THE HUNTER PRIZE
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CARES: Canada's Action for Resilient End-of-Life Services

Dr. Matthew Yau, MSc, MD, McMaster Family Medicine PGY2
Dr. Krish Bilimoria, MD, McGill Internal Medicine PGY2
Samuel Wu, Sabba Health

INTRODUCTION

Palliative care, defined by the World Health Organization, is "an approach that improves the quality of life of patients (adults and children)... associated with life-threatening illness" (1). Residential hospices are community care settings creating a home-like environment for patients at their end-of-life, where 24-hour palliative care be provided by skilled medical practitioners. Compared to Belgium, England, Germany, the Netherlands, Norway, and the United States, Canada has the highest proportion of people dying in acute care hospital settings, and is also the top spender for hospital expenditures at end-of-life (2). By aligning patient preferences, healthcare resources, and financial considerations, Canada can transform end-of-life care, providing comfort to patients and offering a cost-effective, practical contribution against the ongoing burden of patient wait times across the acute care hospitalization journey. We propose CARES: Canada's Action for Resilient End-of-Life Services as our suggestion to improve wait times across Canada.

TERMINOLOGY

The Ontario Palliative Care Network emphasizes that "Palliative care is not a phase or stage of a person's illness", and recommends that "palliative" should not be "a label for patients", given that "palliative care is appropriate at any time a person with a life-limiting illness has unmet needs" (3). This paper draws on sources that reference "palliative patients"; this should be described as patients receiving end-of-life care. Original wording from sources are maintained for clarity.

PROBLEM OVERVIEW

Most Canadians do not want to die in a hospital. This was the result of a pan-Canadian study, where 2,500 respondents were given vignettes of clinical scenarios (4). For the moderate and severe scenarios, most respondents, especially those 65 years or older, preferred a hospice or palliative care unit setting. Unfortunately, this ideal does not reflect reality. In 2020, 54.7% of Canadians died in hospital (5). This is a failing of our system by 1) depriving patients from a more comfortable environment at their end-of-life with decreased usage of health system resources for unnecessary treatments and investigations and 2) depriving other patients access to an acute hospital bed.

the HUB

Hospices are a care setting focused “on the care, comfort, and quality of life of a person with a serious illness who is approaching the end-of-life” (6). They provide constant care with trained nurses, personal support workers, and physicians providing a palliative approach. The benefits of a palliative approach to care have been thoroughly investigated and a clear consensus is recognized in the literature; integration of a palliative approach to care increases symptom control (7), quality of life (8), and increased satisfaction with care (9).

These benefits persist with hospice care specifically. A retrospective cohort study of 800 nursing homes across the United States found that after controlling for clinical confounders, patients in hospice were twice as likely compared to non hospice residents to “receive regular treatment for daily pain” (10). Another study reviewed the last 48 hours of life in 381 patients across hospice and nursing homes; when adjusting for clinical confounders, patients in hospice had a five times greater likelihood of receiving an opioid compared to non-hospice patients (11).

Canada stands out with some of the highest end-of-life hospital costs per person for cancer patients, possibly due to longer stays and more hospital-based deaths. Comparing the last six months of life, Canada’s average hospital expenses (US$21,840) surpass those of England (US$9,352), the Netherlands (US$10,936), and the US (US$18,500) (2). This cost and care discrepancy in Canada is linked to the heavy reliance on hospitals for end-of-life care delivery, impacting both expense and quality (12).

There are significant cost savings when shifting care from an acute hospital bed (~$1000/day) to a residential hospice (~$400/day) (13). These cost savings are accrued via: shortening hospital stays, lower daily expense in home or hospices compared to acute care, decreasing the frequency of ICU admissions, decreasing unnecessary diagnostic tests, investigations, and treatments (14).

How does this all relate to hospital wait times?

Patients who are also waiting for an acute hospital bed are often doing so indefinitely without a clear timeline in sight, with nearly half of palliative patients waiting for care in a more appropriate setting died before they could be discharged to one (15). This is called having a patient at an alternate level of care (ALC). When medical and surgical wards are occupied with ALC patients, the secondary effects are felt throughout the hospital: with increased Emergency Room overcrowding (since patients cannot be moved up from the ER to the ward), and delays in surgical care (due to a lack of a post-operative bed) (16,17). Among the plethora of causes for increasing wait times in Canada, we seek to focus on a common scenario we regularly see on the ground: reducing the number of palliative ALC patients occupying acute care hospital beds.

