

Women *and* Private Health Insurance

Why does Private Health Insurance Matter to Women?

Women have a particular interest in the cost of health services. Women receive the majority of health care in Canada and are the primary providers of paid and unpaid health care within and outside their households. The presence of Medicare—a universal public health insurance system—means that almost all women in Canada can seek basic health care services for themselves and their families without having to worry about how they will pay their medical bills.

Private health insurance is not new to Canadians. Approximately 65% of Canadians have private *supplementary* health insurance to cover the costs of services not covered by Medicare, such as prescription drugs, physiotherapy, long term care, dental care and eye care. However, in recent years, Canadians have witnessed the expansion of *duplicate* health insurance. This form of private health insurance covers the delivery of predominantly private health care services that are already covered by Medicare. This fundamental change may have important consequences for women.

Public or private health insurance matters to women because:

- Women make greater use of health care services than men;
- Women are less likely to have the resources to pay for private insurance;
- Women workers are less likely to have private health insurance through employers;
- Women provide the majority of paid and unpaid care; private health insurance affects women as providers and recipients of care;
- Public health services are a major source of employment for women;
- Funding for public health services affects the conditions of women's work.

Women and Private Health Insurance

WORD SEARCH

Complete the Women and Private Health Insurance word search by circling the following 20 terms hidden in the puzzle below. Understanding the significance of these terms will allow you to better navigate your way through current debates over private health insurance in Canada.

Canada Health Act
Chaoulli
Coverage
Duplicate
Employment
Financing
Health

Inequity
Insurance
Medicare
Patients
Premiums
Private
Privatization

Public
Reforms
Risk Based
Supplementary
Women
Workers

T E D E H Q L J R T A I D I C Y X Z T A
H C M P R U R M S L R U Q N O R Z S U T
J O A P P A L D V F P S K S V A E E D M
I U F H L V C C T L K C D U E T D H J R
S S M I T O I I I R S J Y R R N F L A E
Y G R U T L Y C D T B S N A A E K Q J L
E Z N E B L A M N E V C H N G M B P O Z
D D S U K T P E E O M N O C E E S A R G
R V P M E R I N H N D I B E F L N Y L O
V X B S I T O Y D A T Q E A Y P I H V I
S N A V A W U W M A D Z S H A P L T I A
P U A P N O E S Z W P A G B J U L L D A
H T I N E Q U I T Y H R N Z Y S U A O T
E W O M E N T Y J M Q P E A S Q O E T W
G D E U A A S M R O F E R M C N A H C F
L O P D V G N I C N A N I F I O H R Z A
E L E I J T G K R T M H R H Q U C V M X
W A R L R V M Y M R N P Q E D N M T L R
C P R I S K B A S E D T P J W C S S L O
R H E O I L K P B C J M I O J L R C H J

WHAT FORMS OF HEALTH INSURANCE EXIST IN CANADA?

It's been more than ninety years since Violet McNaughton and the Women Grain Growers in Saskatchewan first called for a universal public health care system that would provide "medical aid within the reach of all." As the primary care providers in their households, they saw first hand the suffering that occurred when medical treatment for ill or injured family members and friends was unaffordable.

Today, Canadians are protected by a system of universal public health insurance financed through general taxation. Known as "Medicare", this system covers the cost of many medically necessary services provided by physicians and hospitals. Approximately 70% of all health care services in Canada are financed this way. The remaining health care costs are paid for privately by service-users as direct out-of pocket payments (15%) and through private health insurance (15%). This level of private health insurance financing is higher than most other advanced industrialized nations where private health insurance accounts for less than 7% of total health expenditures on average.

Although the history of health insurance in Canada begins in the mid 1600s, today's system largely reflects the passage of the **Canada Health Act** by the Federal government in 1984. This act combined the **Medical Care** and **Hospital Insurance and Diagnostic Services** acts to establish public insurance for physician and hospital services across Canada. The *Canada Health Act* is federal legislation that sets the fundamental principles governing public health insurance programs across the country. Under the terms of the *Canada Health Act*, the federal government transfers funds to the provinces and territories to help cover public health costs. Although each province and territory administers its own public health insurance plan, all are required to provide care that is universal, comprehensive and accessible in a system that is publicly administered. Under the *Canada Health Act*, additional user fees or extra billing for services covered by public health insurance are prohibited.

