

Social Protection in Health Care and the Elderly Filipinos in Vancouver

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Abstract

This paper tackles the issue of health care for senior age Filipino workers in Vancouver by highlighting the Canadian health care system. Here the author argues that health care is an important component of social protection not only from a welfare perspective but also as means to achieve economic development and that in certain contexts it is possible to draw a balance between maximization of the national income and equalization of benefits among citizens particularly in the area of health care services.

Introduction

Canada is a model country in the institutionalization of health care as a social policy that is effective and accessible. Optimum health plays a strategic ideological role in a free and democratic Canada, which guarantees health care to its citizens. The question of health needs has always wide implications on the standard of living for generations of Canadians. In the language of democratic consolidation, health care

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is pursued because it makes good economic sense -- the healthier the population, the stronger and more productive they are. Most importantly, there is the well-established tradition of a society where citizens attribute a comprehensive system of equity on health care.

For Asia as a whole, for the past twenty years, social protection measures have become the principal form of intervention to protect the poor and the vulnerable populations in times of economic crisis. It takes on primarily longer term policies that aim to protect and promote the economic and social security or well being of the poor. It is about the specificity of protecting households and individuals against income shocks that threaten their immediate material living conditions. The process of strengthening the capacity of the most vulnerable through social protection is through investments in education and health.

This paper is about social protection as it occupies a central place in the creation of a fairer society by equalizing benefits from education to health services. There is an increasing recognition among policy makers that such a program will help society's most vulnerable people against abuse. The process assures that public funds will be spent on intended programs benefitting target recipients in the creation of infrastructure and opportunities. In a related vein, the most urgent and fundamental task is for governments to increasingly shift the basis of financing for social services such as education and health care, from socially financed universal provision to service payment mechanisms, that is, invest in policies which reach the poorest directly. To date, cash transfers have become a popular form of development policy and programming. The Aquino government tries to insure that the national budget's preparation, allocation and use would significantly benefit the poor. The Php 2 trillion 2013 budget is described to be a bottom up innovation where there is closer citizen engagement through civil society organizations and the local communities. The approved budget for the department of health stands at Php 56.8 billion and Php 56.2 billion for social welfare and development, the agency that is responsible for the government's conditional cash transfer (CCT) program.

Social Protection, Health and Inequality

The ILO defines social protection as the protection which society provides for its members through a series of public measures (ILO, 2002: 3):

- to offset the absence or substantial reduction of income from work resulting from various contingencies, notably sickness, reduction of income from work such as old age, unemployment;
- to provide people with health care; and
- to provide benefits for families.

The ILO has two main objectives from a health perspective. First, to prevent, treat and rehabilitate the health of workers and their families by ensuring the utilization of an effective health services. Second, to ensure financial protection for families through a health financing system based on the principle of solidarity. The focus is on three sets of strategies: extend formal social security; promote decent work conditions and provide programs for informal and migrant workers. Discussions of income security for the poor require identifying policies and institutions that are an integral part of their government's functioning. This sets the terms of ensuring the utilization of needed and effective health services of families. The principle of solidarity serves as the basic building block of financial protection through the analytical tool of a health financing system. There is also the realization that policies that work best depend on a multidimensional approach in the context of overcoming poverty through the coordinated efforts by international organizations. With increasing evidence, measures of social protection have ensured economic growth through health and education policies. Perceived in this way, social protection is more of an investment in growth rather than a response to problems.

There can be little doubt that the trickle-down effect has not instilled prosperity for the majority. In the 1960s and 1970s, economists and development planners then argued that to extend support to the poor in developing countries, the corporate world will be the economic foundation of a well-ordered society. This was predicated upon the belief that employment and general prosperity will follow given the so-called best interests in mind by business people. Far from the trickle-down effect, growth has not necessarily made people better and there is clear evidence that with a market-based economy, if unchecked, inequalities tend to be catastrophic with real incomes among the low-income groups stagnating. The result is a repressive society that has worked to the advantage of the top-income earners and caused marginalization of those at the bottom.

The World Bank has acknowledged that it has taken for granted social protection and as a result, failed to address the needs of the poor. As a response, to reduce poverty and social exclusion, social protection has become a top priority for donor policies and programs. The World Bank developed a tool called Social Risk Management (SRM) that focuses on managing risks before shocks occur (Cook, et al, 2003). It is based on two assessments: the poor are most exposed to diverse risks and the poor have the fewest tools to deal with these risks. The main elements of the SRM framework are: risk reduction measures that focus on reducing risks in the labor market; risk mitigation measures that deal with anticipated shock; and risk-coping mechanisms to relieve the impact of risk.

