Palliative Care

Over the course of the Conversation on Health, palliative care was a frequent topic in discussions related to end-of-life care. The importance of addressing issues related to training health professionals and the delivery, accessibility and the costs of palliative care, both in facilities and in communities, was highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of palliative care.

Accessibility and Costs

Participants suggest that there appears to be a new recognition of the value of and need for palliative care and generally supported investment in these services. They argue that this investment would reduce the demand for acute care beds and aid in waitlist management in the acute care system, while offering more choices to dying patients, and reducing health care costs. Many advocate for a multi-disciplinary approach to a patient-directed, palliative care model, supported by long-term sustainable funding.

Participants are concerned that terminally ill patients and their families often find themselves coping with end-of-life issues in acute medical units while waiting for one of the few available hospice or palliative care beds. They emphasize the idea that access to palliative care should be equal, no matter whether it is provided in acute care, complex care, homecare or residential care settings. One suggestion is to undertake an assessment of the accessibility of specialized palliative services in residential care, which is extremely variable throughout the province. There is also concern that the consent process for palliative care is different in different health authorities. Often, families do not understand what services are available to them and many recommended having a palliative care navigator accessible to patients and families.

Health Human Resources and Training

Many participants describe the benefits of supportive palliative care, where staff members are educated on issues such as pain and symptom management and caregiver support. Despite demographic trends and the projected needs for palliative care in the future, participants widely agree that there is a shortage of health professionals trained in palliative care and insufficient opportunities available for
students interested in this field. Some suggest recognizing palliative care as a specialty in general medicine and providing additional training programs as means to meet the demand for more trained palliative care staff.

It concerned some participants that not-for-profits or over-burdened volunteers run many of the palliative care services available to British Columbians. Many participants support the idea of increasing the number of palliative home care teams and 24 hour palliative response teams. Another suggestion recommends a formalized and consistent palliative care team structure, which would include a social worker to address the psycho-social needs of patients and their families.

As difficult as end-of-life care is, we have to humanize it… each case is unique and requires respect. [The] whole [process of] end-of-life care requires specialized training - you can’t just treat those patients like everyone else, along with everyone else.

- Health Professionals Meeting, Burnaby

Palliative Care in Facilities

Some participants suggest that palliative care beds in complex care facilities would not result in quality care and that palliative patients should not be in acute wards. Others state that hospitals or long-term care facilities have a role in the delivery of palliative care. Many propose that the system needs additional palliative and hospice care facilities to meet existing and future demands and that planning for palliative care should be based on demographics.

Although participants voice concerns related to the lack of stable funding for hospices, many recommend them for the delivery of palliative care, suggesting that they provide quality care and decrease demands on the acute care system. Several participants emphasize that one of the most glaring differences between hospices and residential care is that all hospices have access to the palliative care benefits program while not all residential care facilities do. Participants discuss the need for better partnerships between health authorities and hospice societies and other non-profit organizations. They recommend the creation of clear guidelines to ensure that hospice beds are used appropriately and not occupied by long-term palliative care patients.

Hospice Houses have a different atmosphere and purpose than acute care hospitals or even long term care facilities. Staff at hospices are trained not only to care for the dying person… [they] provide support for family and friends as well. This takes an increased number of staff to effectively accomplish…

- Email, Prince George
Palliative Care in Communities and Caregiver Support

Participants recommend supporting those who want to have palliative care in their homes by providing: a home visit nurse; a tax break for caregivers; 24 hour, on-call access to physicians or nurses to relieve stress on family members; income support for families caring for in-home palliative care patients; and some form of compassionate leave for those involved in palliative care. Many also believe the Government should increase the availability of community respite options to ensure that valued caregivers and contributors to the health care system receive the supports they need.

Conclusion

Over the course of the Conversation on Health, there is widespread agreement on the need to focus on allowing patients to die comfortably and with dignity. Many participants describe providing sufficient resources to palliative care as essential to achieving this goal.

*We spend a lot of time and energy thinking about the baby boomers and the Olympics, but people have always been dying. We are in a death defying culture…We are talking about preventative issues, but at the end of the day we want to be in a place where we are cared for, through all the components of quality end-of-life care: being psychosocial care, your spiritual dimension, as well as your pain and symptom management…That is the specialized care [we want.]*

- Focused Workshop on Seniors and Aging, Vancouver
Palliative Care

This chapter includes the following topics:

- Health Human Resources and Training in Palliative Care
- Accessibility of Palliative Care
- Facility-based Palliative Care
- Hospice Care
- Palliative Care at the Community Level and Caregiver Support
- Assessment and Consent
- Funding and Costs of Palliative Care

Related Electronic Written Submissions:

- The Two Standards of End-of-Life Care in British Columbia
  Submitted by Providence Health Care
- A Submission to the Conversation on Health
  Submitted by the Canadian Cancer Society
- Report to the Conversation on Health
  Submitted by the BC Cancer Agency

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Seniors; Home Care and Support; Death and Dying; Assisted Suicide and Residential Care.

