Women and Private Health Insurance: A Review of the Issues

by

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June 2007

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Women and Health Care Reform is supported financially through a contribution agreement with the Bureau of Women's Health and Gender Analysis, Health Canada. The views expressed in this document do not necessarily represent those of Health Canada.

TABLE OF CONTENTS

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EXECUTIVE SUMMARY

Private health insurance (PHI) is a method of financing health care that is now attracting attention from policy makers around the world. PHI plays different roles in different health care systems and the extent of its use varies. This report considers recent literature about PHI and women in order to identify important issues and topics for future research. Women and men stand to experience the effects of PHI differently, due to their different roles as users and providers of health care. It is crucial to understand the implications of PHI for women as they constitute the majority of patients as well as the majority of paid and unpaid health care providers. The literature reviewed suggests three broad areas of concern: women's access to PHI, the impact of PHI on women as patients, health care workers and unpaid caregivers, and the effects of PHI on public health care systems.

Women as a group have less access to PHI due to their lower incomes and employment status. They also often face higher premiums and even outright denial of coverage. In addition, they risk unstable PHI coverage with changes in employment and personal status, such as divorce. Different women have different relationships to PHI, with those marginalized on the basis of factors such as class, race, sexuality, age, health status, ability and geographical location less likely to have this form of coverage.

A lack of coverage has negative consequences not only for the health of individual women but also for their families and communities. Even when women do have PHI policies, these policies do not always cover the health care services they need. As patients, women with PHI may receive care more quickly, but findings about the quality of care provided are mixed, with research suggesting that PHI can lead providers to prefer profitable or even unnecessary procedures. As health care workers, women can face deteriorating working conditions when they provide the private services that PHI covers. As unpaid caregivers, women can face both a lack of PHI coverage for their families and added work where PHI makes other forms of care inaccessible.

The impact of PHI on public health care systems is also a significant concern for women. Although it is sometimes assumed that PHI and public health care systems exist in isolation from each other, this does not appear to be the case. The available information suggests that PHI negatively impacts public health care systems and that this is to women's detriment. Women stand to lose access to care where PHI undermines public health care systems by draining human resources and funding capacity and adding costs where publicly subsidized.

The findings reviewed in this report suggest that PHI is detrimental to gender equity, negatively affecting women as patients, health care workers and unpaid caregivers. At present literature in this area is still developing, and further research is needed. Important issues for future study include the significance of PHI for different groups of women, the impact of different forms of PHI, the impact of PHI on women as health care providers, and the impact of PHI on different health care systems.

INTRODUCTION

With the trend towards market-oriented reform in health care, the role and impact of private health insurance (PHI) has attracted the attention of policy makers around the world. In this context, this report identifies current issues related to PHI and women, examining experiences with forms of PHI under various health care systems. As Ostlin (2005:8) observes, "From a gender equity point of view health care financing is of interest since it determines the availability of health care as well as who has access to care and the degree of protection from increased health care costs due to acute or chronic disorders."

Because of women's and men's different positions as both users and providers of care, forms of health care financing affect them differently. Understanding the issues PHI raises for women is crucial because women constitute the majority of patients as well as paid and unpaid health care providers. With higher rates of chronic disease and greater reproductive health requirements, women both need and use more health care than men (Lambrew 2001; Forget et al. 2005). As the majority of health care workers, women are among those most affected when health care financing affects providers' livelihoods and working conditions (Ostlin 2005). As the majority of unpaid caregivers it is women who offer care not formally provided, and they who assume increasing burdens as access to formal care is limited (Forget et al. 2005:126). Given the importance of health care for women and their disproportionate involvement in health care provision, the implications of PHI for women are of particular importance.

The literature search on which this report is based was conducted during March and April 2007. The key words most often used in this search were "health insurance" and "women or gender", with "private" used to narrow the search where necessary. A series of on-line databases were consulted, including ABI Inform Global, CBCA Complete, Medline, PAIS, Proquest Dissertations and Theses, Sociology Abstracts, Social Science Abstracts and Women's Studies International. Websites maintained by international organizations, national governments, and nongovernmental organizations were also examined. In addition, a search of the library catalogues at York University and the University of Toronto was completed.

Given the focused nature of this project, it has not been possible to review all material of potential relevance for women. The literature discussed can thus best be understood as a sample of the type of material available rather than an exhaustive survey. An additional limitation relates to the relative scarcity of research on this topic. Ostlin (2005:4), who examines evidence on the effects of health care reforms including PHI on gender equity, states that literature in this area is sparse. Discussing disparities in men's and women's health insurance coverage in the United States, Lambrew (2001:1) explains that although research has shown that uninsured women have greater needs for health care and more difficulty obtaining care then do insured women, differences between men's and women's health insurance coverage have received less attention. Miles and Parker (1997)

suggest that although "there is increased awareness of issues related to sex and sex roles in health care….there is less awareness of how forms of private and public health insurance serve men and women differently."

Although literature on PHI and women is still emerging, the available information suggests a number of relevant issues that this report addresses in four broad sections. Section one considers the nature, extent and roles of PHI in different countries. Offering a brief overview of the state of PHI worldwide, this section provides background information that contextualizes the issues discussed in subsequent sections. Section two examines issues related to women's access to PHI, considering women's lower likelihood of PHI coverage and factors related to this such as employment status and higher PHI premiums. This section also considers variations in PHI coverage among different women, and examines the consequences of a lack of insurance in the United States, where PHI is dominant.

Section three considers issues surrounding PHI, women and health care. It first examines research on the impact of PHI coverage on women as patients, addressing issues broadly related to the notion of choice in PHI, including women's coverage and the type of care received. The impact of PHI on women as both paid health care workers and unpaid caregivers is then considered. Next, section four explores how PHI affects women through its impact on public health care systems. Here, the impact of PHI on wait times, human resources and costs in the public sector is considered. This report concludes by highlighting important issues for future research.

I. THE NATURE OF PHI

PHI is a broad category of health insurance coverage that operates differently in different countries. In order to understand current issues this form of coverage raises for women, some preliminary observations are necessary. Therefore, this section considers how the term PHI is typically defined, the extent of its use around the world, and the different roles it plays in different countries.

What is PHI?