In the meantime, the Organization for Economic Cooperation and Development (OECD) introduced the Development Assistance Committee Development (DAC) which is responsible for the Poverty Network (POVNET) agenda. The DAC-POVNET focuses on poverty reduction, pro-poor growth and trade.¹

The importance of focusing on social protection as a growth strategy reflects the view that social protection is not only a welfare issue but also a social and economic development concern as well. In other words, a new framework of social advantages for the very poor and vulnerable should enable them to achieve a new kind of independence so that they can function, develop and be able to address the barriers to self-concept implementation.

Measures to promote health care may be especially significant in the context of the positive correlation found between health indicators and productivity. Health care has been recognized as valuable not only for its contribution to economic growth but as part of the wider human development objective. Moreover, this should ensure more equitable outcomes where more equal societies are better societies.

Health Care: A Key Policy Issue in Canada

A focus on health care in Canada calls attention to the reality that policies are shaped in and through people's social identities. Traditionally, health care has been closely linked with charitable institutions that have been set up by Catholic and Protestant religious orders.² As the service has been extended and improved, hospitals were established and tended to be not for profit and were run by municipal governments, charitable

organizations and developed community responses in health care that treated all patients regardless of their ability to pay. Furthermore, while government subsidies were availed of, these organizations maintained their autonomy.

In 1946, Saskatchewan introduced the first Canadian universal health coverage. The province had long suffered a shortage of doctors and the coverage led to the creation of a municipal doctor program that would subsidize a doctor who practised in the municipality. Soon after, the idea gained prominence where communities in the various provinces took on the idea of a national health insurance system. In 1957, the federal government passed the Hospital Insurance and Diagnostic Services (HIDS) Act to fund fifty per cent of the cost of such programs for any provincial government that adopted them. The HIDS Act outlined five conditions: public administration, comprehensiveness, universality, portability and accessibility. These remain the pillars of the Canadian Health Act. By 1961, all ten provinces had agreed to start the HDS Act program. In 1966, the Medical Care Act extended the HIDS Act cost sharing to allow each province to establish a universal health care plan. It also set up the Medicare system. Finally, in 1984, the Canada Health Act was passed which prohibited user fees and extra billing by doctors and in the process, secured a national public health care system that has become part of the Canadian identity.³

The model strives to ensure inter-generational equity with respect to the norms and values of a society that makes it a priority for all its individuals to have access to health care. The state policy is one of comprehensiveness, universality, portability, public administration and accessibility in health care. Canada's system has been described as a single payer system where basic services are provided by private doctors with the entire fee paid by the government at the same rate. The approach is to use a mix of public and private organizations to deliver health care and these organizations bill the provincial health authorities. Pharmaceutical costs are set a global median by government price controls. Dentistry and optometry are wholly private. In 2009, Canada spent \$US 5,452 per capita on health care.

Most Canadian hospitals are operated by community boards of trustees, voluntary organizations or municipalities. In some cases, these payments are subsidized by the provincial and territorial governments. Supplementary health benefits include prescription drugs, dental care, vision care, medical appliances, independent living and the services of allied health professionals such as podiatrists and chiropractors. The

average Canadian family pays about 48 per cent of its income in taxes each year. Canadians value their Medicare as a mark of egalitarianism. Though the tax structure is considered steep this is primarily because the host of facilities including health facilities are funded by public funds.

In the May 2011 election, the Conservative Party headed by Stephen Harper secured a majority that also produced a New Democratic official opposition. Throughout the federal election, Canadians made health care their priority concern more than jobs, education and economy.⁴ On health care, Jack Layton of the National Democratic Party expressed the belief that a system without flaws is never possible, what is important is that the totality of the system still works well with costs under control. Further, for a shared future towards a renewed health care, mechanisms must address the need for better drug prescription, access to health care in remote areas and best practices in hospitals and clinics.

Health care continues to dominate important issues in Canada. In July 2012, the Annual Council of Federations met in Halifax and recognized the very strong popular support to secure an effective health care system more than jobs, education, safe communities and balancing government budgets—top issues which were ranked by importance to Canada's future.⁵ The call of the Council for the setting of national standards was commended by the Canadian Medical Association, mindful of the fact that this was the first time in 50 years in the country. This should result in a social pact as regards bulk buying of generic medicine.

With the increasing health care costs, a coordinated approach was seen as the way to take advantage of the very best practices across the country. With the increasing health care costs, a coordinated approach was seen as the way to take advantage of the very best practices from the provinces that have introduced team work in patient care.