**Human Resources and Training in Palliative Care**

**Comments and Concerns**

- Despite demographic trends and the projected needs for palliative care in the future, no additional training programs have been initiated.
- In general medicine, Canada does not recognize palliative care as a speciality.
- There is a human resource shortage in palliative care.
- Palliative care responsibility is often taken on by staff ‘off the side of their desks.’
• Palliative care units are not pleasant places to die, as many of the nurses seem to lack compassion for the patients.

• Nurses are often unwilling to administer the pain medication needed to lower the pain threshold of palliative care patients.

• When a patient is dying in hospital, staff members are very compassionate and supportive.

• Many palliative care services are currently run by not-for-profit or volunteers.

• The *Provincial Framework for End-of-Life Care* released in May 2006 was well received by those working in hospice-based palliative care.

**Ideas and Suggestions**

• There is a need for palliative volunteers in hospitals and a need to channel volunteers into this field.

• Palliative care providers must be informed of the specific needs of individual patients.

• Palliative care should be provided by well coordinated interdisciplinary teams. These could be private, public, or volunteer based.

• More palliative home care teams and 24 hour palliative response teams are needed. There should be a formalized and consistent palliative care team structure which includes a social worker to address the psycho-social needs of patients and their families.

• Change the emphasis of medicine to address the needs of the elderly and those with terminal illnesses through palliative care.

• As difficult as end-of-life care is, we have to humanize it. We are not cattle, each case is unique (culture, family dynamics, religion, etc.) and requires respect. The whole discipline of end-of-life care requires specialized training.

• Pastoral care or chaplains should be available to check in with staff and family during the dying process.

• Connect Phase 1 clinical trial volunteers to palliative care services in Vancouver.

• Doctors and nurses need to be educated about palliative care options and provisions.

• Some remote communities might be willing to offer services for end-of-life patients, since small communities can have personal relationships. Explore this possibility of obtaining local help.
• More end-of-life beds are needed in the community. Supportive, palliative care, where the staff is educated on issues such as pain and symptom management and caregiver support, is very beneficial.

• Recognize that staff and health care providers are human and should be allowed to grieve and acknowledge their loss when a patient dies.

**Accessibility of Palliative Care**

**Comments and Concerns**

*Palliative Care Bed Shortages*

*Regional Access Issues*

*Public Education and Promotion of Services*

• **Comments related to palliative care bed shortages:**
  - Palliative beds have been closed in some areas, yet are vital to the health care system. These cost cutting measures need to be reconsidered.
  - Too often terminally ill patients and their families find themselves coping with end-of-life issues in acute medical units while waiting for one of the few available hospice or palliative care beds.
  - The amount of palliative care services does not meet population needs. For example, Parksville/Qualicum has one of the largest aging populations, but only one palliative care facility.
  - Some communities do not have palliative care facilities, only beds in hospital.

• **Comments on Regional Access:**
  - The Tofino area needs more in the way of palliative and respite care. Currently there is one privately funded palliative care room in the hospital, but many more are needed.
  - In Liverpool, England, a study was carried out on end-of-life care, discussing their whole system and all the pathways needed to navigate the palliative care system. They created an amazing road map.
  - Palliative care is still well administered in Cranbrook, despite the fact that the hospice has been de-funded.
  - Fraser Health provides great services in terms of palliative care.
  - The palliative care ward and Vancouver General Hospital provide excellent care.
Many patients wish to die at home and Victoria Hospice's palliative response team, along with home care support are working together to help achieve the patient's desire by visiting the home as needed. The Palliative Response Team works 24 hours per day, 7 days per week, 365 days per year so that if there is a crisis at the home, the team, comprised of a nurse and a counsellor and at times a physician, can attend quickly to get the pain under control. If a patient is on the palliative care unit, the staff and volunteers attend to the patient's and family's needs and it is not uncommon for patients to become stabilized and return home for a time or even for them to die at home, if that is desired.

Not all communities have access to palliative care, especially for non-cancer patients.

