office of palliative care was not actually set up.

Ms. Sharon Harper: It was not specifically an office on palliative care. It was a focal point on palliative care within Health Canada.

Mr. Don Davies: Okay.

We also know that the bilateral health agreement set out the four different areas: spreading and scaling evidence-based models of home and community care that are integrated with primary health care; enhancing access to palliative and end-of-life care; increasing support for caregivers; and enhancing home care infrastructure, including digital connectivity and other types of technology.

Do I have it correct that we're not going to really know how we're doing on that until five years have passed? I guess I'm asking how we are doing in terms of provinces meeting those goals.

Mr. Marcel Saulnier: We know now that as a tradition of receiving federal funding, provinces are reporting to the federal government on an annual basis and confirming that the investments they said they would make are in fact being made. In terms of achieving the goals, the measurement on progress is being done through the auspices of the Canadian Institute for Health Information and the tracking of these common indicators that have been developed. That is an unfolding process. The first report came out a year or so ago, and there will be annual reports on that.

Mr. Don Davies: I'll direct that to Madame Lawand. How are the provinces doing in meeting those goals?

Ms. Christina Lawand: What we have agreed on with the provinces and territories, as part of the common statement of principles, is that we're working with them to develop 12 indicators to measure progress on all the shared health priorities, not just palliative care.

There is one indicator that we're working on for palliative care around the concept of dying at home rather than in hospital. That aims to inform us about access to palliative care to allow people to die at home. That is still in progress. The indicator won't be released until 2022.

Mr. Don Davies: I see.

The only three indicators that have been released so far don't relate to palliative care. Is that right?

Ms. Christina Lawand: That being said, we're still going to continue to work on measures—

Mr. Don Davies: I'm going to try to squeeze in one more question, if I can. I want to follow up on Monsieur Thériault's questions.

In terms of Canada ranking 11th among other countries, surely there can't just be the existence of a national framework that determines rankings. There must be certain best practices that other jurisdictions are doing that are given ranking.

For the jurisdictions that are doing well and delivering better palliative care to their citizens, can you give us a flavour of some type as to what they are doing that might be instructive for Canada?

Ms. Christina Lawand: It's a great question.

I think there's a bit of a gap in research. We need to understand more about the countries that are doing better and what they are doing better. For example, when we look at our measure of primary care physician preparedness, the countries that did the best there were the Netherlands and the U.K. Those two countries have focused a lot of effort on their primary care services and their community services. They are quite a bit further ahead of the game than us.

In Canada, we've slowly been pushing toward community care in the last 30 years or so, and it's taken a while to get there. These countries are quite a few years ahead of us in that domain. That could be one possible explanation, but we still need to study it further to understand what those countries are doing well.

• (1620)

The Chair: I'm sorry; you're over the time.

We don't really have time for a full round two, but I'm going to suggest to the committee that we have an abbreviated round two in which the Liberals and the Conservatives would have one question of five minutes, and the Bloc and NDP would have their two-and-a-half-minute questions as they would in a normal round two.

Would that be acceptable to everybody?

That being the case, we go to Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you all for being here. Your taking the time is greatly appreciated.

I come from rural Canada, in the southeast corner of Saskatchewan. I appreciate the fact that both of you talked about rural Canada, because it's a very important aspect. When we look at palliative care in rural Canada, we have big challenges there, and home care is being utilized quite extensively to try to bridge that gap.

We see a lot of funding going to urban centres, but not so much to rural Canada. There are a number of primary health care practitioners we're short of: medical doctors, specialists in palliative care, etc. I like hearing what you had to say about having primary health care practitioners involved in this aspect of things.

One of the things I'd like to hear a comment on is EMS. I get it that in big centres EMS is mainly acute care, but in rural Canada, the EMS services are out there, and the reality is that, in certain rural areas, they might be able to provide those services. My understanding is that they've even looked at offering those opportunities. I would like to hear some comments on those thoughts from both of you.

Mr. Marcel Saulnier: I can start.

Yes, for sure, EMS and paramedic services are increasingly becoming a very important extension of the health care service delivery model in several jurisdictions, particularly those with rural and remote populations forming a big part of their population. I think some of the best examples in Canada have come up. It started in Prince Edward Island and Nova Scotia, where all of the EMS providers are being trained to deliver palliative care services and are being deployed throughout those jurisdictions. As you know, both of those jurisdictions have very large rural populations. That model is also in place in Alberta and is increasingly being taken up across the country. I think it's a very good example of innovation that is showing strong promise of being deployed across the country.

Ms. Christina Lawand: Yes, I think the example that Mr. Saulnier is speaking to is highlighted in our report as well. There's the Canadian Foundation of Health Care Improvement, which has highlighted some of the most exciting, innovative practices out there, and this one of offering emergency medical services is really making a measurable difference in the jurisdictions that have implemented it in preventing unnecessary emergency room visits at the end of life and allowing people to get the care at home.

