AM

Canada

General data

POPULATION, 2024
41,288,599

SURFACE KM², 2022
15,634,410

PHYSICIANS/1000 INH, 2021
2.46

NURSES/1000 INH, 2021-2022
10.31

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
16

GDP PER CAPITA (US$), 2023
53,431.19

HEALTH EXPENDITURE PER CAPITA (US$), 2021
6,470.07

UNIVERSAL HEALTH COVERAGE, 2021
91

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

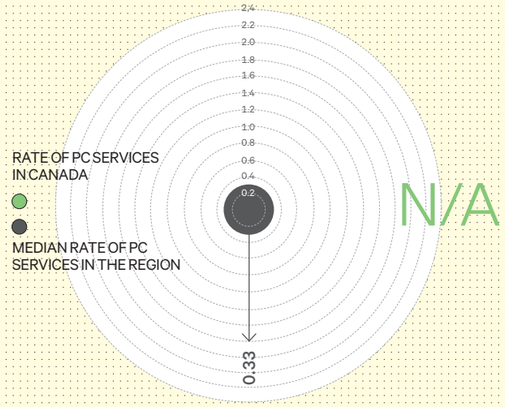
1 EMERGING
2 PROGRESSING
3 ESTABLISHED
4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

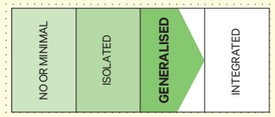
Total number of Specialized PC services: **N/A**

Rate of PC services per 100,000 inhabitants: –

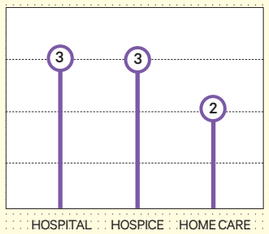
Canada in the context of the region



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

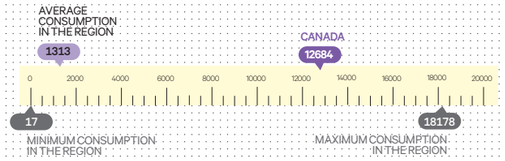
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

TOTAL NUMBER: **N/A**

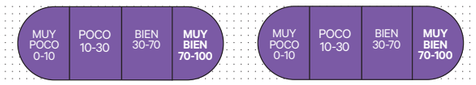
Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **12,684** S-DDD/MILL INHABITANTS/DAY

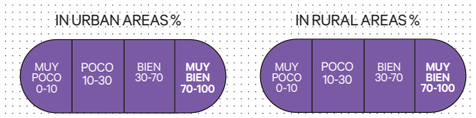
Canada in the context of the region



Overall availability of essential medicines for pain and PC at the primary level



General availability of immediate-release oral morphine at the primary level



Ⓒ Research

PC-related research articles: 4

Existence of PC congresses or scientific meetings: 4

Consultants: Leonie Herx, Ebry Kaya, Jose Pereira, David Henderson.

National Association: The Palliative Care Coalition of Canada.

Data collected: November 2024-June 2025

Report validated by consultants: Yes

Endorsed by National PC Association: No

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **12/18**

Nursing schools with mandatory PC teaching: **N/A**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 2

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 4

Advanced care planning-related policies: 3

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People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

4

Strong national and sub-national presence of palliative care advocacy and promoting patient rights (as a professional association of Palliative Care, i.e.).

In Canada, national advocacy for palliative care is led by the Palliative Care Coalition of Canada, a group of over 30 national organizations, including patient rights groups and the Canadian Hospice Palliative Care Association. Other key contributors include The Canadian Society of Palliative Care Physicians, Pallium Canada, The Canadian Virtual Hospice, and Covenant Health Palliative Institute (with the project Palliative Care Matters). At the provincial and territorial levels, approximately 75% of provinces and territories have organizations working on palliative care advocacy. These efforts focus on improving access to services and ensuring palliative care is recognized as a healthcare priority.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

3

There is/are national policies or guidelines on living wills and/or on advanced directives but not a national policy.

Canada has a national initiative on ACP, primarily led by the Canadian Hospice Palliative Care Association through the "Speak Up" campaign, which provides extensive resources for patients, the public, and healthcare professionals. Additionally, Advance Directive Canada offers tools and information to assist in understanding and developing ACPs. However, Canada's federal system means that ACP policies and regulations fall under provincial and territorial jurisdiction. Most provinces and territories have policies, guidelines, and initiatives that govern ACP and substitute decision-making, though terminology varies. For instance, some jurisdictions recognize Power of Attorney as the highest level of substitute decision-making authority. If the criterion focuses on national visibility and promotion, Canada qualifies as Level 4. However, if it requires a single national government policy, it aligns more closely to a lower level.

Policies

Ind 3

3.1. There is a current national PC plan, program , policy, or strategy.

2

Developed over 5 years ago.