- **Comments on public education and promotion of palliative care options:**

  - A partnership between the BC NurseLine, a provincial tele-triage and health information call centre, and the Fraser Health Hospice Palliative Care Program allows for after hours access to care and information for dying patients and their families. This program has improved outcomes of symptoms management, cut down on the number of visits to our overloaded Emergency Rooms, and enhanced the support for families of the dying. With the majority of Canadians saying that they want to die at home, it is likely that more of these services will be needed in the future.

- There are some palliative care programs that work well for the patient.

### Ideas and Suggestions

**Regional Access**

**Public Education and Promotion of Services**

**An Integrated System of Service Delivery**

**Cultural Sensitivity**

- **Ideas about regional access to palliative care:**

  - Access to palliative care should be equal, no matter if it is provided in acute care, complex care, home care or residential care settings.

- **Ideas about education and promotion of palliative care options:**

  - Many people are not aware of the palliative care services available to them so doctors should provide this information to everyone.
• Palliative care should be made more accessible for seniors.
• Provide education related to the availability of palliative care for seniors.
• Use the NurseLine to initiate access to palliative care resources for patients.

• Ideas about an integrated system of palliative care delivery:
  • Palliative care needs an integrated, government funded system where quality of care does not depend on ability to pay.
  • Invest in palliative care so people may pass on in a relatively painless way.
  • Provide adequate palliative and hospice care and more choices for patients and families dealing with end-of-life (provide translations of materials to increase accessibility).
  • Palliative care should focus on allowing patients to die comfortably and with dignity.
  • Support a multi-disciplinary approach to a patient directed, palliative care model, including long-term sustainable funding.
  • Options and choices related to the quality of palliative and end-of-life care, including palliative units, hospice, residential care and home care options, should be available and accessible to patients.
  • An assessment of the accessibility of specialized palliative services in residential care is needed. It is currently extremely variable across the province. Specialized palliative care services are teams that can work with residential care and other health care providers, to manage symptoms and improve the quality of life for those with a chronic, unpredictable illness.
  • Recognize the variable needs and levels of palliative care patients (tertiary, hospice, etc).
  • Provide better treatment and palliative care for AIDS patients.
  • Hospice and palliative end-of-life care should be designated as a core service under the BC Ministry of Health. Health Authority performance agreements should include this important and neglected area.

• Ideas about cultural sensitivity:
  • Provide palliative care homes that are quiet, fully staffed, and that support various ethnic beliefs. Accommodate the diversity of cultures in palliative care settings.
  • Provide a room in the palliative care section of the hospital for First Nations families, where there are staff members educated to understand the culture.
Facility-Based Palliative Care (Long Term Care Facilities & Hospitals)

Comments and Concerns

- Palliative beds in complex care facilities will not result in quality care. Palliative patients should not be in acute wards.
- There are inequities in what is provided in the community, hospice/acute care, or palliative units versus residential care.
- Palliative care facilities cannot provide the means for families to live with patients during their stay.
- In residential care, patients do not receive palliative care from staff due to lack of resources and training as well as a lack of access to doctors or other specialists with palliative expertise.
- Palliative care is different in smaller communities. Ending life in a hospital bed is not acceptable.
- To add to services for residential care, the Ministry of Health developed a program called Added Care. This allows residential care managers to request extra staff for a patient who may be near the end-of-life and needs more assistance and companionship. However, other pressures on the system have conspired to the point that this program is now rarely used for patients at the end of their life. Often, Added Care is used for people with dementia who have marked behavioural challenges and are waiting for a place in a special care unit or for older adults who are awaiting transfer to geriatric psychiatry units. Added Care is being used for safety reasons while patients wait for an appropriate bed to become available rather than providing the additional end-of-life services as the program was designed to do.
- Leaving a patient in a palliative care ward is a way for some families to absolve themselves of responsibility for the care of their loved one.
- As a society, we have to accept that we will all die and in palliative situations test results need to be reviewed and accepted. Many times there is no need to do one more cat scan or emergency Magnetic Resonance Imaging (MRI) scan as the doctor already knows the outcome from conducting previous tests. In long-term care facilities these tests are often done just to satisfy families or the doctors and are not of any real value to the patient.
The Delta Hospital does not seem to have a Standards and Procedures Policy in place regarding Palliative Care.

