The Canadian Medical Insurance and the Care of the Elderly
■ A Lesson for Taiwan

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ABSTRACT

This is a study of the health insurance, especially the care of the elderly in Canada and how these Canadian programs could help Taiwan to develop a qualitative care for its citizens. The characteristics of the Canadian health insurance system as revealed through its upheld principle are namely, universality, accessibility, comprehensiveness, portability and public administration. These principles have served as guidelines to all Canadian health care programs.

In regard to the care of the elderly in Canada, the best example is Ontario's program of Human Habitat. This program is based on idea called the Eden Alternative which emphasizes a wholistic atmosphere of a living environment. Home care is another way the Canadian government developed to enhance the elderly's self-worth by helping them live in their own familiar homes with dignity and comfort.
Taiwan is contemplating a social program to help her elderly. A monthly cheque similar to the Canadian old age pension is under consideration at the moment. Would Taiwan develop a good qualitative program ? If so, the Canadian system could serve as good model for Taiwan to ponder.

Key words: Medicare, Senior Home, Human Habitat.

I. INTRODUCTION

A comprehensive and universal medical insurance system has been implemented in many countries in the world in the last few decades including Taiwan. This paper is an attempt to look at the Canadian medical insurance program and how she takes care of her elderly through the program called Home Care. Taiwan's newly introduced Health Insurance Program has been positively responded by its insurers yet the cost to maintain this program cuts deep into government's budget. Still, senior citizen care is a uncultivated land in Taiwan except the basic medicare

C.E.P.S.

covered by the insurance policy. Can Taiwan learn from Canada is a question this paper attempt to discover.

II. A BRIEF HISTORY OF CANADIAN MEDICARE SYSTEM

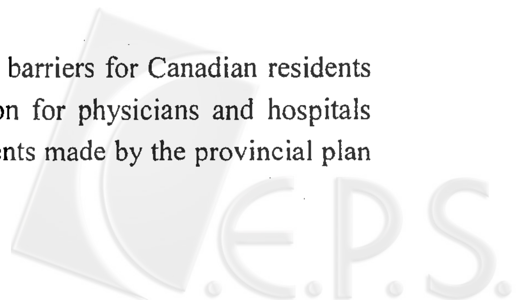
Prior to the 1940s, medical care in Canada was mostly private. Starting in 1947 the provincial government of Saskatchewan, under the leadership of the Rev. Thomas Douglass , the then premier, introduced a provincial hospital care plan which motivated the national interest in such a service to all people within the land. In 1948 the federal government of Canada offered to pay part of the cost of provincial hospital insurance plans. In 1957 the " hospital Insurance and Diagnosis Services Act " was passed by the Canadian Parliament which lay the foundation of the future national health care system. By 1961 all provinces had taken up the offer. Canadian public hospital and health care system were formally developed.

In 1962 the province of Saskatchewan further extended the plan to cover physicians' services. This led to a bitter strike and soon afterward, the government of Rev. Thomas Douglass in Saskatchewan was brought down. Doctors felt this new scheme would undermine their independence and they would become government' employees. A solution was agreed upon later to allow physicians to practice outside the plan if so chosen. Though this new attempt to include physicians' services brought down Rev. Douglass' government, the medical care act, however, was adopted by the federal government to offer matching grant of 50 percent of the costs for the provinces that introduced satisfactory medical plan. By 1971 all provinces joined in this public insurance.

III. THE PRINCIPLES OF CANADIAN HEALTH ACT

Five principles of the medical care were laid out in Canadian Health Act of 1984. The provinces joining the program must observe these principles in order to be qualified for the matching grant from the federal government. The five principles are:

1) Universality: all residents were entitled to health insurance coverage.
Some provinces charged premiums while others provided insurance out of tax revenues. This principle on universality forbad provinces from denying any residents from joining the program.
2) Accessibility : there could be no financial or other barriers for Canadian residents to receive medical services. Reasonable compensation for physicians and hospitals were given and extra-billing to patients beyond payments made by the provincial plan was forbidden.