Mr. Robert Kitchen: Right, and taking those dollars to put them where.... We can look at EMS services versus the time that's taken up tying up hospitals, etc.

You also both talked a little bit about the training of the practitioners and how little palliative care is in the medical training and the nursing training, etc. Would you agree that it's imperative upon the professional bodies to incorporate that part, not only in the accredited college training, but also in their post-graduate training for their practitioners in every aspect? When you look at all the professions that you listed, I suspect that every one of them.... It behooves us to be telling them that they should be educating their practitioners on the issues of palliative care and how we want to assist people in their homes.

• (1625)

Mr. Marcel Saulnier: Yes, I think there's progress being made in that area as well. The Royal College of Physicians and Surgeons has extended the training required for palliative care specialty. Quite apart from the College of Physicians and Surgeons and other nurses and providers, there is really effective training being made available through organizations like Pallium Canada, which has trained 20,000 providers since its inception, so that's really making a very strong contribution to training and competencies out there in the system.

Mr. Robert Kitchen: Ms. Lawand, do you have anything you might want to add?

Ms. Christina Lawand: At the time of our report, we cited some information from the Canadian Partnership Against Cancer survey of medical schools, which did, indeed, find there were potentially some training gaps. While 90% of medical curricula had lectures related to palliative care, just 12% of students were required to participate in mandatory clinical rotations, for example. They found that hands-on experience to be lacking, but promising initiatives like LEAP, which is a program to train people who are already working, are helping to fill some of that gap for sure.

The Chair: Thank you, Dr. Kitchen.

I go now to Mr. Van Bynen for five minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you. I appreciate your being here and giving us the information we've heard thus far. I want to carry on a little further from a question that was raised by Mr. Kitchen, and that is the cost of health care and the cost of critical care beds that are being occupied by people who should be receiving palliative care. Is there a mechanism or some way that we can actually define the cost of palliative care in critical care beds across Canada, across a province or across a hospital?

Ms. Christina Lawand: It's a really interesting question. We took the costing piece out of the scope of our report because it was a more complicated question and we needed more time to work on it, but it's something we could potentially look at, for sure, in terms of analyzing those costs. We know, generally speaking, that end-of-life costs are one of the largest expenses in health care. The last year of life is one of the most expensive times in a person's life.

Mr. Tony Van Bynen: One of the goals of Health Canada's action plan on palliative care is to raise awareness about how advance care planning, end-of-life care discussions and palliative care can improve the quality of life of Canadians with life-limiting illness. Can you tell me what role public awareness and education play in improving the access to palliative care in Canada?

Ms. Sharon Harper: I'm sorry, could you repeat the last part of your question?

Mr. Tony Van Bynen: What role do public awareness and education play in improving access to palliative care in Canada?

Ms. Sharon Harper: Actually, that's a very important question. Information about palliative care and understanding about palliative care is a huge question because a lot of Canadians do not understand what palliative care is, and what they do understand is very worrisome to them. That creates a barrier to early referral to palliative care because they believe that curative care and palliative care cannot coexist, that if they're referred to palliative care there's nothing else that can be done for them.

End-of-life care planning is arguably something we should all do in terms of planning for the care we want at the end of our lives, being clear and explicit about that with our families, our health care providers and everyone we can explain it to, so we're sure we get the care we want at the end of life. However, naturally, it is something I think most people put off a little too long. It's another area we are focusing on in the action plan, to make sure people have conversations about what they want at the end of life.

Mr. Tony Van Bynen: I've been a director of a bereavement centre in Newmarket, and the concern there is that conversations about death and dying simply aren't happening early enough. However, I know the Salvation Army, Doane House Hospice and the Margaret Bahen Hospice have taken on programs like death cafés. Have you been involved in any of these programs, and/or are you interested in partnering with these organizations so these conversations get started early enough?

• (1630)

Ms. Sharon Harper: Yes, death cafés are a way of making people aware and getting them more comfortable talking about end of life. In fact, our official languages program has developed a series of micro grants that serve to help people who want to create things like death cafés in order to encourage this kind of conversation. They would receive some funding through Health Canada in order to do that for official languages minority communities. Also, Pallium Canada has created kits for people who want to create compassionate communities, which would also help to focus attention on these discussions, as well as create community capacity to care for people at the end of life.

Mr. Tony Van Bynen: Thank you. What are the initiatives the federal government will be undertaking as part of this framework on palliative care in Canada to support equitable access to palliative care in Canada? We've heard a lot about the inequities in how that's delivered. What initiatives are being planned or have been planned?