**Ideas and Suggestions**

- Planning for palliative care resources and facilities needs to be based on demographics.
- More palliative and hospice care facilities are needed to meet existing and future demands. More palliative care centres or palliative units in acute care should be supported.
- Reopen palliative units to facilitate continuity of care.
- Hospitals have a role in the delivery of palliative care.
- We need palliative care homes so that palliative patients can be looked after in a less clinical environment. This will also open up much needed hospital beds.
- Areas of hospitals should be set aside for palliative care in a hospice-type setting, with rooms set aside for family members. In these areas providers should have the flexibility to do what they think is needed (candles, music, cultural requirements).
- Two palliative care beds at a hospital are better than none.
- Long-term care facilities should be providing end-of-life care.
- The government should make a commitment to offer palliative and end-of-life care to residents in all the residential care units in British Columbia.
- Turn closed acute facilities into palliative beds.

**Hospice Care**

**Comments and Concerns**

- Comments on funding of hospices:
  - There is a lack of funding and services for hospice care.
  - Hospices spend more money on patients rather than on residential facilities.
• Currently one of the most glaring differences between hospices and residential care is that all hospices have access to the palliative care benefits program and not all residential care facilities do. This means that if special medications or equipment are needed for someone who is dying, then that must be applied against the global budget of that facility. This makes it tempting for facility managers to send these patients to acute care when they get complex symptoms as their costs will disappear and the patient will be happy because in acute care they do not have to pay for daily care.

• Hospice beds cost half as much as acute care beds.

• Hospice is a perfect example of public and private partnership.

• Comments on referrals to hospices:

  • In our current system we tend to refer those with cancer to hospice and those with non-cancer illnesses and particularly those with dementia, to residential care. This is primarily because of the predictability of the disease. Hospice wants people who have an estimated length of life of two to three months and residential care does not have an average length of stay. We all try to avoid sending someone to a new place just before his or her death, however, both with the unpredictability of death, and the pressures in our acute care system, this regrettably still happens.

  • Doctors and nurses are primarily focused on the preservation of life and are not utilising hospice appropriately.

  • Referral to hospice is not automatic once a patient is designated to palliative care. Each area sets their own rates for palliative care patients.

  • Too many people die in acute care in hospital because doctors do not refer to hospice.

  • If all the patients currently dying in residential care and their families were to understand that there are higher staffing levels and more services available in hospice, and were to prefer this option, we would have many more requests for transfer to hospice from residential care. It would then be clear that this option is not available for everyone.

• Comments on accessibility of hospices:

• Hospices are overwhelmed.

• In reality there are two standards of end-of-life care in British Columbia: The younger patients without cognitive impairment and with cancer die in a hospice. The hospice has higher staffing levels and operates on a larger per diem rate so there are more services and people available to maintain quality of life. The older
patients with cognitive impairment and multiple non-cancer illnesses die in residential care, which has at least $100 per resident, per day less to provide what should be the same care.

- There is stigma associated with accepting care in a hospice instead of acute care.
- There are no hospice homes in rural areas.
- Our system has also evolved alternatives to acute care for those needing chronic ongoing care. We have increasing numbers of hospices, and home-like, small care facilities that provide end-of-life care for those who are estimated to live two to three months or less.
- Hospice is a flexible, coordinated environment. You have the option of moving patients into a hospice where there is care, but also to move them back home when they are feeling better and only need partial care. Hospice can function as sort of broker or buffer, allowing the individual to make their own choices.
- Prince George has an excellent hospice facility.

**Ideas and Suggestions**

- **Funding of Hospices**
- **Referrals to Hospices**
- **Accessibility of Hospices**
- **Guidelines for Running Hospices**
- **Staffing Hospice**

- **Ideas about funding of hospices:**
  - Ensure adequate funding for all aspects of hospice care.
  - Free-standing hospice houses are a cost-effective and compassionate solution to the end-of-life care dilemma.
  - More money should be allocated to hospice societies. They are a tremendous help but must spend a good deal of time and effort fund raising in order to stay afloat. With palliative beds already available, why not give them the money needed to keep going.
  - Encourage bequests to hospices.
  - Free-standing hospices should be funded appropriately from public funds. Hospices should not have to be seen as a volunteer effort.
  - It is cheaper to have a dying person in a bed in a hospice house rather than in an acute care hospital bed. There is a volunteer base available to draw from so hospice is cheaper to run, and draws less funds from the hospital.
Better partnerships are needed between health authorities and hospice societies and other non-profit organisations.

**Ideas about referrals to hospices:**
- We need to educate nurses and doctors with regard to hospice.
- Create a policy to support the referral of all end-of-life patients to hospice and increase public awareness related to the services they can provide.
- Home care nurses are good at referring patients to hospice services.