3) Comprehensiveness : all medically necessary services must be insured. This at least provided the basic medical needs for all those seeking health care though it was difficult to define at times what services were medically necessary.
4) Portability: Portability was important for labor mobility and economic efficiency. To uphold this principle, coverage must be maintained when a resident moved within the country or traveled outside Canada with limited coverage. The new entrances to Canada however must wait for a transitional period (usually three months) without coverage in order to keep people from entering the country simply to get medical care.
5) Public administration: the administration of the health insurance plan must be on a nonprofit basis. This is to ensure that privatization of this health policy, if launched as a replacement later, could not be commercially-based..

IV. CONTROL AND IMPLEMENTATION

The Canadian health system puts great emphases on equal medicare availability to all residents and on the professionalism of doctors. Patients are free to choose their doctor and to visit as often as they wish. This however, poses a problem of potentially overusing of the system. Doctors as agent practitioners in their professionalism thus have to play the role of the gate keepers. For instance; patients are only allowed access to specialists if recommended by a GP. The general practitioners uses their expertise to tell the patient whether s/he needs further more expensive / extensive care. Some provinces, for instance, Ontario will pay doctors not on per service basis but according to how many patients they have under their care. Therefore there is a possibility that 'supply can create its own demand'. Governments have made serious attempts to limit the supply in several ways, for instance, to limit the number of positions in medical schools, thus limiting the overall number of doctors. Some provinces have directly limited the number of doctors allowed to practice through a system that each physician is required to have a ' billing numbers' issued by the government for the provincially run insurance schemes. Others use this approach to try to direct doctors towards practice in regions where there are shortages. Finally, most provinces limit the numbers of certain types of operations, for instance, hip replacements. This has resulted in long line ups for these procedures and the public has difficulty deciding how serious a problem is. This is an emphasis on preventive medicine and on doctor limiting excess demands on the system.

An issue which arises frequently in the Canadian system is whether patient should pay some of the costs of services directly ? This undoubtly would deter overuse in some sense and thus reduce overall health care expenditure. Yet this measure is against the five principles the care system intends to uphold. Therefore, this so-called extra-billing is rejected.

E.P.S.

Should doctor be able to opt out of the medicare system ? in other word, can doctor open a private clinic totally outside the medicare system ? The Canadian system will allow such an option but their patients will not be reimbursed by the medical plan and if doctors do this, they must operate entirely outside the plan. They cannot offer a mix service partly paid by the insurance and partly paid by the patient. This rule is to prohibit ' balance billing'. As a result, there is very little private services in Canada. Doctors can however offer services not covered by the plan, for instance, various types of cosmetic surgery deemed not necessary.

Allover, Canadian health care system provides every resident a worry-free service that every sick resident can at least receive a basic medical care regardless of color, religion, gender, education or age.

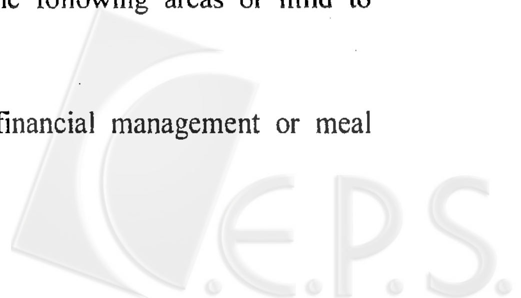
V. MEDICARE PROGRAM AND THE CARE OF THE ELDERLY

But what does this care system mean to an elderly who can no longer take of themselves ? Medical and hospital care are universally insured in Canada, but community and institutional continuing cares are not. The basic medical care is given through the health insurance program but and the care of the elderly is delivered through the contracted agencies, professionals, home care and volunteer agencies, day centers, day hospitals, acute and rehabilitation hospitals and long term care institutions such as nursing home as well as family and specialist physicians. In Canada the current situation emphasizes the need of an integrated care for the frail elderly (SIPA).

The concept of SIPA is developed through Quebec. In 1995 the McGill University and the Universite de Montreal research group on Intergrated Services for the Frail Elderly (Systeme de services integers pour personnes agees en perte d'antonomie (SIPA) came up with this idea. SIPA is a community-based primary care system based on a patient-focused model designed to meet the needs of the frail elderly and to assure comprehensive care, integration of all available services and continuity of care by all professionals and institutions involved. It is responsible for primary and secondary medical and social services, prevention, rehabilitation, technical aids and long term care but not for ultra-specialized services such as transplantation.