A method of financing health care, health insurance aims to offer protection from the unpredictable and potentially ruinous financial costs associated with ill health by pooling financial risk among many people over time (Thomson & Mossialos 2004:7). The *OECD Adhoc Group on Private Insurance* considers the difference in how insurance is funded to be the key criterion in distinguishing between private and public insurance. It is suggested that "Ultimately, all money comes from household income, but in public insurance programs this money is channeled through the State, via a general or social insurance tax collector, whereas in private insurance the money is paid directly to the risk pooling entity" (Colombo & Tapay 2003 as cited in Savedoff & Sekhri 2004:4).

One crucial difference between public health insurance and PHI relates to the way that contributions are typically determined. Unlike public insurance, which is typically

associated with contributions related to income, PHI premiums are generally risk-rated (on the basis of an individual's risk of ill health) or community-rated (on the basis of the average expenditure incurred by a "community", such as a particular company or a specific geographically defined area). Since there is "no link between the price of premiums and personal income, private health insurance leads to a regressive distribution of financial burden—that is, poorer people pay proportionately more than richer people" (Thomson & Mossialos 2004:10).

Savedoff and Sekhri (2004:4) point out that a variety of arrangements are described under the umbrella of "private" insurance. These authors propose "it is useful to recognize the spectrum of arrangements that range from purely private, for-profit commercial insurance to purely publicly funded and publicly managed insurance", with various combinations in between. In practice, PHI may be voluntary or compulsory, for-profit or non-profit. Within different markets there are differences in insurers' behaviour in terms of the structure of benefits, premiums and their method of calculation, cost-sharing arrangements, and insurers' relationships to health care providers (Colombo & Tapay 2004a:12).

The extent of PHI around the world

PHI is one of several health care financing strategies and the extent of its use varies internationally. Both high-income and low-income countries generally finance health care in a number of ways, including general tax revenues, social insurance contributions, PHI premiums, direct out-of-pocket payments and community financing (Ostlin 2005:8). "Although most countries have some type of PHI market, data on private insurance expenditures, populations covered, premiums charged and impact on the health care system, are very limited" (Savedoff & Sekhri 2004:4).

Savedoff and Sekhri (2004:6) offer a succinct overview of the international situation based largely on data available through National Health Accounts, finding there are thirty-nine countries in the world in which PHI exceeds 5 percent of total health expenditure (THE). Although PHI markets tend to be more developed in wealthier countries, almost half (46 percent) of the countries in which PHI exceeds 5 percent of THE fall into the low and lower-middle income categories (Savedoff & Sekhri 2004:6). Regionally, Latin America has the most countries with PHI coverage, as policy makers have often adopted this form of insurance as a means by which to attract private funds to the health sector, with Chile being a prime example. PHI markets also exist in Africa, where community health insurance schemes are fairly extensive in some countries, as well as in North Africa and the Middle East (Bahrain, Lebanon, Morocco, Saudi Arabia and Tunisia all have significant PHI markets). PHI markets can also be found in Asia (where India is the largest market); however this is the region in which out-of-pocket expenses account for the highest proportion of total health spending (Savedoff & Sekhri 2004:7).

In 2000, seven countries stood out as funding over 20 percent of THE through PHI: Brazil, Chile, Namibia, South Africa, USA, Uruguay and Zimbabwe. In all of these countries PHI constitutes the main form of coverage for some segment of the population

(Savedoff & Sekhri 2004: 8). As one might expect given the presence of only one high-income country and many lower income countries on this list, the dollar amount spent varied widely. Whereas Zimbabwe spent $171 annually per capita on health care, the United States spent $4499 per capita, the highest amount of any country in the world (Savedoff & Sekhri 2004:8).

In OECD countries, the majority of health financing comes from public sources, which on average account for 72 percent of THE, compared to 6.3 percent for PHI (Colombo & Tapay 2004a:11). The United States is the only OECD country where PHI expenditure exceeds a third of THE at 35 percent (Colombo & Tapay 2004a:11). PHI accounts for between 10 percent and 15 percent of THE in the Netherlands, Canada, France, Germany and Switzerland (Colombo & Tapay 2004b:8). Australia, Ireland, Spain, New Zealand and Austria have levels of PHI financing between 4 percent and 10 percent of THE, and in all other OECD countries this source of financing contributes less than 4 percent of funding (Colombo & Tapay 2004b:8). Writing of the European Union, Mossialos and Thomson (2004:17) note that while sustained economic growth and cuts to public expenditure on health care during the 1980s did increase demand for PHI in some member states that carried over into the 1990s, coverage in many states has remained fairly stable for some time now.

Different roles of PHI

PHI plays different roles in different places due to factors such as different historical patterns of development, variations in the rules and arrangements of statutory health care systems and discrepancies in national regulatory regimes (Mossialos & Thomson 2004: 15). Internationally, financial institutions such as the World Bank and the International Monetary Fund have pressured governments to reduce spending on social services and expand the role of the private sector in financing as well as delivering health care (Mehrotra & Delamonica 2005). Various institutions, research personnel and laws in different countries have a myriad of ways of classifying and labelling the roles of PHI, complicating cross-national comparisons. Usefully, the OECD identifies four main categories of coverage: (i) primary, (ii) duplicate, (iii) complementary and (iv) supplementary (Colombo & Tapay 2004a:31).

Where PHI is *primary*, it offers the only available access to health insurance coverage because individuals do not have access to public health insurance. Primary PHI may involve *principal* cover, where it is the only available access to cover because a social security scheme does not apply, or it may involve *substitute* cover, which substitutes for coverage that would otherwise be available from publicly financed insurance schemes (in this case individuals are eligible for public coverage but choose to opt out). In the United States, the Netherlands and Germany, and for smaller populations in Belgium, Spain and Austria, PHI plays a primary role in providing health insurance coverage.

In the United States PHI is the main method of funding health care for the working population, where it is purchased on a voluntary basis mainly through employers. It operates in conjunction with publicly funded health care, which is available to certain groups. Medicare offers social insurance to most of those aged 65 and over and to the

severely disabled. Medicaid and the States Children's Health Insurance Program (SCHIP) provide insurance for eligible low income families and children, the low income elderly and the disabled (Colombo & Tapay 2004a:32). Other populations are "directly provided with health services funded from general tax revenue or through public and private insurers. These include active and retired military personnel and their families, war veterans and government employees" (Thomson & Mossialos 2004:8). In the Netherlands, about a third of the population relies on PHI for principal coverage, being ineligible for public sickness fund insurance (Colombo & Tapay 2004a:32). In Germany, individuals above a certain income have the option of opting out of public insurance and instead purchasing PHI. An estimated 9.6 percent of the population has done so (an additional 14 percent could opt out but prefers not to) (Colombo & Tapay 2004a:33). The Swiss take a different approach, requiring all residents to purchase PHI since 1996 (Colombo & Tapay 2004a:33).