Given our country's strong commitment to public funding for universal health care, private health insurance in Canada has been largely restricted to **supplementary** health insurance that provides coverage for services not covered by Medicare. Only 65% of Canadians have supplementary private health insurance, which for most people is offered as part of their employment benefits.

Duplicate health insurance is a private system that provides coverage for privately delivered health services as an alternative to treatment within the public system. Under this system, people who can afford to do so may seek treatment for services covered by the public system in private clinics in order to get care more quickly. Six provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island, and Quebec) have legislation that explicitly prohibits duplicate private health insurance for services already covered by Medicare.

HEALTH INSURANCE IN CANADA CONT'D

Recently, powerful interests have challenged the legislation that restricts the expansion of private health insurance. Supporters of duplicate private health insurance argue that people have an individual right to purchase health services and health insurance and that physicians have a right to treat private patients. In fact, physicians in Canada may choose to treat private patients, but in most provinces they are required to opt out of the public system if they do so. Some advocates of private health insurance claim that a parallel private health care system will reduce pressure on the public health care system by providing additional sources of financing. Some argue that private health insurance used to purchase private health care services will reduce wait times and improve choice and access to care among those who have this type of coverage. Several federal and provincial policymakers as well as the Canadian Medical Association have been influenced by these arguments, expressing interest in expanding a mixed system of public and private care which they say will save taxpayers money and increase timely access to care.

Current evidence supports the very real possibility that in Canada, an expanded system of private health insurance will exist in the future. In 2005, the Supreme Court of Canada ruled that Quebec's legislation banning duplicate private health insurance violated the Quebec Charter of Human Rights and Freedoms (*Chaoulli v. Quebec*). It was ruled that Quebec could not prohibit an individual from purchasing private health insurance and obtaining private care when lengthy wait times prevented them from receiving timely access to care within the public system. In the same year, the province of Alberta requested proposals for a duplicate private health insurance plan while the government of British Columbia initiated public consultations on the future of health care, suggesting a potentially greater role for private health insurance and private care.

The number of private surgical clinics has also greatly increased in some parts of Canada. Private surgical clinics attract patients by offering them quicker service. For example, following the *Chaoulli* decision, the Cambie Surgery Centre, a private hospital in Vancouver, began to offer surgery to paying customers who wanted to avoid wait times in public hospitals. According to a 2006 article in the *New York Times*, the growth of private clinics in Canada means that "private insurance companies are about to find a gold mine."

Approximately 70% of all health care services in Canada are financed through Medicare. The remaining privately funded 30% is higher than most other advanced industrialized nations.

WHAT DOES AN EXPANDED SYSTEM OF PRIVATE HEALTH INSURANCE MEAN FOR WOMEN?

Women in particular should be greatly concerned with the movement towards expansion of private health services funded by private health insurance. It matters to women if health service costs are covered by public insurance or paid for privately because women, on average, earn less than men and face higher poverty rates. This means that many women are unable to pay for extra services or to purchase private insurance. This concern is compounded by the fact that given their reproductive health needs, their higher rates of chronic disease and longer lifespan, women make greater use of health services than men. Women also count on publicly-funded health services as the primary unpaid care providers of their children, elderly parents, and others. The ability to get these services directly affects their workload at home. Women are also the majority of paid health care workers. Canada's publicly-funded health care system provides an important source of employment for women and is critical to the wages and working conditions for women who do provide this work.

Women, Private Health Insurance and Paid Work

Private health insurance coverage reflects gender inequity in the labour market. Women are over-represented in low status, low income and service sector occupations where they are less likely to receive private health insurance coverage as an employment benefit. Women are also more likely than men to be outside the paid labour force or to be employed in precarious or part-time work where private health insurance coverage is low or non-existent. The presence of gender-based harassment in the workplace also means that women may be at greater risk of losing private health insurance if they find themselves forced to change jobs.

Women who make changes in work and family relationships risk losing private insurance coverage. Women who take time off work to raise children or care for other family members, or who reduce their hours of work to manage family responsibilities run the risk of losing their private health insurance when it is tied to their employment. Women also risk losing their health insurance if their employers cut back benefits. Supplementary health insurance coverage has dropped significantly in Canada since over the past decade many employers reduced benefits in the face of rising insurance costs. Women whose private health insurance is tied to their spouse's employment benefits also risk losing coverage through divorce, widowhood, or when their spouse retires or experiences job loss.