Organizational Arrangement and Redistributive Income

Wherever possible, democratic societies design their own systems of income redistribution. However, difficulties with income assignment in a democracy are usually compounded by the peculiar dynamics between the various organizational arrangements. The broader model of viability of governments require certain economic prerequisites and narrowing the gap between the rich and the poor involve highly complex institutional capacities. In Canada, they have publicly-funded private

delivery health care providers with patients given complete freedom of choice as to the doctors to consult with and facilities to use. General taxation is used as the main source of financing for health care. The medical provider gets paid a fixed fee for the care provided. The system is for the most part publicly funded yet most of the services are provided by private enterprises. Most doctors do not receive an annual salary, but receive a fee per visit or service. Medicare consists of several different systems managed by each province or territory and provides services to all residents. The Federal government distributes funds to the provinces for health care with provinces fostering their respective systems to meet certain criteria.

Canadian life expectancy for males was 78 years old and 83 years old for females and the health care program has a guaranteed income for Canadians over the age of 65 who are legal residents. There is the Old Age Security (OAS) pension, which is a monthly benefit to the senior citizens. The OAS is available to those who are still working or have never worked. For the Canadian Pension Plan (CPP), eligibility, age, legal status, length of stay as well as how much and how long one has contributed to the CPP are considered for qualifications. Filipino retirees enjoy pensions with a monthly taxable benefit.

The Philippine Diamonds Society of British Columbia

To date, there are around 500,000 Filipino Canadians in Canada. The number of Filipinos entering in Canada annually rose to a 10-year high in 2008 and over a hundred thousand Filipinos have become Canadian citizens already in that same ten-year period. Some 23,700 Filipinos entered Canada in 2008 compared to some 9,200 who entered in 1999. The number has made the Filipinos the third biggest foreign population behind the Chinese and the Indians. The 427,000 Filipinos in Canada in 2010 are predicted to increase to 1.021 million by 2031. In 2009, Canada was a major source of remittances to the Philippines, totalling US\$ 1.9 billion.

In May 1979, the Philippine Diamonds Society of British Columbia was organized by young immigrants who sponsored their parents to join them in Canada. The next step was to map out the Society's foundation in anticipation of the need for cultural identity and human interactions.

The purposes of the Society include (PDS, 2009):

“Unite the senior citizens and/or landed immigrants of Filipino origin in British Columbia through cooperative efforts and harmonious undertakings;

“Arouse the interest of both the young and the elderly in preserving the Filipino heritage and culture;

“Enrich the social, civic, cultural, economic and spiritual life of the members through various constructive activities and programs;

“Help the members especially the newcomers adapt to the Canadian way of life;

“Set up projects that will promote and enhance the social, civic, cultural economic and spiritual well being of the members;

“Extend assistance to the members in their efforts to obtain from agencies, governmental or otherwise whatever benefits or human rights which are rightfully due them; and

“Extend financial aid from the General Funds of the Society to the designated beneficiary or beneficiaries of the deceased member or members aside from voluntary contributions from the members.”

On 13 August 1979, the constitution of the Society was drafted, certified and the yearly election of officers has become a major event. Through a government grant, the Society was able to buy a building in Vancouver City, British Columbia.

With PDS, the vulnerability of the elderly is very much reduced with structures that operate with an agreed order and arrangement. Canada also provides home adaptations for seniors' independence that will help them perform daily activities in their home safely. With ages ranging from 60s to 90s, and with games, dancing and birthday celebrations, the PDS has emerged as a new guardian of health care focusing on humans as social beings in the context of cultural life and fellowship.

Conclusion

While there is concern that public expenditures on health care have grown enough and ought to be reduced or stabilized, the simple fact in Canada may be that public health care is always a top issue because the majority wanted it so. Old age pensions, socialized medicine, are primarily distributive and it is in this context that there is so much enthusiasm for social protection in health. Considerable progress in extending social health protection in both developing and developed countries has been made. The imperatives of development require that individuals and groups be protected against adverse turn of fortune owing to forces beyond their control. The Canadian narrative shows that it is possible to draw a balance between the maximization of the national income and the equalization of incomes among citizens through health care. It is a study of how society enhances democracy and polity by assigning a major part of its income on a system of equity through an effective health care system.

Endnotes

¹ <http://www.oecd.org/dac/povertyreduction/povnetmandate2007-08.htm>

² http://www.huffingtonpost.com/jack-layton/defending-canadas-health_b_248212.html

³ http://www.canadaupdates.com/blogs/health_care_system_at_canada (accessed 5 August 2012)

⁴ <http://www.canadaupdates.com/content/health-care-top-issue-among-voters-canada-16376.html> (accessed 5 August 2012)

⁵ <http://www.cbc.ca/news/politics/story/2012/07/24/pol-premiers-advancer-nanos-poll-priorities.html>

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