**Ideas about accessibility of hospices:**
- Establish hospice facilities and homes and expand existing programs.
- Encourage and support hospice care in communities with proper facilities and Palliative Response Teams.
- Every community should have a hospice house.
- Encourage hospice societies in small communities where they do not currently exist.
- Hospice services could be extended to provide some follow-up with the bereaved.
- There is a need for co-ordinated hospice support systems in the Cranbrook area to service the valley.
- Somehow, we need to be able to reach out or find a way to bring marginalized people in to hospice care so they are not left behind.
- Free-standing Hospice Houses shorten waiting lists for acute hospital beds.

**Ideas about guidelines for running hospices:**
- Every hospice is run separately but we need more uniformity.
- Clear guidelines must be created to ensure that hospice beds are used appropriately and not occupied by long-term, palliative care patients.
- Targets could be set with regards to the number of hospice beds set up, possibly on a per capita basis and then a project plan carried out, including the roll out of public education related to hospice care and the overall standardization of care.

**Ideas about staffing of hospices:**
- Volunteers can be trained to provide hospice care.
- Hospice houses have a different atmosphere and purpose than acute care hospitals or even long-term care facilities. Staff members in hospices are trained
not only to care for the dying person, but to provide support for their family and friends as well.

- There doesn’t have to be a sacrifice of quality of life at the end-of-life. If patients register for hospice or palliative care with a hospice society, they will have highly trained and compassionate physicians, nurses, counsellors, therapists and volunteers all working in the patient’s and family’s best interests. The focus in hospice is on dying with as much joy and as little physical and psychological pain as possible.

- Staffing ratios are different in hospice than in hospitals.

### Palliative Care at the Community Level and Caregiver Support

#### Comments and Concerns:

- **Community-Based Care and Home Care**
  - Support for Caregivers

- **Comments on community-based care and home care:**
  - There is a lack of weekend and after-hours care for community services, that is, palliative care; which would otherwise support those who want to stay at home for as long as possible.
  - There is a lack of home visits by doctors for palliative care patients.
  - There are not enough resources for palliative care in the home.
  - There is no night coverage for palliative care in communities.
  - Palliative Care provides a positive model for community care.
  - There is a new recognition of the value and need for palliative care services as defined by communities.
  - Palliative home care should be regarded and administered as a very effective alternative to acute or even round-the-clock hospice care.
  - There is a growing acceptance in the community of allowing people’s individual choice around when and how to end their life.

- **Comments on support for caregivers:**
  - The emotional and financial cost of a relative's end-of-life care can be a heavy burden on families.
Everyone has the right to die with dignity in the care of sympathetic professionals. Family members cannot give the care needed, or anticipate each step along the way or the care needed in the final moments.

Look at veterans benefits (having someone stay overnight so the support person can get a good nights rest) as a model of good supportive services for caregivers.

Having the option of providing palliative end-of-life care to family members at home can be a positive experience for all involved.

**Ideas and Suggestions**

**Community-Based Care and Home Care**

**Caregiver Support**

- **Ideas about community-based care and home care:**
  
  - Expanding home-based palliative care programs is an option and would free up some beds for people who cannot die peacefully at home.
  
  - Develop a community-based palliative care system.

- **Ideas about caregiver support:**
  
  - If a person is dying at home, give enough help to the spouse and family. There is a lot of strain and work involved. If a person is dying in hospital, move the patient to a quiet room so that family can attend.
  
  - Support those who want to have palliative care in their homes by:
    
    a. providing a home visit nurse;
    b. loaning medical equipment at low rental rates;
    c. providing a tax break for caregivers;
    d. providing 24 hour, on call access to physicians or nurses to relieve stress on family members;
    e. providing income support for families caring for in-home palliative care patients;
    f. providing access to 24 hour nursing support via phone and/or home visits for pain management; and,
    g. granting some form of compassionate leave for those involved in the palliative care or the supportive care of a family member, not unlike maternity leave.
• If we can ensure that those who are bereaved get the appropriate attention and have access to support we can prevent long-term problems.

• Patients and families need support and staff should have the flexibility to take the time to provide support when necessary.

• Have a palliative care worker follow up with the family after the patient dies.

• Caregivers should have training on end-of-life issues including what to expect.

• The *Palliative Care Book* should be provided to caregivers before the patient leaves the hospital so that they have an understanding of what resources are available and what to expect. Fear is one of the biggest obstacles to feeling comfortable providing the care the patient needs.