Duplicate PHI provides individuals already covered under public health systems with private coverage for the same set of services, typically involving different providers or levels of service. Unlike those with substitute coverage, individuals with this type of insurance are not entitled to opt out of the public system. Australia and Ireland offer the most significant cases of duplicate PHI among OECD countries as nearly half of the populations in these countries purchase this form of insurance. Individuals can insure treatment provided in private hospitals and treatment provided in public hospitals as private patients, and doctors often have appointments in both the public and private sectors. Duplicate PHI also exists with a lesser population share in countries such as New Zealand (35 percent), Portugal (15 percent) and the United Kingdom (10 percent) (Colombo & Tapay 2004a:34). In Canada the role of PHI varies between provinces. Traditionally, PHI for publicly insured health care was prohibited in British Columbia, Alberta, Manitoba, Ontario, Quebec and Prince Edward Island, and permitted in New Brunswick, Newfoundland, Nova Scotia and Saskatchewan (Flood & Archibald 2001). However, the Supreme Court of Canada's 2005 ruling that Quebec's prohibition of PHI for services covered under the public system violates Quebec's *Charter of Human Rights and Freedoms* is seen as having opened the way for change (Flood, Roach & Lorne 2005).

Complementary PHI complements publicly insured services or those offered by other forms of PHI, covering either all or part of the costs not otherwise reimbursed, such as co-payments. Most OECD countries have small complementary PHI markets, linked to the size of co-payments. France and the United States are the only OECD countries with significant markets for complementary PHI. In France, this form of insurance covers the cost sharing required in the public system as well as medical goods and services not publicly covered. In the United States, those eligible for Medicare can buy Medigap policies to cover co-payments and gaps in coverage. Limited PHI coverage of cost-sharing exists in countries such as Ireland, Denmark, Germany, Sweden, Italy and Luxembourg (Colombo & Tapay 2004a:39). In Canada cost sharing is not used for publicly insured services, while cost sharing for drugs is at the discretion of the provinces (Colombo & Tapay 2004a:36). Complementary PHI is allowed for services that are not publicly insured (Colombo and Tapay 2004:35).

Supplementary PHI provides coverage for health services not covered under public schemes. Colombo and Tapay (2004:39) explain that although all OECD countries where PHI markets exist have some form of supplementary insurance, the specific goods and services covered typically depends on those provided in the public system. Although coverage varies it may include goods and services such as long term and rehabilitative care, dentistry, pharmaceuticals, elective care, luxury care or alternative medicine. This type of PHI is often bundled together with other types of insurance. It is sometimes sold separately, as is the case in Canada where most provinces prohibit other types of PHI for areas covered by public health insurance. It is estimated that in 2000, 65 percent of the Canadian population was covered by this form of PHI, mainly through employers (Colombo & Tapay 2004a:39).

Thomson and Mossialos (2004), who refer to PHI as "voluntary health insurance" or VHI, offer a slightly different five-part typology. In this case, the categories preferred are: dominant, compulsory, substitutive, complementary and supplementary PHI. Where PHI is *dominant*, it is the principal method of funding health care for the working members of the population. Where PHI is *compulsory* all residents are required to purchase private insurance. *Substitutive* PHI is purchased by those excluded from *or* allowed to opt out of participating in some or all aspects of public health insurance. *Complementary* PHI covers services excluded or not fully covered under public health insurance. *Supplementary* PHI addresses the same range of services as public health insurance.

II. WOMEN AND ACCESS TO PHI

The literature suggests the importance of a number of issues related to gender inequities in access to PHI. This section begins by considering findings concerning gender and PHI coverage. It next explores how women's employment status affects PHI coverage, and considers the stability of women's coverage. The implications of PHI risk selection strategies for women are then examined. Discussion next turns to variations in PHI coverage among different women and finally to the consequences of a lack of health insurance.

Gender and PHI coverage

As Lippman and Quesnel-Vallee (2006:2 of 4) point out, PHI "makes access to services a matter of ability to pay rather than a matter of need." In general, research considering determinants and predictors of PHI coverage emphasizes the importance of class-related factors. For instance, in a literature review commissioned by the U.S. Department of Health and Human Services, Office on Women's Health, Brittle and Bird (2007:67) find that the primary predictors of insurance coverage in the United States are income and employment status.

A number of studies also point to the significance of gender. Mossialos and Thomson (2004:38) found that the determinants of demand for PHI in the European Union include income, age, gender, occupational status, educational status and area of residence. They observe that those who purchase supplementary PHI tend to come from higher income groups, have higher occupational status, and come from wealthier regions than those who do not. They find that although the profile for complimentary PHI purchasers is more varied, those likely *not* to have it are people with low incomes and without employment, including "students, some women, the unemployed and elderly people" (Mossialos & Thomson 2004:16).

In their study of the situation in Ireland, Harmon and Nolan (2001) suggest that perceptions about wait times and the quality of public care are important in explaining demand for PHI, as are individual characteristics including education, age, gender, marital status, family composition and income. They find that higher levels of educational attainment increase the probability of being insured, and that those who are younger have a higher probability of choosing private insurance than those who are older. In this case women appeared to be more likely to be privately insured then men, yet the authors caution that this relationship was "rather weak and unstable" (Harmon & Nolan 2001:141).

Findings from other countries indicate women are less likely to have PHI. For instance, Gibson and Fuller (2006:31) draw on data from the 2004 Statistics Canada Workplace and Employee Survey Compendium to show that when it comes to supplementary insurance in Canada women fare worse then men, with less than half of female workers covered by a supplementary health benefits plan. This trend is not confined to wealthy countries: women in Chile are significantly less likely then men to purchase this form of insurance, making up only 34 percent of those who do (Hofter 2006:429).