SIPA would serve as a single entry point for all frail elderly, who are deemed eligible if they were severe disability in one of the following areas or mild to moderate disability in two:

- Activities of daily living,
- Instrumental activities of daily living such as financial management or meal preparation.
- Mobility,



- Mental status and incontinence.

All eligible elderly people would be registered in SIPA following evaluation. Although self-referral or referral by a healthcare professional would be allowed, there would be incentive for a SIPA center to seek out eligible patients. Within SIPA, care would be provided by an inter-disciplinary team comprising health and social services and its goal would be to use services and resources in the most appropriate and efficient way by employing evidence-based geriatric interventions. Elderly people will be encouraged to remain patients of their family doctors or to choose the SIPA physician. This system is more likely to invest in prevention, rehabilitation and home services in order to decrease inappropriate and more expensive use of acute care hospitals.

Besides this institutional facilities for the elderly, Home Care also provides needs for the elderly in Canada. Home Care is defined as array of services which enables an incapacitated client to live at home as a substitute for long term care or acute care alternatives. Such a care will not only reduce expenses, also it provides client a sense of self-worth by living at home.

Evelyn Shapiro, a well-known authority on Canadian home care described the general objectives of Canadian provincially coordinated home care programs in the following manner:

1. enable people to remain in or return to their homes
2. ensure that people function as independently as possible at home
3. sustain the health and involvement of the family

The top four target groups for home care health and support services in Canadian Home Care Programs (CHCP) include:

1. those discharged from hospital that need relatively short-term help until they have recovered from an acute episode.
2. those in the community or in hospital who might otherwise require a nursing home bed
3. those who require support to prevent the social or functional deterioration that would lead to future admission to a nursing home
4. those who require care to avoid a hospital admission

There are three models providing the services: firstly, the maintenance and preventive model which provides services such as home help, personal assistance, housekeeping, meals-on-wheels, counseling, public health services to people with health and functional deficits in the home setting. Secondly, the long-term care substitution model which provides home care services for persons who would otherwise require long-term institutionalization. Thirdly, the medical model which provides needs to those who would otherwise have to be hospitalized.

The first model can be easily identified but the second and the third models

C.E.P.S.

often function like private nursing homes. The deliverance of services however, depends on Canadian Home Care Program staff or external agencies which are contracted by the government. Clients are usually charged a fee for service or user fee for non-clinical services such as homemaking, personal assistance, house-cleaning, meals-on-wheels, transportation and supplies and equipment. Users fees are based on a sliding scale according to one's income. Professional home care services such as nursing, therapy, counseling and case management provided on a visit basis through CHCP's are available to eligible clients at no expense to them.

VI. AN IDEAL NURSING HOME

Dr. William H.Thomas, the chief physician of Chase Memorial Nursing Home in the community of New Berlin near Syracuse, NY, said that the biblical story of Garden of Eden gave a good indication of what paradise is supposed to be – a perfect human habitat where pets, plants and children were around. He experimented an Eden program that does away the heavy reliance on prescription drugs and replaces them with a less programatic structure that seeks to eliminate three plagues of the typical long-term care institution: loneliness, helplessness and boredom. The Wellington Nursing Home in Hamilton, Ontario, a 102-bed facility with 127 full time and part time staffs which opened in 1991 followed this Eden pattern. As one enters the nursing home, s/he will be surprised to see two dogs and four cats roaming the halls at will. There is also Floppy the bunny, budgies and friendly animals. Most residents have pet birds or live plants in their rooms. There are ten principles the Eden Habitat upholds. Below are six principles which to me are most renovative and representative of this new spirit of nursing home:

1. An understanding that loneliness, helplessness and boredom account for the bulk of suffering in a typical nursing home.
2. A commitment to adopt the human habitat model that makes pets, plants and children the pivots for daily life in the nursing home.
3. Providing opportunities to give as well as receive care by promoting residents participation in the daily round of activities that are necessary to maintain the habitat.
4. Providing easy access to companionship by promoting close and continuing contact between the elements of the human habitat and the residents.
5. De-emphasizing the role of prescription drugs in the resident's daily life and committing these resources to the maintenance and growth of the habitat
6. Edenizing is a process, not a program and that the habitat, once created, should be helped to grow and develop.