• The Government of British Columbia should increase the availability of community-based respite options to ensure that valued caregivers and contributors to the health care system receive the support they need to continue to provide care to their loved ones and reduce the risk of being admitted for care themselves.

**Assessment and Consent for the Provision of Palliative Care Services**

**Comments and Concerns**

*Assessment for Palliative Status
Consent Processes*

• **Comments on assessment for palliative status:**
  
  • Many service providers do not consider pain as a vital sign and they do not offer enough counselling for care preferences.

  • Patients receive differential treatment from some community organizations depending on whether they have palliative status.

  • People dying with a non-cancer illness tend to lose out on receiving palliative care services because of the difficulty of predicting when they are going to die. Many health care providers see palliative care as a service that is only to be used for the last weeks or last few months of life. Since they do not know when these people will die, and are reluctant to make predictions and be wrong, they hesitate to involve palliative care. The public’s perception is also that palliative care is only for
the actively dying and therefore people tend to avoid accessing services in a timely manner.

- **Comments on consent processes in palliative care:**
  - The consent process for palliative care is different in different health authorities. Often families do not understand what services are available to them. Misunderstandings related to the level of intervention consent form can also act as a barrier to providing sufficient care.
  - The truth must be told. Palliative care and hospice is euthanasia pure and simple.
  - Constantly drugging someone when they are not in pain is a way of sweeping them under the rug and only lifting that rug when the patient has died.

**Ideas and Suggestions**

**Assessment for Palliative Status**

**Consent Processes and Advanced Care Planning**

- **Ideas about assessment for palliative status:**
  - General practitioners who have a patient in palliative care don’t necessarily know how the system works. Therefore, having someone with experience in navigating this system available to make the process less confusing for patients, their families and their physicians can be beneficial.

- **Ideas about consent processes in palliative care:**
  - Advanced care planning goes a long way in helping people understand the notion of the quality of life at end-of-life and makes it something they can prepare for.
  - Treatment options should be openly discussed with people who are dying and their families.
  - Keep palliative care, living wills and euthanasia as separate types of care.
  - Provide the appropriate resources to educate families so that they understand the implications of delaying the appropriate level of treatment and how this can result in the need for acute care.
  - Patients and their families need more awareness of the palliative care resources and services available to them.
• Terminally ill individuals who are no longer of sound mind should obtain only palliative care. Using life prolonging measures is inhumane when the patient is terminally ill, and their condition is painful and frightening.

• Develop a policy regarding the transition from long-term palliative care, to end-of-life palliative care.

**Funding and Costs Related to Palliative Care**

**Comments and Concerns**

- There is a lack of funding for palliative care

**Ideas and Suggestions**

- Remove the per diem charges for palliative care patients who go to a hospice house.
- Change the billing system to support more palliative care services for seniors.
- Audits of physician's end-of-life care decisions for hospitalized care should be performed. Too much expensive and useless care is being provided to dying patients.
- Fund all prescription medications and care for palliative care patients who choose to stay at home in the same way that they would be funded in acute care.
- Sustainable funding is needed for free standing palliative care and hospice facilities.
- Proper palliative care can reduce some acute care costs.
- PharmaCare must give all patients access to the Palliative Care Benefits Program no matter what type of facility they are in. This would eliminate the need for facilities that do not have access to the program to use their global funding to provide adequate pain and symptom management for their patients. It may also reduce the transfer of patients from residential care to acute care
- Revisit the Added Care program to separate the requests for added care due to behavioural challenges or short-term medical morbidity, and end-of-life care, providing separate and adequate funding for end-of-life care within facilities.
- Provide the same funding per Elder to all facilities. This disparity needs to be corrected if facilities are going to provide adequate end-of-life care. It is not possible to define who is 'palliative' in a facility and then add funding in the last few months because of disease unpredictability and because almost all of these people are in the last months of their life regardless.
• Health dollars and resources need to be allocated to provide a consistent standard of care for hospice, palliative, and end-of-life care.
• Providing affordable, high-quality home care and hospice, palliative end-of-life care to all British Columbians through the publicly-funded health care system can be cost effective and is the right thing to do.
• Costs for the last few months of life care and treatment should be publicized and respite care versus heroic treatment should be the norm. What are the costs and what percentage of these people survive? This should be publicized.
• The Ministry of Health should designate and fund hospice, palliative, end-of-life care as a core service within British Columbia and recommend that the Government of British Columbia contribute to and support national standards for home care and hospice, palliative, end-of-life care delivery programs.