PHI and women's employment

Ostlin (2005:4) observes that schemes such as PHI "are likely to increase inequities, particularly in access to care and health-seeking behavior and this may affect women more, as they generally have fewer financial resources." Writing of the United States, where PHI is prevalent, Miles and Parker (1997:218) confirm that "differences between the sexes in vocational, familial and political roles and in economic states affect what insurance men and women receive." A link can be made between women's employment and access to PHI, as their ability to purchase this form of coverage is affected by their concentration in the low-income and low-status areas of employment with limited benefits.

As Lippman and Quesnel-Vallee (2006:1 of 4) point out, women tend to be "poorer than men, with jobs that are more often precarious, non-unionized and part-time." In general, they "work for less pay, in smaller firms, at lower rank, with fewer benefits, with less union participation then men; they are also more likely to work part-time" (Miles & Parker 1997:218). Dewar (2000) found that in the United States gender-based employment segregation affects the likelihood of PHI coverage, with those employed in male dominated industries more likely to have coverage. Lambrew (2001:7) found that

while women who were full-time employees were somewhat more likely then men to have health insurance, women were more likely than men to work part-time, and only 31 percent of part-time workers were offered health insurance. In Canada, female industry and service sector workers have the lowest rates of PHI coverage in the country (Cyrus & Curtis 2004:27).

While a number of authors underline that gender, employment and PHI are related in ways that disadvantage women, a contrasting view is offered by Merzel (2000), who investigated factors associated with gender differences in health insurance coverage in a low-income inner-city community in Central Harlem, New York City. Merzel states that she did not find strong patterns explaining gender differences in coverage. She found that women employed full-time were more likely to have insurance coverage, but this was not true for men. She recommends addressing gender disparities by increasing public and private coverage available to men.

Stability of women's coverage

Stability of coverage is another important issue related to women's access to PHI. Writing of the United States, Miles and Parker (1997:218) note that women are more likely than men to change jobs for family reasons, including childbearing. They point out that this makes women "more vulnerable to becoming ineligible for PHI or to paying higher premiums because of medical conditions that have developed during interruptions in private health insurance coverage and adversely affects their eligibility for pension-based insurance" (Miles & Parker 1997:218).

Anderson and Eamon (2005) examined the stability of health insurance coverage for low-income working women in the United States, and found that only 51 percent of those surveyed had stable coverage from 1995 to 1997. Health insurance stability was significantly higher for those with higher levels of welfare receipt, more hours of work, fewer job changes, higher levels of education, locations outside of central cities, or who were African American or Hispanic. Significantly, these authors urge caution in the interpretation of their findings due to the truncated age range addressed in their sample (31 through 38 years). They note their finding that African American and Hispanic women enjoy greater health insurance stability is surprising given previous research suggesting lower coverage for people of colour (Anderson & Eamon 2005:15). The Kaiser Women's Health Survey revealed one in ten women with coverage at the time of the survey in the summer and fall of 2004 had been uninsured at some point earlier that year. Among those who had lacked insurance for a period, 38 percent had been without health insurance for a year or more (Salganicoff, Ranji & Wyn 2005:15).

An additional issue connected to the stability of women's PHI coverage relates to their coverage as dependents. This is a significant issue in the United States, where 57 million non-elderly women receive PHI coverage through their spouse's employer (Henry J. Kaiser Family Foundation 2007:1). When women are insured in this way they are vulnerable to losing coverage should their relationship status change, as in the case of divorce or the death of a spouse. For instance, Weir and Willis (2002:17) found modest effects of widowhood events on loss of health insurance in the United States. Moreover, women married to older men can lose their PHI coverage once their spouse becomes

eligible for Medicare at age 65 (Kasper 2004 as cited in Brittle & Bird 2007:69). Women insured as dependents are also vulnerable to losing PHI coverage should their spouse lose his job, or if an employer drops family coverage or raises premiums and/or out-of-pocket expenses to unaffordable levels (Salganicoff, Ranji & Wyn 2005:14; Henry J. Kaiser Family Foundation 2007:1). This second trend can be discerned in Canada, where escalating costs of supplementary private insurance mean even less access as employers decide such benefits are unaffordable. Gibson and Fuller (2006:32) cite data from Statistics Canada's 2004 Workplace and Employee Survey Compendium to show that supplementary health coverage among Canadians fell by almost 25 percent between 1995 and 2000.

Risk selection: women may pay more for PHI or be denied coverage

Risk selection is a profit maximisation strategy PHI providers use to avoid covering higher risk individuals. This strategy can have important implications for women. Mossialos and Thomson (2004:18) caution that "Insurers operating in a competitive environment may have strong incentives to lower their costs by risk selection, encouraging custom from individuals with below average risk and discouraging or refusing custom from individuals with above average risk." This, they note, is likely to occur where insurers "are able to reject applications, exclude pre-existing conditions and cancel contracts" (Mossialos & Thomson 2004:18).

Where allowed by state regulation, insurers may prefer a risk-rated strategy, which allows them to determine premiums on the basis of the risk posed by individuals over a community-rated strategy which allows risk to spread over a group of people. "As a result of risk selection in markets for private health insurance, some groups of people may not be able to obtain an affordable level of coverage or any coverage at all" (Thomson & Mossialos 2004:11). Considering the situation in western Europe, Thomson and Mossialos (2004:11) observe that those most likely to face barriers to purchasing PHI include young adults, older people, those in poor health or with disabilities and individuals in lower income groups.

Where regulation permits, risk selection can disadvantage women in particular. This has been well documented in Chile, where women face higher premiums due to factors including greater reproductive health care needs and higher incidence of chronic illness (Pollier 1999). Examining the situation in the United States, Miles and Parker (1997) and Bogarin (2005) point out that woman who have experienced domestic violence are often unable to obtain PHI due to the risk they are considered to represent. To illustrate this point, Miles and Parker (1997:218) refer to a spokesperson for one firm who justified either completely excluding such women or charging them higher premiums by equating them with "diabetics who do not take their medication." Such findings suggest that insurers' risk selection strategies can make PHI less accessible and even completely inaccessible for women.

Variations in coverage: men vs. women and different groups of women

Where health insurance is market-based, as in the case of PHI, significant variations in coverage emerge between men and women, as well as among women. The United States offers an important case in this respect since large numbers of people there depend on PHI for their health insurance coverage: approximately 59 percent of the U.S. population is covered by PHI, with 92 percent of this coverage linked to employment (The Commonwealth Fund 2006 as cited in Brittle & Bird 2007:66).