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Women, Private Health Insurance and Financial Inequities

Women may be denied coverage or face higher premiums where private insurance companies use risk selection to reduce their costs. Private health insurance companies sometimes attempt to maximize profits by selecting customers, restricting coverage or setting premiums based on an individual's presumed health risks. Where government regulations allow this practice, private health insurance companies may deny or restrict coverage on the basis of a pre-existing health condition, a family history of disease, or other factors deemed to increase health risks, including sex and gender.

In various countries, risk-based insurance schemes have tended to place some groups of women at a disadvantage. Some private insurance policies place restrictions on coverage for maternity care while others charge higher premiums to women of child-bearing age. Some private insurance companies in the United States have refused coverage for women victims of domestic violence, whom they considered to have higher health risks. Some companies have also refused or restricted coverage or charged higher premiums to people with serious health problems, people with disabilities or chronic conditions, older adults and people with low incomes. It is important for women to read the fine print of any private health insurance policies. They may find that the very problems that pose the greatest risk to their health are not fully covered.

Private health insurance may increase health care inequities between those who have coverage and those who do not. While Medicare operates on the principle that health care should be provided on the basis of need rather than ability to pay, there are still many health services only available to those who can afford private health insurance or direct payment. The 2001 Commonwealth Fund International Health Policy Survey reported that 38% of Canadians with only Medicare coverage did not get the dental care they needed because of the expense, compared to 17% of those who had Medicare and private health insurance. Similarly, 19% of those with only Medicare coverage did not get prescription drugs because of the costs, compared to 10% of those who had both Medicare and private health insurance. As a result, women without private insurance are more likely to go without drugs, dental care, eye care, home care, physiotherapy and various other health services.

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This is most starkly illustrated by the inequities in health care in the United States where most of the working population must rely on private insurance. Forty million Americans have no health insurance, because they are not eligible for public programs and they cannot afford to purchase private health insurance. People who have no health insurance to cover their medical bills often forego or delay seeking medical care, at great cost to their health and their lives.

It has been estimated that 18,000 Americans die annually because they lack health insurance. American-based research also suggests that women's access to private health insurance is influenced by their income and employment status, as well as their racialized identity, sexuality, age, ability and geographic location. It is particularly concerning that marginalized groups of women are among those to have no private health insurance and thus less access to health care because they tend to experience greater disparities in overall health and well-being.

Public health insurance is more equitable than private health insurance in the way it is financed. Public health insurance is based on a progressive financing system whereby those with higher incomes pay more through taxation. Private health insurance financing tends to be regressive. Under systems of private health insurance, the financial burden often shifts away from the healthy and wealthy and raises costs for those who have less income or have medical conditions through regressive premium payments. Since women's average income is significantly lower than men's, women pay less for public health insurance. Similarly, women with lower incomes will pay less than those with higher incomes.

In some countries, risk-based private insurance programs have placed women at a disadvantage. In Chile, for example, women are charged higher premiums because they make greater use of reproductive health services and have higher rates of chronic disease. Under risk-based programs, women deemed to be high risk may be charged higher premiums. Since the highest income groups tend to be the healthiest, lower income women may end up paying higher premiums. Even if the premiums are the same, those with lower incomes will pay a higher proportion of their total income for private health insurance.

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Women, Private Health Insurance and Timely Access to Appropriate Care

Private health insurance does not always provide women with the care they need. In the United States for instance, where private health insurance is widespread, some policies do not cover services such as maternity care, contraceptives, mammograms or abortions. Women with pre-existing medical conditions, women who experience domestic abuse, and women with a family history of health concerns may not be covered under risk-based private health insurance programs.

Private health insurance does not guarantee better quality of care. Private health insurance that covers treatment in private health facilities may provide privately insured individuals with faster access to care, but it may also influence the type of care provided. In some countries, private maternity patients face higher rates of obstetrical interventions. In Greece, for example, it has been found that privately insured women receiving maternity care in private hospitals are more likely to have their babies delivered by Caesarean section, despite a higher risk of complication with C sections compared to spontaneous vaginal deliveries.

