

COMMENTARY

Why Private Health Insurance Is a Gender Issue

by Alison Jenkins

Canadians are justifiably proud of our publicly-funded health insurance system, which was developed to be available to all Canadians. Admittedly, however, this system faces a number of challenges. In addition to shortages of health care providers and controversies surrounding wait times for referrals and treatment, services such as oral and eye care, drugs and rehabilitative programs are simply not covered by public health insurance. Those who need these services must therefore pay for them out-of-pocket. As uninsured medical care can be expensive, many insurance companies offer supplementary private health insurance plans. In most provinces, these private plans are only permitted to cover services that are not publicly insured. Private health insurance is most often available through group plans offered by employers through third-party insurers, such as Blue Cross. In 2000, an estimated 65 percent of the Canadian population was covered by this type of private health insurance.^[1]

The appropriate role of private health insurance has become the subject of intense political, legal and economic debate. Unfortunately, the gendered implications of private health insurance have not often been examined. Because women are the majority of health care users and providers, paid and unpaid, they stand to be particularly affected by decisions made about the roles of public and private health insurance.

Although some argue that expanding private plans to include parallel coverage for publicly insured services can reduce pressure on the public health care system by creating alternatives, international evidence suggests otherwise. In countries that allow citizens to “opt-out” of the public health insurance system, the impact of private health insurance is most obvious: resources are lost, services disappear and more care is left to unpaid providers – most of whom are women. But even in countries such as Canada, where public health care is financed through taxation, private health insurance can create additional strains on the public health care system by fostering competition, driving up prices, and siphoning scarce resources out of the public sector.^[2] Cross-national comparisons within the Organization for Economic Co-operation and Development (OECD) suggest that wait times in the public health care system lengthen when health care providers can earn more in the private sector and leave the public system for higher salaries.^[3] In the absence of timely access to services and providers, the work of caring falls to women.

Are Different Groups of Women Similarly At Risk of Developing Heart Disease?

There are differences in heart disease risk among diverse groups of women. Subpopulations of women encounter different health risks based on biological, social, historical and economic differences. In particular, non-white ethnic minority and low-income women are among those who have greater risk of heart disease and encounter more barriers to preventive health care. In Canada, for example, Aboriginal women have, on average, lower education, employment levels and annual household incomes, as well as higher rates of risk factors (such as tobacco use and obesity) and CVD compared with Canadians of European ancestry.^[9] Historical changes in food consumption and activity levels have likely influenced Aboriginal people’s higher rates of obesity, particularly abdominal obesity, which is a known risk factor for cardiovascular disease.^[9] Similarly, studies conducted in the US reveal that Black and Native American women are most likely to be living with multiple risk factors for cardiovascular disease, while Asian women are the least likely.^[10,11] Other studies have found that Black women in the US report more risk factors, and have the highest rates of coronary heart disease morbidity and mortality followed by Hispanic and White women.^[6, 12-14] More research, however, is needed to clarify the reasons for these patterns.

Research has shown that women who have lower levels of educational attainment, low incomes, and higher levels of unemployment are more likely to experience more than one risk factor as they age.^[10] For example, both smoking and obesity are more common among individuals facing greater social disadvantages.^[15-17] For instance, women living on a low income are typically more likely to be unemployed, under-educated, and to have fewer social networks, which may in turn limit their ability to engage in healthy behaviours,^[18] and have been associated with higher rates of CAD^[19] and CHD.^[20] Some evidence also suggests that women living on a low income are more likely to live in environments that do not support healthy living and therefore are at greater risk for CHD.^[21,22] Poorer neighbourhoods generally have more fast food outlets, fewer full-sized grocery stores, fewer fitness facilities and public green

spaces, which may restrict physical activity. Social and environmental factors that produce chronic stress, including poverty and insecure environments, may also contribute to unhealthy behaviours or prevent women from attending to their health.^[23] Lack of access to health care, healthy food options, exercise facilities and social support networks are significant social, economic and environmental impediments to good heart health among women.

How Can We Design Programs and Policies to Promote Heart Health and Prevent Heart Disease among Diverse Women?

Address Economic and Social Inequalities

If women are to adopt heart healthy behaviours, policies and programs need to address social and financial barriers to health. In areas where the status of women is low and where income inequality is high, the health of women and children is worse.^[24] Status and inequality are directly influenced by policy. For example, in a study of the effect of state level policies on women's health in the US, researchers found that low socio-economic status is the primary indicator of heart disease mortality in women, and a larger risk factor for women than men.^[24]

Cultural and environmental issues are also relevant to women's heart health. Focus groups with high risk women revealed a number of factors that prevented them from being physically active, including cultural barriers (e.g., cultural values of physical activity, body image, etc), social support, family care giving demands, physical barriers and policy issues such as cost, lack of child care or personal safety.^[25] Various environmental issues present barriers to women's ability to reduce their risk of heart disease, including inclement weather, limited daylight, lack of sidewalks, traffic and distance.^[25] Similarly, research has revealed environmental barriers, such as a lack of available healthy food choices or safe and affordable places to exercise affect women's ability to eat well and engage in physical activity.^[26] Policies and programs are therefore required that address

At the same time, private health insurance tends to be less accessible to women than it is to men. With lower incomes, women as a group have fewer resources with which to pay for care.^[4] Private health insurance is offered mainly through large employers, but women are more likely to be employed in small companies, and in non-unionized or low-status sectors where benefits are limited or non-existent. For example, workers in female-dominated industries, such as the service sector, have the lowest rates of private health insurance coverage in Canada.^[5,p9]

Similarly, women are more likely than men to work part-time or on a casual basis due to care-giving responsibilities, making them ineligible for a variety of benefits, including private health insurance. Women also move in and out of the labour force more frequently than men because of child-bearing and higher rates of chronic diseases. In such cases, they not only lose private health insurance coverage during their absence, but may be denied coverage upon returning to work because of medical conditions that have developed while they were out of the workforce.^[6] Changes in personal circumstances also render women vulnerable when they are covered as dependents; death of a spouse or divorce can result in the loss of private health insurance coverage.

More research is needed to evaluate the full implications of private health insurance for women, particularly research that addresses the needs of different groups of women and the strengths and weaknesses of various forms of private health insurance. But the broad conclusion that emerges from an analysis of the existing research is that this form of health care financing is detrimental to gender equity.^[5]

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