Ms. Sharon Harper: That's a very interesting question. Right now, the ones we can talk about are the ones that are already in play. We talked about increasing the capacity to have end-of-life care conversations in South Asian communities, and that is one way to increase the equitable access. There are a number of other projects that are under consideration, but they have not yet been approved, so I can't really speak to them at this point.

The Chair: Thank you, Mr. Van Bynen.

[Translation]

Mr. Thériault, you have two and a half minutes.

Mr. Luc Thériault: Thank you.

Earlier, after your excellent answer, I realized that, basically, we would have much to gain from working to integrate care. When the curative treatment is completed, patients are in a no man's land, waiting for an appointment with their general practitioner and for the specialist who treated their cancer, for example, to coordinate cessation of care. Then suddenly, that doctor tells the patient that their work is done and advises them to seek palliative care.

You are saying that, if we could integrate care between the end of the curative phase and the palliative care continuum, we would

save a lot of money, and in doing so, we would improve accessibility to that care, because we would have more resources.

You are also saying that palliative care units in hospitals are reserved for extreme cases, when someone is admitted to the emergency room and will not be discharged. I understand that we need to be able to provide that palliative care setting. However, ideally, we should be able to offer home care as much as possible. That's what I understand from your answer earlier.

Do I understand correctly?

Ms. Christina Lawand: Yes, I said that earlier identification would mean the services could be set up in the community. As you said, there needs to be better integration of palliative care when a patient is receiving curative care and they are diagnosed with a terminal illness.

Mr. Luc Thériault: That does not mean that a request for physician-assisted dying cannot emerge from a situation where the best palliative care is provided. It means that palliative care and physician-assisted dying should not be mutually exclusive. It is not a failure of palliative care when someone receiving palliative care requests physician-assisted dying.

Ms. Christina Lawand: All I can tell you is that, according to our data, patients who received medical assistance to die had also received palliative care. So one doesn't preclude the other. They are two different concepts and two different choices at the end of life.

• (1635)

The Chair: Thank you, sir.

[English]

Mr. Davies, you have two and a half minutes, please.

Mr. Don Davies: Mr. Saulnier, according to the framework on palliative care in Canada, the time frame of the framework development process did not allow for a thorough engagement process with indigenous people around palliative care. I think you touched on that. We know Health Canada has pledged that it will engage in ongoing discussions with national indigenous organizations about indigenous-led engagement processes towards the development of a distinctions-based palliative care framework for indigenous peoples. Can you update the committee on the progress of those discussions and when you might expect to publish a distinctions-based palliative care framework for indigenous peoples?

Mr. Marcel Saulnier: Sharon?

Ms. Sharon Harper: Health Canada is working with Indigenous Services Canada to include palliative care as part of their engagement with first nations communities on a continuum of care. There are a number of different distinctions-based groups within this, so we've had to look at how to work with all of them individually.

We've also had extremely informative discussions with representatives of the Canadian Indigenous Nurses Association and the Indigenous Physicians Association of Canada, and these discussions helped shape several of the activities described in the action plan. We also heard from Inuit and Métis groups that we should start by looking at what has already been heard from them, so we've done a literature review on what they've already said around health care and palliative care. We will now move forward with our discussions with national indigenous organizations and representatives of urban indigenous peoples to work on indigenous-led engagement for a framework on palliative care.

Now, I cannot tell you exactly the time frame for that, because this is something that will be worked on with the groups that will be doing the engagement.

Mr. Don Davies: I want to pick up on a question from my colleagues across the way. I think it was actually Ms. Jansen.

It seems almost counterintuitive. If palliative care services are provided in hospital, they're paid for, but it's more expensive; if palliative care services are provided at home or in a community-based setting, they're not paid for, but it's less expensive. It's as though we set up our structure so that our public system is paying for the most expensive delivery of service.

Has Health Canada given any thought to that? I think the question was, should we be expanding our public payment so that we can actually provide not only better services in the community, but at lower cost?

Mr. Marcel Saulnier: That is central to the idea around the common statement of principles with provinces. Whether it's home and community care or mental health and addiction services, those are both areas that are delivered in the community. They can be delivered in a hospital setting, but much more expensively.

There is a broad consensus around the country to reorient and redirect service delivery, where possible, to the community. Those investments that were made, the \$6 billion for home care and the \$5 billion for mental health and addictions over 10 years, are very much directed at increasing capacity at the community level to deliver those services.

The Chair: Thank you, Mr. Davies.

Thank you all for being here. You've been a great panel. You're the first panel of this study. How many panels we have is something we are going to discuss in the next hour, but you guys are the first. You've set us on our way. Thank you very much for your time.

With that, we will go in camera. We will resume in a few minutes.

[Proceedings continue in camera]

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