Women in the United States are slightly more likely than men to have health insurance coverage, mostly "because their higher poverty rates and greater eligibility for public insurance has meant that women are covered through Medicaid at twice the rate of men" (Lambrew 2001:v). However, uninsured women account for 19 percent of the non-elderly population of women in the United States (Henry J. Kaiser Family Foundation 2007:1).

Lambrew (2001:3-4) explains that uninsured men and women share a number of characteristics: they tend to have low incomes, work in small businesses, and disproportionately belong to racial or ethnic minority groups. They are typically younger and are less likely to be married. However, Lambrew (2001:5) also points to significant gender differences in coverage: older women are 20 percent more likely to be uninsured than older men. Although "single people in general are more likely to be uninsured, married women comprise a greater proportion of uninsured people than married men (49% vs. 40%)" (Lambrew 2001:5). Uninsured working women are one-third more likely to work part-time, and women are more than twice as likely as men to obtain employer-based health coverage through their spouse (Lambrew 2001:6-7).

Among women, the poor, the near poor, single parents, those with less than a high school education, those aged 19-24, women of colour and the foreign born are among the least likely to have health insurance (Henry J. Kaiser Family Foundation 2007:2). According to the Henry J. Kaiser Family Foundation (2007:2), uninsurance rates for women between ages 18-64 are:

- 41 percent for poor women[1]
- 32 percent for near poor women
- 26 percent for single parents
- 36 percent for those with less than a high school education
- 31 percent for those age 19-24
- 38 percent for Latinas
- 34 percent for Native Americans
- 34 percent for the foreign born

Geography is also an important factor, with findings from the Kaiser Commission on Medicaid and the Uninsured (2003) showing 25 percent of those living in rural areas are

[1] This report uses the federal level for poverty (FLP), which was $15,577 in 2005 for a family of three. "Poor" describes a family income <100 percent FLP, while "near poor" describes a family income of 100-199 percent FLP.

uninsured and that rural residents tend to be uninsured for longer periods then those in urban centres (as cited in Kasper 2004:107). Individuals in worse health are also at greater risk of not having insurance, with more than one in five reporting they are uninsured (Salganicoff, Ranji & Wyn 2005:16). Disabled women also face significant challenges. Disabled adults in the United States are more likely than non-disabled adults to depend on public insurance, and to report unmet needs and greater service use (Sommers 2007). Sommers (2007) found that access to health insurance is most problematic for the less disabled, who had higher incomes relative to the more disabled and were less likely to qualify for public coverage. Low-income adults with work limitations but no other indication of disability had the lowest levels of insurance coverage, with over one third uninsured.

In the United States, women in same-sex relationships also have lower rates of coverage. Heck, Sell and Gorin (2006) found that compared to women in opposite-sex relationships, women in same-sex relationships had a lower likelihood of (i) health insurance coverage, (ii) visiting a medical provider in the past 12 months, and (iii) having a usual source of health care. These women were also more likely to report having unmet medical needs as a result of cost issues. In contrast, it was found that men in same-sex relationships had health care access that was equivalent or greater than that of men in opposite-sex relationships. Corliss (2004) found that men and women in same-sex and opposite-sex unmarried partnerships were more likely to lack PHI, especially employment-based PHI.

Consequences of a lack of health insurance coverage

Research from the United States reveals that a lack of health insurance coverage negatively affects individuals, families, communities and society as a whole. To date, much of the literature in this area has focused on what happens when individuals do not have any health insurance coverage at all. However, it is equally important to understand that even those with some form of health insurance can suffer from a lack of coverage. Beyond considering whether an individual has a PHI policy, it is crucial to examine exactly what a policy covers, how much and for how long, as well as the particular eligibility rules that apply. Although such details have generally attracted less attention, the implications of inadequate coverage among individuals with PHI policies must also be taken into account.

Salganicoff, Ranji and Wyn (2005:v) report that women who do not have insurance "consistently fare worse on multiple measures of access to care, including contact with providers, obtaining timely care, access to specialists and utilization of important screening tests." Significantly, 67 percent of uninsured women reported delaying or foregoing care due to costs (Salganicoff, Ranji & Wyn 2005:28).

A study about the impact of insurance coverage on the treatment of cardiovascular disease—a leading cause of death and disability in the United States—offers an example of how a lack of health insurance can disadvantage women in particular. Examining gender differences in the management of risk factors, Murasko (2006) found that a lack of insurance lowered utilization of preventative services for both men and women in the

general population. However, among those previously diagnosed with this disease a lack of coverage was found to be more strongly associated with lower rates of screening, pharmaceutical management and physician contact among women than among men.

It is widely acknowledged that a lack of health insurance has important implications for individuals' quality of life. As Ostlin (2005:9) notes, "The consequences of people's inability to pay for [health care] services are untreated morbidity, reduced access to care, long-term impoverishment and irrational use of drugs, such as the use of contraindicated drugs for women in pregnancy." The tremendous human suffering that occurs is examined in detail in the ethnographic work of Sered and Fernandopulle (2005), who capture the grim realities of daily life without health insurance in the United States. Ultimately, a lack of coverage can be deadly: an Institute of Medicine report estimates that every year 18,000 people in the United States die unnecessarily because they do not have health insurance (Institute of Medicine 2002 as cited in Henry J. Kaiser Family Foundation 2007:2).

The work of the Institute of Medicine (IOM) in the United States makes it clear that the consequences of a lack of health insurance extend far beyond individuals. In the latest of a series of reports by its Committee on the Consequences of Uninsurance, the IOM (2004) underlines that a lack of health insurance can place individuals and their families in desperate financial straits, noting that medical bills have been found to be a factor in nearly half of all bankruptcy cases in the United States (Jacoby et al. 2000 as cited in IOM 2004:50). When uninsured individuals, who, as explained above, are often low income, do seek out care, they are likely to be charged more because unlike large insurers they are not typically able to negotiate discounts (Miller 2003 as cited in IOM 2004:49). Moreover, the costs of treating the uninsured, who are more likely to seek treatment at an advanced stage of illness—and therefore are often more difficult and expensive to treat—are borne by the larger community. Beyond the various costs directly related to caring for the uninsured, there are many other costs to consider as well. Communities with high rates of uninsurance can face numerous problems, including less access to health care, greater risk of some communicable diseases, and increased burdens on public health resources (IOM 2004:50-56). The economic value lost because of poorer health and shorter lives among the uninsured is difficult to calculate, but it is thought to be substantial. According to one estimate, losses in the United States range between $65 and $130 billion annually (IOM 2003b as cited in IOM 2004:58).