Using national discharge data from 2021, CIHI found that 44,034 (1.52%) of admissions were for palliative care and 103,033 (3.55%) were with palliative care across acute inpatient hospitalizations in Canada (excluding Quebec) (18). While the proportion of patients receiving palliation is minute compared to other reasons for hospital admission, these patients are staying in hospital much longer than other patients, often awaiting transfer to another facility such as a hospice.

The national average length of stay in hospital in 2021 was 7.2 days, but this is nearly double for patients receiving palliative care in hospital. Patients admitted for palliative care had an average length of stay in hospital of 12 days, and 17 days for those patients with admissions with palliative care (18). Of these days, patients receiving palliative care remained ALC for a median number of 10 days/patient. The proportion of admissions with reported ALC days was only 5.8% nationally (129,764) in 2021 (18). Extrapolating from this, patients admitted for palliative care represent a 33.9% share of patients with reported ALC days.

These data reveal shortcomings where our acute hospital system is not fit for purpose, and where it requires support from an even more overburdened community healthcare system. Of all patients admitted for palliative care, 71% died in hospital during their 12 average day stay (16% within the first 24 hours of admission). Only 12% were discharged home, and 10% to other settings including hospice and long-term care. The median of 10 days of ALC care can be multiplied by 44,034 hospitalizations for palliative care: waiting for hospice, palliative care unit, or home supports that could have been allocated to another patient requiring acute hospital services (ER care, post-operative care, etc).

The 2023 CIHI report found that 49% of hospices were always or usually operating at full capacity. Around 50% of operating costs are raised yearly by the hospices through charitable organizations, while the other portion is funded by government sources (18). Hospices also rely significantly on the assistance of volunteers - most importantly patient's families and friends providing informal care (19). While the request for more funding has been a priority for the QELCCC in its Budget 2023 submission, regrettably Budget 2023 did not include funding earmarked for palliative care or hospice care (20). We fear that a lack of expanded service at the end-of-life will only exacerbate the existing burden of patients in acute care hospitals who may be better suited to be cared for either in hospice, palliative care units, or at home with hospice nursing.

Addressing wait times across the inpatient care continuum must be thoughtful of where our care resources are often inappropriately overutilized: at the end-of-life.

RECOMMENDATIONS

Increase the total number & distribution of hospice beds across Canada

It is deceptively challenging to know the total number of hospice & palliative care beds nationally, with most recent estimates from Ontario having 270 hospice beds (12), Alberta having 250 beds (21), and British Columbia having over 300 hospice beds (22). We conservatively estimate approximately 1,000 hospice beds funded by provincial ministries of health across Canada, leading us to a ratio of approximately 2.5 hospice beds : 100,000 population. In keeping with benchmarks from other countries, the Auditor General of Ontario recommended that the ratio of hospice beds be 7-10 : 100,000 population (23). This leads to an estimate of ~4,000 provincially funded residential hospice beds or an increase in hospice capacity by over 3,000 beds.

Beyond increasing the total number of hospice beds, it is also critical to acknowledge that across nearly all provinces, there are regional health districts that do not have access to any form of hospice for either direct hospital or community referrals (12). Both quantity and distribution of hospice services remain a significant challenge to hospice's effectiveness in relieving acute care hospitals from palliative ALC patients.

Staff current & new hospices with skilled healthcare workers

Canada's progressive immigration policies have brought in numerous skilled workers to address increasing labor needs in sectors such as technology and agriculture. To directly increase the Canadian hospice workforce, we suggest broadening current federal skilled worker express entry programs.

The Government of Canada's Global Skills Strategy (GSS) is a preferential immigration program launched in 2017 in response to growing shortages of skilled workers in key sectors like technology and education in Canada. Administered by Immigration, Refugees, and Citizenship Canada (IRCC) and Employment and Social Development Canada (ESDC), the program expedited processing of visa and work permits for foreign skilled workers amongst select high-skills job categories (24).