Canada has a National Palliative Care Framework, developed following the Framework for Palliative Care in Canada Act, which was passed by Parliament in 2017. The framework itself was released in 2018, followed by a Health Canada Action Plan in 2019, which outlined a five-year strategy to address key issues. However, very little progress has been made, and as correctly noted, nothing has been actively evaluated or audited. A key example of this lack of implementation is the Office of Palliative Care, which was recommended in the framework to coordinate national efforts but was never established. While PC policies fall under provincial and territorial jurisdictions, their implementation remains highly variable. Some provinces have dedicated PC policies and regulations, while others incorporate PC within broader healthcare strategies. In terms of monitoring and evaluation, there is a national quality-of-care process that includes PC, but There are no measurable targets or indi-

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

4

The Indicators to monitor and evaluate progress are currently implemented.

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Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

cators in the national plan and no specific indicators have been actively implemented or consistently updated. Only examples examples of what provinces and regions can do to address priorities are given.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

PC is not explicitly recognized as an essential service under the Canada Health Act, which defines the core services that provinces must fund as part of healthcare delivery. This omission means that PC is not mandated federally for UHC, allowing provinces to decide whether or not to fund it, resulting in wide disparities in access and quality across the country. The 2017 Palliative Care Act led to the development of the National Palliative Care Framework (2018), updated in 2023, but this did not change PC's status under the Canada Health Act. National PC organizations have been advocating for decades to have PC formally recognized as an essential service, but this has not yet been achieved. Given this reality, the fact that PC is not included in the national UHC framework remains a major challenge for equitable access.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no authority defined.

Canada does not have a dedicated national "Office for Palliative Care", despite the 2017 Framework for Palliative Care Act mandating its establishment to coordinate the implementation of the framework and action plan. A comprehensive search of official Canadian government websites has found no evidence. While Health Canada has some personnel covering PC, their role is primarily administrative, focusing on reporting requirements rather than actively overseeing or developing PC policies. There is no systematic national monitoring of PC, and no structured federal oversight body to ensure consistency across provinces and territories. Although the government of Canada has established frameworks and action plans to improve PC, and Health Canada has responsibilities in this area with a role of coordination or supervision, but there is no national office exclusively dedicated to PC. PC governance falls under provincial Ministries of Health, but there is no uniform national structure. Some provinces have designated PC leads, while others do not—largely due to PC not being recognized as an essential service under the Canada Health Act. A national secretariat for PC existed in the early 2000s, but was eliminated over 12 years ago. Since then, development has lacked centralized coordination.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

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Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

4

At least one national conference specifically dedicated to palliative care every 3 years - At least one national conference specifically dedicated to palliative care every 3 years.

Canada has multiple national scientific meetings and conferences specifically dedicated to PC: the Canadian Society of Palliative Medicine (CSPM) holds an annual national conference, the Canadian Hospice Palliative Care Association (CHPCA) also organizes an annual conference, the Montreal International Congress on PC takes place every two years. Additional provincial conferences and meetings occur regularly, such as the ALP and CHPCO conferences

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

4

Denotes an extensive number of articles published on the subject.

Canada has a strong presence in PC research, with high-profile researchers and a national group dedicated to advancing the field. A key initiative is the Pan-Canadian Palliative Care Research Collaborative (PCPCRC), a network of over 100 members, including researchers, healthcare providers, policy stakeholders, trainees, and patient-caregiver partners. The PCPCRC aims to improve clinical practice, service delivery, and data standardization through collaborative research. In 2021, it received funding from Health Canada's Health Care Policy and Strategies Program, supporting 14 projects on new therapies, innovative models, and strengthening national research infrastructure.

Medicines

Ind 8

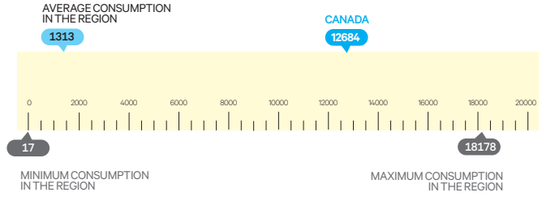
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids.

12,684

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



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Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

In both urban and rural primary care facilities, people have access to pain and PC medications as listed in the WHO Model List of Essential Medicines. However, while medications are available in acute care settings (funded by health authorities), outpatient prescription drugs are not as readily accessible and often come at a cost to the patient. Additionally, injectable medications are less available for home-based care, which may limit effective symptom management for patients receiving PC outside of hospitals. Importantly, Northern Territories, many rural areas, health facilities in prisons, and particularly First Nations, Inuit communities and Metis, lack access to these medications. Many essential medications are either unavailable or not covered by health plans. Furthermore, outside hospital settings, many drug plans do not cover these medications unless a patient qualifies for palliative coverage, which is typically restricted to the last six months of life.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

4

Very good: Between 70% to 100%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

4

Very good: Between 70% to 100%.