III. PHI, HEALTH CARE AND WOMEN

As patients, workers and unpaid caregivers, women develop complex relationships with health care systems (Ostlin 2005:6). In an attempt to capture some of these complexities, this section begins by examining issues related to the health care that women with forms of PHI coverage receive and proceeds to consider the impact of PHI on women as workers and unpaid caregivers. It first highlights issues arising from the existence of different PHI policies, which may or may not increase choice for women able and willing to purchase them. It next considers the coverage offered to women under different PHI policies, and identifies important gaps. Thereafter, discussion turns to the health care

women with PHI receive, where obstetric care is discussed as an important case where profit-making influences the care provided. Finally, research pointing to the effects of PHI on women as workers and unpaid caregivers is considered and issues of poorer working conditions in the private sector and increased work for women as unpaid caregivers are highlighted.

Women as patients: does PHI expand women's choices?

According to the Canadian Medical Association (2006:viii) a review of international experiences shows PHI can provide "greater choice and access to services for those who can afford it." Similarly, Thomson and Mossialos (2004:14) suggest, "Depending on its role, PHI can offer an alternative to public coverage and increased choices of insurers, providers and treatments." However, these authors caution, "PHI can increase choice for some, but not to the extent often suggested, and under certain circumstances it may even restrict choice" (Thomson & Mossialos 2004:4). They explain,

> In theory offering more than one product ("product differentiation") allows people to choose a benefit package tailored to meet their needs. However, it can also be used to segment the market, giving private health insurers greater opportunity to select risks. Consumers may be confused by a wide range of products and find it difficult to make value-for-money comparisons, particularly if different insurance companies use different terms to describe their benefit packages (Thomson & Mossialos 2004:14)

Additional confusion arises because individuals cannot easily predict the care (and thus the coverage) they will need in the future when purchasing PHI policies. Therefore, although the existence of PHI policies can mean individuals are confronted with a variety of options, a lack of information can make it extremely difficult to make appropriate choices even among those who can afford to finance health care in this way.

As Gibson and Fuller (2006:36) observe, variations in coverage between different PHI policies mean that not all of the individuals who have PHI face the same benefits, deductibles and co-payments. Such variations are a concern for women, with findings suggesting that the PHI coverage women have may not cover the services they need, or be sufficient to make health care affordable. For instance, Miles and Parker (1997:218) point out that some PHI policies in the United States do not cover preventative services that are important for women, such as mammograms and Pap tests. Zimmerman and Hill (2000) reveal that 9 percent of privately insured women in the United States have policies that exclude maternity coverage, and 27 to 36 percent of insurance plans do not cover induced abortion (as cited in Brittle & Bird 2007:67). These authors point out that while just 16 percent of Health Management Organizations (HMOs) do not cover oral contraceptives, only 31 to 60 percent of other plans offer this coverage (Zimmerman & Hill 2000 as cited in Brittle & Bird 2007:67). Significantly, cost pressures are increasingly acting as a barrier to health care even for women with PHI coverage. In 2004, 17 percent of women reliant on this form of coverage reported postponing or going without needed care because it was not affordable (Salganicoff, Ranji & Wyn 2005:28).

The actual care that women with PHI receive constitutes another crucial concern. On one hand, PHI is held to offer "enhanced access to timely care" for those who have this type of coverage (Colombo & Tapay 2004a:13). However, findings on the quality of care that individuals with PHI receive are varied. Colombo and Tapay (2004:14) suggest, "in most countries private health insurers have not engaged in significant efforts to influence the quality of the health care services they finance." These authors note that the United States is the only OECD country where private insurers have been significantly involved in directing and overseeing certain aspects of care delivery, and they note that overall the evidence of the impact of managed care on the quality of care provided is mixed (Colombo & Tapay 2004a:14). For instance, Cleary, Zaslavsky and Cioffi (2000) considered differences in women's and men's assessments of Medicare managed care, private insurance plans offering managed care to Medicare beneficiaries. They found that although women rated their care slightly more positively then did men, they may have encountered slightly more problems getting referrals, equipment and assistance. Women were also found to be less likely to report that their plan provided help, equipment and services (Cleary, Zaslavsky & Cioffi 2000). Gonen (1999) suggests that while the emphasis on primary care typical in managed care can be positive for women, not all efforts take gender into account. This author points out that the cost containment pressures driving managed care may compromise the quality of care delivered (Gonen 1999:12S).

There are indications that PHI coverage may effectively limit patients' health care options to those that are most profitable for providers. In this regard, obstetric care offers an important example. Mossialos et al. (2005:288) observe that higher caesarean section (CS) rates are consistently predicted by private insurance or private hospitals and associated with financial incentives. Outlining the substantial risks involved with this procedure, these authors point out that studies in the U.S., the Netherlands and the U.K. in the early 1990s found that maternal mortality was 2-4 times higher and incidence of morbidity was 5-10 times greater with CS than with spontaneous vaginal delivery (Mossialos et al. 2005:288).

In their study of hospitals in Athens, Greece, Mossialos et al. (2005) found that women who gave birth in private hospitals with private insurance had a substantially greater likelihood of delivery by CS (65.2 percent) than both patients in private hospitals without private insurance (23.9 percent) and patients in public hospitals (41.6 percent). Shorten and Shorten (2004) show that in Australia rates of obstetric intervention, including elective CS, induction of labour (IOL) and use of epidural anesthetic are much higher in private hospitals. These authors also found that less favorable birth outcomes, including emergency CS, instrumental births, episiotomy and tear(s) requiring suturing (TRS), are substantially more likely to occur in private hospitals. These authors observe that the use of private hospitals for childbirth has increased with increases in PHI coverage, concluding "incentives to increase private health insurance coverage appear to be having a negative impact on childbirth" (Shorten & Shorten 2004:27).

Murray and Elston (2005) interviewed obstetricians in Chile to gain insight into the causes of higher CS rates in the private sector. It emerged that many of those interviewed

routinely resorted to regulating the timing of births in order to manage their own time—and earning capacity—most efficiently, suggesting the importance of financial incentives in promoting intervention. CS was seen by many as quick and reliable, and on this basis was widely preferred. Such findings suggest that PHI can limit choice in health care among those who have this kind of coverage when profitable medical procedures are preferred by providers.