The GSS program's operational capacity can be leveraged as a swift implementation and budgetary pathway for expediting processing and issuing visas and work permits for foreign trained healthcare workers to join the Canadian hospice workforce. IRCC's own evaluations report calls out a discrepancies between the IRCC and ESDC's definitions for "highly skilled workers" (based on National Occupation Classification codes) as a known issue that is preventing the inclusion of more healthcare professions from being able to take advantage of the GSS.

Amending the GSS program design to include hospice-focused healthcare profession NOC codes [Appendix #1] would visa and work permit applicants of these professions to benefit from expedited processing times, and for hospice employers to benefit from dedicated support to attract and bring these workers to work in hospices.

By increasing the hospice workforce, we stand to improve wait times in hospitals by reducing the burden of ALC patients, and make Canada's end-of-life services resilient to the demands of an aging population.

FUNDING OVERVIEW

A) Expanding Federal Express Entry Immigration Process

- The Federal Express Entry Immigration Process is used to manage Express Entry immigration for all provinces excluding Quebec. This program not only covers the processing of applications, but it also covers the cost of pre-arrival services and post-arrival settlement service to immigrants. This program is organized at Immigration, Refugees, and Citizenship Canada (IRCC).
- A recent costing analysis was completed of the Federal Express Entry Immigration Process, indicating that at the current level of immigration processing, the gross cost would be $792 million over 5 years, with fees recovering $743 million, for a net total cost of $48 million, or a net total cost per admitted permanent resident in 2022-2023 of $91 (25).

- We look to recruit: 1) palliative care nurses, 2) registered practical nurses, 3) social workers, 4) multi-faith spiritual care therapists, and 4) personal support workers to increase the staffing at Canada's 88 residential hospices, and for eventual expansion of 30 additional hospices in high-needs regions (14).
- Therefore, we estimate that with each hospice staffing 1 nurse: 4 beds, that for an expansion of ~3,000 additional hospice beds across Canada, we would expect 750 additional nurses / registered fractional nurses, 30 additional social workers, 30 spiritual care therapists, and 750 personal support workers: yielding a total of 1560 new immigrants to be requested through the program.
- This would yield a net cost to the government of ~$150,000 under the Parliamentary Budget Office's own costing analysis. Per their analysis, IRCC does not require hiring further staffing to process additional applications within their 6 month target.

B) Funding New Hospices

- Given that hospices across the country are most commonly independent corporations that seek funding from their provincial government body, often only for human resources costs, their funding appears to be precarious from year to year (26–30).
- According to Residential Hospice Working Group, in 2010 the average 10 bed hospice had a projected annual budget of $1.6 million, with provincial government support only covering nursing & personnel salaries at $900,000 ($90,000 / adult hospice bed). Non-clinical staff (~$600,000) and operational costs ($~150,000) are often fundraised by the hospice organization themselves through community fundraising and private donations (31).
- While some provinces such as Ontario are now recognizing the value of hospice care and are increasing operating budgets (32), this does not appear to be shared across all provinces.
- We recommend that the federal health transfers direct funding not only to 1) nursing & personnel salaries at hospices, but 2) hospice operational costs, and 3) capital costs of developing new hospices.
- To target an increase of 3000 operational hospice beds across the country, this would yield an additional $270 million in annual clinical costs for hospice care.
- To build the infrastructure to support these beds, this would represent $900 million in one-time capital development costs (at an estimated $3 million / 10 bed hospice per the Residential Hospice Working Group projection for capital costs).

C) Reducing System Wide Costs & Decreasing Hospital Wait Times

- It is well described that approximately 1.1% of the population consumes ~20% of the total health care costs in the final 6 months of life (33).
- Beyond this, the cost associated with staying in an acute care hospital *waiting* for a form of residential care (long term care, assisted living, palliative care, and hospice care) is substantial.