Contrary to popular belief, research evidence does not support the claim that private health insurance reduces wait times in the public health care system by reducing demands on public facilities. In fact, private care financed by private insurance may exacerbate staff shortages and adversely effect wait times. International studies of countries with duplicate private health insurance and parallel private health care services have shown no significant reduction in wait times. For example, in Australia, duplicate health insurance and the expansion of private health facilities has not reduced wait times for treatment in the public system. In Britain and Israel, it was found that allowing doctors to practice in both public and private systems contributed to staff shortages and longer wait times in the public system.

Duplicate private health insurance to cover private health care services would enable *some* people to get faster service. According to the Canadian Health Services Research Foundation, a parallel private health care system would mean quicker care for private patients but longer wait times for those who rely on the public system. Similarly, a Manitoba study found that doctors who treated both public and private patients tended to make their public patients wait more than twice as long as the wait times of doctors who worked solely in the public system.

Contrary to popular belief, research does not support the claim that private health insurance reduces wait times.

As patients waiting for care, as unpaid care providers for families, and as public health care workers coping with staff shortages, women may experience greater barriers to accessing and providing appropriate health care under an expanded private health insurance system.

If physicians are able to earn more money treating private patients than they can working in the public system, there is a very real danger that financial incentives will draw physicians and other health care personnel away from the public system. This could create shortages in the public system that would lengthen waiting times and make care less accessible to those without private insurance. As patients waiting for care in the public system, as unpaid care providers for family members and friends waiting for care, and as public health care workers coping with staff shortages, women may experience greater barriers to accessing and providing timely, appropriate health care under an expanded private health insurance system.

Women, Private Health Insurance and the Erosion of Public Health Care

Private health insurance could undermine public health financing, rather than make it more sustainable. Advocates of private health insurance argue that it reduces public health care costs and patient demands on the public system by diverting some people (those with private health insurance) to private health care facilities. Yet, the real impact may be quite the opposite.

By drawing human resources out of the public system, private health insurance and private health service delivery pose a threat to the quality of care for those who depend on the public system. A decline in quality of care may lead to poorer health among public service users which would lead to greater costs and demands on the public system. Consider, for instance, the current situation in Germany, where people are allowed to opt out of the public health insurance program and purchase private health insurance. The expansion of private health insurance has undermined the financial stability of the public system because many people with higher incomes have withdrawn from the public system. This has resulted in declining average premium revenues in the public system and increasing average public health expenditures, as those in the public system tend to have higher health needs than those who have left the system for private care.

WHAT DOES EXPANDED PRIVATE HEALTH INSURANCE MEAN FOR WOMEN? CONT'D

Private health insurance also costs the public system when private health insurance is partially financed by government subsidies. For example, Australia used a system of public subsidies to encourage people to purchase private health insurance, based on the assumption that this would significantly reduce public hospital expenditures. However, the amount paid in subsidies far surpassed any savings, costing taxpayers billions of dollars each year. Similarly, in Canada, the government offers tax breaks to help cover the costs of private health insurance premiums. In 2004, these tax breaks cost taxpayers approximately 5 billion dollars. As a study of health care financing in OECD countries by Tuohy and colleagues (2004) concluded, "A resort to private finance is, on balance, more likely to harm than to help publicly financed systems...."

As the majority of health care workers, women have benefited when public health care has been well-resourced. Privatized health care facilities often introduce cost-cutting measures that undermine working conditions for health care workers. In addition, private health insurance companies maximize their profits by avoiding high-risk clients and coverage for the most costly procedures. If private insurance companies and private health clinics concentrate on the most profitable procedures, then the most difficult and costly care will be more concentrated in the public system. This could intensify workloads among those women who provide the majority of care within the public system. At the same time, working conditions could deteriorate within the public system as staff shortages are made worse by health care personnel leaving to practice in the private system.

Instead of expanding publicly-funded health services to reduce the burdens of women's unpaid care work, private health insurance may undermine public health care by perpetuating the notion that many forms of health care are a private responsibility. Under the North America Free Trade Agreement and the General Agreement on Trade in Services, private health insurance is classified as a financial service rather than a health service. This means that it is subject to rules that would allow private insurance companies to demand compensation from Canadian governments if those governments were to take any action that would reduce the market for private health insurance. In other words, private health insurance could make it more difficult for the Canadian government to

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expand Medicare to cover drugs, home care, nursing home care, dental care, or other services because such expansion would mean a loss of business for private insurance companies. Private health insurance could thus make it more difficult to expand the coverage of public health insurance in the future.