PHI and women's work: women as health care workers and unpaid caregivers

PHI can affect not only the health care women receive but also that which they provide, both paid and unpaid. In many countries, women are both the majority of formal lower-tier health care workers and informal caregivers (Ostlin 2005:8). The impact of privatization on women's work in the health care sector has attracted attention. As Ostlin (2005:4) has observed,

> Privatization, accompanied by emphasis on reducing costs and maximizing efficiency, may have an important impact on gender equity in health care access and financial protection. In some countries patient/staff ratios have been raised, personnel have been shifted, duties have been reassigned to less skilled workers and the use of casual workers has increased. The negative consequences of these policies affect women more than men since women are over-represented among both patients and health care personnel.

Although the gendered impact of the privatization of health insurance in particular has as yet received less attention, it appears that this form of health care financing and the private care it often involves may lead to deterioration in working conditions in the health care sector. As Lippman and Quesnel-Vallée (2006:2 of 4) explain, "Whether or not they are "for-profit", private services offer lower wages and poorer working conditions—both risks to health—to aids, cleaners, food service providers, etc. the majority of whom are women".

PHI may also affect women as unpaid caregivers. Salganicoff, Ranji & Wyn (2005:49) highlight the scope of women's work in this regard, characterizing women in the United States as "health care leaders" in their families. These authors observe that it is mothers who "are the primary caretakers of their children's needs, including their health," and that nearly four in ten adult women have dependent children (under age 18) at home (Salganicoff, Ranji & Wyn 2005:40). They found that in addition to childcare responsibilities, more than one in ten mothers also cares for a chronically ill or disabled family member (Salganicoff, Ranji & Wyn 2005:40). Four in ten caregivers was in a low income family, almost half had a chronic health condition, and a quarter described their health as fair to poor (Salganicoff, Ranji & Wyn 2005:41). In their ethnographic study *Uninsured in America*, Sered and Fernandopulle (2005:77-85) discuss how caregiving and a lack of insurance can intertwine, since as unpaid caregivers women are not considered "employed" and thus do not have access to employment-based PHI coverage (except possibly as a dependent). To the extent that a lack of PHI makes formal care inaccessible, it may also increase the work of unpaid caregivers. As Forget et al.

(2005:126) note, "In Canada, as elsewhere in the developed world, women continue to provide most of the caring labour in the household and therefore will bear the greatest burden of any reduction in hospital care or publicly provided home care that shifts the burden of care on to the household."

IV. PHI, PUBLIC HEALTH CARE SYSTEMS AND WOMEN

This section considers how PHI affects women through its impact on public health care systems. Although it is sometimes assumed that PHI and public health care systems exist without much impact on each other, research shows otherwise. Colombo and Tapay (2004:15) find that "Public and private financing do not operate in isolation. Rather, they are intertwined by complex financial and real flows, as well as incentive structures." As Hurley et al. (2002:23) observe, "The image of an independent, isolated parallel system of private finance is false; interactions between the public and private insurance sectors are complex and unavoidable." Tuohy, Flood and Stabile (2004), who consider the effect of private finance on publicly funded health care systems in the OECD, find that the nature of this impact depends on how the relationship between public and private finance is structured.

The information available suggests that PHI negatively impacts public health care systems and that this is to women's detriment. Women require "different and, on average, more health care than men" (Lambrew 2001:1). They have greater reproductive health care needs as well as higher rates of chronic illness and some mental health problems including depression (Lambrew 2001:1). As Forget et al. (2005:126) observe, "studies in various health care systems have found higher mean and median health care utilization by women of most adult age groups." These authors investigated the use of physicians' and acute-care hospital services funded by public insurance in Manitoba, Canada, finding that for those between the ages of 15 and 65, the mean costs incurred by women exceeded those of men (Forget et al. 2005).

Having reviewed findings on health care reform and gender equity, Ostlin (2005: 8) concludes that taxes and social insurance schemes are the most equitable means of health care financing. Forget et al. (2005:124) concur, contending that Canada's public health care system, with its "first dollar" coverage for medically necessary physician and hospital care[2], "best addresses the risks women face in terms of higher lifetime care utilization." These authors point out that women have a particular interest in maintaining public health care and resisting market-oriented reform because lower labour force participation, lower employment status and less access to employer-provided health insurance mean women have fewer resources with which to pay for care (Forget et al. 2005:125-126). The impact of PHI on public health care systems is thus an important

[2] As Forget et al. (2005:123) explain, "Canadian health insurance provides first dollar coverage—a system with no user fees, co-payments or deductibles—for physician and hospital care. Any Canadian citizen or legal permanent resident may receive care without any out-of-pocket expense."

concern for women. Below, two frequently discussed aspects of this impact are considered: wait times and costs in the public system.

PHI, public sector wait times and the limits of human resources

The impact of PHI on public sector wait times has been vigorously debated, with proponents claiming that the expansion of private coverage can reduce wait times in the public sector. This does not, however, appear to be the case. In their investigation of the impact of private funding on public health care systems, Tuohy, Flood and Stabile (2004:376) find that "international evidence provides no grounds for believing that the existence of a privately insured sector parallel to the public sector reduces overall waiting lists or times." Indeed, these authors find that examination of cross-national data "suggests a positive association between the level of insurance coverage for services provided in a parallel private system and the size and length of public-sector waiting lists" (Tuohy, Flood & Stabile 2004:374-375). In another article, Flood, Stabile and Kontic (2005) draw on evidence from OECD countries to show that PHI does not lessen pressure on public systems, and does not allow many people to avoid wait times.

Hurley et al. (2002:22), who examine the system of duplicate PHI in Australia, conclude that one of the most important lessons it offers is that "the introduction or expansion of a parallel private finance will not reduce wait times in the publicly financed system." This was also evident in Canada during a period in which cataract surgery was offered on a private basis, albeit subsidized by Medicare, in Manitoba. It was found that by the time this practice was disallowed in 1996, waiting times were lowest for privately provided services (about four weeks), higher for services provided by surgeons who practiced only in the public sector (ten weeks), but highest of all (twenty-three weeks) for publicly financed services provided by surgeons who practiced in both sectors (DeCoster et al. 1998 as cited in Tuohy, Flood & Stabile 2004:374).