- A business case from the HPCO states that the average cost of staying in a residual hospice is estimated at $436 per day, less than even the lowest intensity form of in-hospital alternate level of care bed, which is estimated at $850 per day (31).
- While the initial capital investment of hospice infrastructure and staffing of hospices appears significant ($450 million annually in staffing, $1 billion in infrastructure costs), it appears having a reduced length of stay in hospital would have sizable savings for the system that might justify these costs.
- Per a CD Howe Report on palliative care, if the costs associated with end-of-life ALC days in acute care were spent instead on the beds where the patients were waiting for residual care, the saving in Ontario would be $161 million annually, and if extrapolated to the rest of Canada, then $400 million per year: just moving patients to a bed in the location they are waiting for (12).
- While this would not present directly as a cost saving, we believe that this would relieve in-hospital waiting lists proportionately: alleviating burdens in the emergency room, acute medical wards, surgical wait lists, and in-hospital services (Radiology, Laboratory work, among others) and encourage an acute care system that is more fit for purpose.

RISKS TO EXECUTION & APPROACH TO MITIGATE RISKS

Funding end-of-life care is a bipartisan issue. Death and dying is a human experience that unites us all, and increasing funding and support for healthcare teams focused on helping those in need should not be a contentious issue. Indeed, a national survey found that Canadians supported the integration of national standards of palliative healthcare services into the Canada Health Act (34). Nonetheless, we anticipate three major risks to executing our project: 1) the governance and licensing of foreign healthcare workers, 2) retention of healthcare workers in underserved communities, and 3) demands of increased healthcare budgeting.

As the majority of healthcare professions are regulated in Canada, professional colleges play an important role to license and recognize foreign-trained healthcare workers. There is already a trend towards expanding support and funding to these regulatory bodies to streamline and ensure fairness with the process of recognizing foreign trained professionals (35). Some of these programs require a period of supervised practice, which our group would certainly continue to recommend to ensure that staff who have started to work through the immigration pathway adhere to similar standards to those practiced by Canadian-trained staff members.

The retention of healthcare workers in underserved communities continues to be a challenge with any form of skilled immigration proposal. We recommend that skilled workers that enter through this program participate in a return of service agreement to a local community, committing this person to a minimum 3-5 year stay within the community as a contingency to acquiring permanent resident status in Canada. This model of return of service has been well-documented across other forms of medical training, specifically in the rural & military return of service programs for young trainees (36).

Lastly, we anticipate that demands for further funding from the federal government for healthcare will likely be challenging to execute in the upcoming budget. We believe that with an appropriate estimate of the relative cost saved within acute care hospital beds, scaling hospice care would be preferred as the more responsible priority sector to fund in health.

CONCLUSION

In order to tackle the wicked problem of wait times, we have identified patients receiving end-of-life care as a target ripe for optimization, starting with bolstering the hospice system through building beds and amending the Global Skills Strategy to include hospice workers to attract talent, and earmarking federal bilateral health transfers specifically for hospices to pay them.

Given the plethora of research demonstrating that ALC beds are a real contributor to healthcare delays, that hospice care is an excellent resource for patients that accrues significant health systems savings, and that the hospice system is one that is uniquely fragile to the worldwide healthcare personnel shortage, we believe that focusing on improving end-of-life care commands distinct urgency.

This proposal is universally politically palatable, it generates cost savings, it is practical and feasible, and most importantly, it can initiate substantial and meaningful impact for Canada's healthcare system and its patients.

APPENDIX #1

List of Hospice-related Healthcare Professional NOC codes:
3011 – Nursing co-ordinators and supervisors, 3012 - Registered nurses and registered psychiatric nurses, 3132 – Dietitians and nutritionists, 3141 - Audiologists and speech-language pathologists, 3142 – Physiotherapists, 3143/3144 - Occupational therapists & Other professional occupations in therapy and assessment, 3211/3212 - Medical laboratory technologists & Medical laboratory technician and pathologists' assistants, 3214/3215/3216 – Respiratory therapists, clinical perfusionists and cardiopulmonary technologists & Medical radiation technologists & Medical sonographers, 3232/3236 - Practitioners of natural healing; Massage therapists & Other technical occs. in therapy and assessment, 3233 - Licensed practical nurses, 3413/3414 - Nurse aides, orderlies and patient service associates & Other assisting occupations in support of health services

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