Undermining Medicare will perpetuate health and social inequities among women. As funding and support for public health services decrease, so too will the accessibility and quality of health care services for those women and families who cannot afford private health care. It is also unclear how the expansion of private health insurance and services will affect Status First Nations and Inuit women who receive funding for health care services and programs for themselves and their families directly from Health Canada.

The erosion of public health care and the privatization of health care insurance may threaten the pursuit of a woman-friendly agenda for health reform. A woman-friendly health care system would aim to make health services more accessible by expanding publicly-funded health service. Expanding public health insurance coverage would improve access for women who currently can't afford services not covered by Medicare. It would also aim to reduce the burden of women's unpaid care work and expand formal services in the public sector to provide employment opportunities and good working conditions for health care workers, the majority of whom are women. A woman-friendly health care system would offer real alternatives for care within the formal care system rather than relying so heavily on women's unpaid care work in the home. Yet, private health insurance may reduce the expansion of publicly-funded health services, undermine the working conditions of women health care workers and increase expectations for women's unpaid care work.

It is also unclear how the expansion of private health insurance and services will affect Status First Nations and Inuit women who receive funding for health care services and programs for themselves and their families directly from Health Canada.

WHY IS PRIVATE HEALTH INSURANCE AN ISSUE FOR WOMEN?

Because a publicly-funded health care system is important to women. It provides universal access to health care services, which women use more than men. It provides employment opportunities for health care workers, most of whom are women. It provides formal health care services that reduce the demands for women's unpaid care work in the home.

Because private health insurance is beyond the reach of many women. Private health insurance and private health services may offer benefits to *some* women, but privatization places many women at a disadvantage.

Because private health insurance makes health care less equitable. Private care funded by private health insurance may influence the kind of services women receive, and not always for the better. It does nothing to improve wait times for women who rely upon the public system. Privatized care may contribute to staff shortages and increased workloads, thus undermining working conditions for health care workers.

Because private insurance may allow *some* women to purchase care as an alternative to unpaid care work in the home, but many women will continue to shoulder this workload unless it is provided by an adequate public care system. Private health insurance will make it more difficult to reform the health care system to better address women's needs.

Private health insurance is beyond the reach of many women. Private health insurance and health services may benefit *some* women, but privatization places many women at a disadvantage.

Thinking Women:

Rethinking Private Health Insurance

As debates about private health insurance continue and new policies and legislation are developed, we must ask critical questions to ensure that the issues for women are fully understood and addressed. In considering the contexts of women's and men's lives, we must ask:

- What is private health insurance and what is its relationship to health care services?
- Will the increased availability of private health insurance and private health services respond to women's health needs?
- How will increases in the availability of private health insurance affect women's access to services and the quality of public health services?
- Which women will be affected by an expansion of private health insurance? Who will benefit and who will be left out?
- What does an expansion of private health insurance mean for women as paid health care providers, service users and unpaid care providers?

selected resources

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who we are and what we do

Women and Health Care Reform consists of Pat Armstrong (Chair), Madeline Boscoe, Barbara Clow, Giovanna Costa, Karen Grant, Margaret Haworth-Brockman, Beth Jackson, Ann Pederson and Morgan Seeley. We are a collaboration of the Centres of Excellence for Women's Health, the Canadian Women's Health Network and Health Canada's Bureau of Women's Health and Gender Analysis, funded through the Women's Health Contribution Program. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. For more information on our work, visit our website at www.womenandhealthcarereform.ca.

Contact us at whcr@yorku.ca

For more information about the Women's Health Contribution Program visit:
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ordering information

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or ordered free from:

Canadian Women's Health Network

203 – 419 Graham Ave.

Winnipeg, MB R3C 0M3

Tel. (toll free): 1-888-818-9172

Email: cwhn@cwhn.ca

www.cwhn.ca

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*“Allowing private provision
and financing of services...
makes access to services a
matter of ability to pay
rather than a matter of need.
They exchange inequity for
equity and lead to further
differentials in status between
the rich and the (majority
female) poor.”*

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