The research reviewed suggests that PHI can pose a significant challenge for the capacity of public health care systems through draining human resources from the public to the private sector, with implications for wait times for patients with public health insurance. Mossialos and Thomson (2004:20) caution that "The existence of VHI [voluntary health insurance, referred to here as PHI] could present a barrier to access in the statutory health care system for some individuals and population groups if it creates distortions in the allocation of resources." They suggest that "This scenario is most likely where the boundaries between public and private health care are not clearly defined, particularly if capacity is limited, if providers are paid by both the public and the private sector and if VHI creates incentives for health care professionals to treat public and private patients differently" (Mossialos & Thomson 2004:20).

Significantly, Hurley et al. (2002:20) point out that "The supply of many health care resources (e.g., physicians, nurses, technicians) is relatively inelastic in the short run. The public and private sectors must compete for these limited resources, and the resulting competition can increase input prices." To support their case, these authors note that physicians in the UK can earn 3-4 times more working in the private sector than in the NHS (citing Propper & Green 1999), and suggest that anecdotal information indicates

considerable differences in earnings potential in the private and public sectors in Australia (Hurley et al. 2002:20). The net result, they contend, is that a parallel private insurance sector can mean that "the publicly financed sector must either provide fewer services or increase funding to maintain the previous real servicing levels" (Hurley et al. 2002:21).

PHI and costs for public health care systems

The research consulted suggests that PHI can lead to important costs for public health care systems, both in terms of support lost and subsidies paid out. Writing of the implications of private health care funding in western Europe, Thomson and Mossialos (2004:10) observe that where individuals with PHI are entitled to opt out of public health insurance the state's capacity for pooling risk is reduced. They caution that this practice threatens the long-term financial stability of statutory (public) health care systems (Thomson & Mossialos 2004:4). Tuohy, Flood and Stabile (2004:387) point out that forms of private health care financing, such as PHI, may also undermine public support for funding public health care. They explain,

> The concern is often expressed that a decline in the public share of total health expenditure (and conversely a rise in the private share) will erode support for the public system as middle- to upper-income individuals opt for the private sector and no longer wish to support tax-funded health services. The example of the United States, in which the public share of total health spending is relatively low and in which various attempts to mobilize public support for universal health insurance over the past three decades have come to naught, is typically adduced in this regard. Data from some other individual nations also bear on this relationship. Timothy Besley and his colleagues, drawing upon data from the British Social Attitudes surveys from 1986 to 1991, have shown that those in Britain who have private insurance are somewhat less likely than those who do not to support increased funding for the public system (Besley et al. 1996:35–37).

Beyond draining resources from public systems, PHI can also be an expensive proposition in its own right. Hurley et al. (2002) examine the system of duplicate PHI in Australia and find that the cost of the subsidies used to encourage the purchase of private coverage exceeds any savings to the public health care system that this strategy might incur. They state, "Australia's policy of subsidizing private insurance to save costs in the publicly financed hospital system has been a dramatic failure that, on balance, annually costs the public purse billons of dollars" (Hurley et al. 2002:19). These authors point out that this is consistent with evidence that in the UK subsidies to private insurance are not self-financing (citing Emmerson, Frayne & Goodman 2001) and that tax subsidies are a very expensive way to expand private insurance coverage in the United States (citing Gruber & Levaitt 2000). Thomson and Mossialos (2004:4) caution that tax subsidies for PHI are inefficient, noting that they distort signals about the real price of insurance and generate transaction costs..

Having considered the impact of private finance on public health care systems in the OECD, Tuohy, Flood and Stabile (2004:393) conclude that "a resort to private finance is, on balance, more likely to harm than to help publicly financed systems, though the effects will vary depending on the form of private finance." Those such as Thomson and Mossialos (2004), Greb (2005), and Colombo and Tapay (2004) contend that regulation can help to improve the functioning of PHI and limit its negative impact on public health care systems. However, Hurley et al. (2002) caution that Australia's experience shows it is extremely difficult to effectively regulate health insurance companies to pursue public objectives. Overall, findings suggest that PHI negatively affects public health care systems, the very systems that women rely on to obtain the care they need.

V. CONCLUSION

This report has highlighted important issues emerging from the literature pertaining to PHI and women. It began by considering the nature of PHI in general and proceeded to examine three areas of concern for women: access to PHI, the implications of PHI for women as patients, health care workers and unpaid caregivers, and the impact of PHI on public health care systems. The broad conclusion that has emerged is that this form of health care financing is profoundly detrimental to gender equity. This is because:

- Women as a group have less access to this type of insurance due to lower incomes and employment status as well as higher premiums and outright denial of coverage.
- Women face the risk of unstable PHI coverage with changes in employment and relationship status.
- Different women have different relationships to PHI, with those marginalized on the basis of factors such as class, race, sexuality, age, health status, ability and geographical location less likely to have this form of coverage.
- A lack of coverage has negative consequences for the health of individual women as well as their families, communities and society as a whole.
- Even when women have PHI coverage, these policies do not always cover the health care services they need.
- Women with PHI may receive care more quickly, but findings about the quality of care provided are mixed, with research suggesting that PHI can lead providers to prefer profitable or even unnecessary procedures.
- Women, as the majority of the workers in the health care sector, can face deteriorating working conditions when they provide the private services that PHI covers.
- Women, as the majority of unpaid caregivers, can face both a lack of PHI coverage and added work where PHI makes other forms of care inaccessible.
- Women stand to lose access to care where PHI undermines public health care systems by draining human resources and funding capacity and adding costs.

Given the above points, it is clear that PHI negatively affects women.

Issues for future research

The literature reviewed in this report points to a need for further research on PHI offering gender-based analysis. Research to date suggests that PHI raises concerns for women on a variety of fronts, yet coverage of relevant issues is inadequate. Given the importance of this form of health care financing and its many possible implications, research is needed in areas including:

- The significance of PHI for different groups of women.
- The impact of different forms of PHI on women.
- The impact of PHI on women as health care workers.
- The impact of PHI on women as unpaid caregivers.
- The impact of PHI on public health care systems as a women's issue.
- Qualitative research to compliment the quantitative approaches prevalent in this area.

Further study of these issues would seem to be especially urgent in a policy environment where advocates of PHI are aggressively promoting an increasing role for this method of health care financing. With existing findings suggesting that such measures have far reaching implications for women as patients, workers and unpaid caregivers, examining these issues further should arguably be an important priority.

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