

Rural–urban inequities in palliative care

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There are significant inequities in the delivery of palliative health care between rural and urban populations in British Columbia. These inequities have, like many other areas of health care, been amplified by the current pandemic.

According to Statistics Canada, on average, BC's rural populations are older, poorer, and have a higher chronic disease burden than urban populations.¹ It might be thought, therefore, that the Ministry of Health and health authorities would recognize this inequity and assign palliative care resources accordingly. In fact the opposite is true, and like many other inequities, the COVID-19 pandemic has worsened this divide.

Both the 2018 Health Canada Framework on Palliative Care² and the BC Centre for Palliative Care³ address the need for equity in the delivery of palliative care services. Under its guiding principles, the BC Centre for Palliative Care states that “All individuals and families have equal access to hospice palliative care services when they need it and where they need it: at hospitals, long-term care facilities, hospices, and the home.”³

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Unlike other health care services (e.g., neurosurgery), palliative care services can only be effectively delivered in a patient's home community. There are many reasons why this is currently not being achieved equally across the province, including:

- Many rural communities have few or no palliative care beds. And as financial burdens increase, some health authorities are agreeing to staff new beds only if the local community pays for the design and building costs of new palliative care facilities. When built, residential hospice palliative care programs have often been at least 50% funded by charitable donations.³ This discriminates in favor of urban centres where wealthy benefactors and corporations looking to make donations are more likely to be based.
- The current fee-for-service remuneration structure does not lend itself well to the increased time demands of physicians providing palliative care. Most sessional payment schemes and on-call payment arrangements exist only in urban centres. This acts as a financial disincentive for physicians who specialize in palliative care to move away from urban centres and limits the amount of time that physicians in rural areas can dedicate to palliative care. This stands in contrast, for example, with funding for medical assistance in dying assessment and provision, where physicians are adequately compensated for their work and travel.

- Unlike in urban areas, it is relatively uncommon for appropriately trained community nurses to be available on a 24-hour basis. This pushes more rural palliative care patients facing a symptom crisis to attend the emergency department and be admitted to an acute care bed, ultimately increasing global health care costs.

Rural palliative patients tend not to attract political attention. Their suffering often takes place in isolation, away from the centres of power. It can be hoped that, as health policy analysts address the inequities uncovered by the pandemic, the plight of rural palliative patients receives equal consideration. ■

—David May, MD

References

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