There are opponents to this Edenization of nursing home yet the Wellinton experience proved this new experienment proved to be valuable.. It has been a

C.E.P.S.

powerful tool for improving the quality of life for residents living in long cares facilities. One lesson we learn from this Eden Alternative is that the delivers of daily care must be taught to see nursing homes as habitats for human being rather than institution for the frail and elderly. It is a HOME, but an institution.

VII. WHAT CAN TAIWAN LEARN FROM THE CANADIAN EXPERIENCE ?

From the above description of the Canadian Medical Insurance, home care and how Canada takes care of her elderly, there are indeed many things Taiwan can learn. The following points are recommended for Taiwan to ponder :

1. Primary Health Care System must be developed – the role of general practitioners must be emphasized. Patients in Taiwan are free to see any doctor of their choice. There is not a system of general practitioners to serve as gate-keepers of the health insurance program and serve as counselors to patients for whether or not a specialist is needed for further examination and treatment. Patients are left alone wondering what medical specialist they should see. As a result, specialists are usually inundated with common cold patients while the patients who really need the care of the specialists have to compete by waiting for their turn. Interestingly, these specialists would not turn away any patients, as in Taiwan physicians are paid on the number of services they provide. Thus, any patients knocking at the doctors' doors will get their turns, regardless of the number of time they visit in a day. No wonder physicians in Taiwan usually see more than one hundred patients a day . How can a quality of care be maintained with this kind of system ? A primary care system and a referral system must be developed to enhance the quality of care. If this system is implemented, in addition to better care, it will also save money for the government by reducing the patients' hospital visits.
2. Since insurance is operated centrally, portability in Taiwan is not needed. Patients, however, can see any doctor in any hospital throughout the country. This motivates a tendency that bigger hospitals are attracting more and more patients, while private clinics are becoming smaller and smaller as patients believe that bigger hospitals are instrumentally better equipped and their doctors more adequately trained. The result : bigger hospitals are becoming bigger and community clinics can hardly survive.
3. Home care is not yet available in Taiwan except in veteran's home for those discharged mainlanders without any relatives in Taiwan . Traditionally, the family is the basic caring unit for the elderly yet the social change taking place in the last few decades has disrupted this traditional virtue. Some families now hire live-in nannies (usually from Thailand, Vietnam, Philippines. Malaysia…) to take care of their elderly. The language barrier between the care providers and receivers often

C.E.P.S.

causes many misunderstanding and problems. The government must look at the rapidly increasing numbers of the elderly and come up with a comprehensive social welfare system for the seniors. One of these should be the construction of senior citizens' and nursing homes.

4. The Eden Alternative can be a good model for Taiwan's nursing care-home. The government of Taiwan is considering an old age pension given to all senior citizens. All senior citizens older than 65 are eligible to receive $ 3000 NT each month. Though the intention of this old age pension is good, it, however, would help little to the care of the elderly. This budget could be diverted to a more needed social program such as the construction of nursing homes. The Canadian model of human habitat can serve as a good model for Taiwan.
5. Seniors' Day Care Center must be developed. For those who stay at their own homes, a day care center would be ideal for them in the daytime while their care providers, e.g. children, are away at work. The center can plan versatile programs for the seniors to enjoy.
6. For those staying at homes due to the shortage of senior citizen homes or nursing home, Home Care Program is another thing Taiwan can learn from Canada. This is the easiest way to implement in terms of all recommendation mentioned above. Many religious agencies in Taiwan have developed many caring program but this Home Care idea such as meal-on-wheel, house-keeping assistance...etc are yet to be seen.

VIII. CONCLUSION

Canadian health insurance and care system to the elderly have been regarded as one of the best in the world. Taiwan can really benefit from it.

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