In Canada, the availability of immediate-release oral morphine in primary care settings is generally high. There have been instances of medication shortages, such as a national shortage of liquid hydromorphone a few years ago. To address these issues, a governmental committee actively monitors and develops strategies to minimize such disruptions. Moreover, while opioids are generally available through pharmacies across the country, access in very rural and remote regions, particularly in Northern Canada, can be limited. In these areas, major barriers exist to accessing opioids, affecting the consistency of PC services.

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Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	12/18	In Canada, approximately 12 out of 18 medical schools (67%) include some form of compulsory PC education at the undergraduate level, while 17 out of 18 (94%) offer it as an optional subject. However, in some cases, PC education is provided by family doctors rather than PC specialists. However, when focusing on clinical rotations, as analyzed by Gagnon et al. (CMAJ Open, 2020), the numbers are lower. Only 2 out of 17 schools had mandatory PC clinical rotations, 13 offered them as optional, and 2 did not offer them at all. In 2015/16, only 29.7% of medical students completed a clinical rotation in PC, though this marked an improvement from 2011/12 (13.6%). A major component of PC education is residency medical training, which varies significantly across universities. According to Gagnon, around 58% of family medicine residents completed PC rotations between 2007 and 2017. Participation rates were 64% in geriatrics and psychiatry, 34% in anesthesiology, 31% in internal medicine, and 28% in neurology.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	17/18	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	N/A	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	N/A	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognised by the competent authority in the country.	●●●● 4 Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.	Palliative Medicine is officially recognized as a subspecialty by the Royal College of Physicians and Surgeons of Canada (RCPSC) for both adult and pediatric care, and acknowledged by national and provincial regulatory bodies. There are two training routes: A two-year Royal College Subspecialty program leading to certification. A one-year Enhanced Skills program from the College of Family Physicians of Canada (CFPC), offering specialized training but not at the subspecialty level. While all provinces recognize the Royal College credential, only some accept the CFPC Certificate of Added Competence (CAC) in Palliative Care. The Canadian Society of Palliative Medicine (CSPM) recommends minimum credentialing of either Royal College certification or CFPC CAC(PC). However, no mandatory credentials are required to practice as a PC specialist, so many clinicians lack formal training. The CSPM has also developed National Quality Standards for PC, to be released in spring 2025, which state that specialists must hold Royal College certification.

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Provision of PC / Specialized Services

Ind 13

13.1. There is a system of Specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	●●●○ 3 Generalized provision: Exists in many parts of the country but with some gaps.	Canada has a generalized but uneven provision of specialized PC services, with significant regional disparities. The system is classified as Level 3 (Established)—available in many parts of the country but with gaps, especially in rural and remote areas. Hospitals: PC teams and units are present in a growing number of hospitals, though access varies by region. Free-standing hospices: Mainly in urban areas. Alberta has sufficient beds, while Ontario and others are underserved. No hospices exist in the Territories. Home care teams: Availability varies widely; access declines outside major urban centers. Many rural or remote areas lack any form of homecare. There is no national or provincial registry of PC programs, complicating national-level service quantification. Some regional health divisions have their own registries. Canada lacks a unified national definition of "Specialist PC" regarding physician remuneration. Family Medicine–trained PC physicians are usually paid at generalist rates, while those with other specialties are paid accordingly—even when performing the same PC work.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	●●●○ 3 In a growing number of private hospitals.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	●●●○ 3 Found in many parts of the country.	
13.4. HOME CARE teams (Specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	●●○○ 2 Ad hoc/ in some parts of the country.	RATE OF SPECIALIZED PC SERVICES/100,000 INH MEDIAN RATE IN THE REGION 0.33 CANADA N/A 0 1 2 3 4 5 0 MINIMUM RATE IN THE REGION 3.13 MAXIMUM RATE IN THE REGION N/A ← SPECIALIZED PALLIATIVE CARE SERVICES
13.5. Total number of Specialized PC services or teams in the country.		

Ind 14

14.1. There is a system of Specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	●●○○ 2 Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.	Although some major Canadian cities have well-established pediatric PC programs, nationwide access remains limited and uneven. Services are concentrated in urban centers, with virtual teams supporting remote areas, but equitable coverage is not yet achieved. Specialized programs operate in Vancouver, Edmonton, Calgary, London, Hamilton, Toronto, Ottawa, Montreal, and Halifax. Outside these hubs, access is scarce, and fewer than 18% of children needing PC actually receive it. Many regions rely mainly on virtual teams, such as the UBC Vancouver service, which provides on-call support across British Columbia and Yukon. Pediatric hospices are also rare, with only five nationwide: Canuck Place (Vancouver), Rotary Flames House (Calgary), Emily's House (Toronto), Roger Neilson Hospice (Ottawa), and Le Phare (Montreal).
14.2. Number of pediatric Specialized PC services or teams in the country.	N/A PPC TEAMS	