A) Gender Differences in (Private) Health Insurance in Austria

Private health insurances in Austria are, in general, supplementary to the general health system. On the one hand, they provide benefits such as more comfortable rooms during a hospital stay, different food choices, etc. (a “hotel character”). On the other hand, they provide more independence concerning the choice of doctors, therapies, midwives, treatments, shorter waiting periods for an operation, etc.

All private health insurances have gender specific differences: women, until the age of 50/55, generally pay approximately a third more for their contributions as compared to men of the same age who have entered into a health insurance contract at the same time (Kafka 1998).

Arguments in support of this gender difference in contributions are, in general, the risk of costs for pregnancy and childbirth, as well as women’s higher life expectancy. Furthermore, insurance companies refer to the necessity of exact cost calculations to survive in competitive liberal market economies.

Actually, Anna Diamantopoulou, EU-commissioner for employment and social affairs, states that women’s contributions to private health insurance are as much as 90% greater than men’s at the same age. In terms of the risk of costs for pregnancy and childbirth, even in the general health insurance system there are few measures for risk adjustment (Feuerstein/Kollek/Uhlemann 2002: 211-215). Risk adjustment exists, for example, between health-funds with higher and lower incomes and expenses. This is important for health insurances with a high percentage of retirees, such as the insurance company covering farmers in Austria. This means, in conclusion, that measures for risk adjustment for gender specific issues such as pregnancy and birth must be developed in the private as well as in the public health insurance systems.

Maria Hofmarcher, economic expert at the Institute for Advanced Studies (IHS) in Vienna, points out that higher expenses for women in Austria’s social (general) health
insurance would result from private contributions to social health care in the future (see Der Standard 22 May 2003: 9). This is a situation which is actually being discussed in Austria. This means that women’s average income – a third less as compared to men – would be matched with a third higher expenses in health care. Actually, this hypothesis is, already, in part implemented in the demand for private contributions for some benefits in public health care in Austria (payment contributions for consulting a doctor, day-rates when staying in hospitals, spas, payments for medications, etc.).

Furthermore, Hofmarcher’s investigation includes a gender specific view of yearly medical consultations. The result is that women’s rates are higher. Possible causes of this difference have already been examined and must be examined in detail in the future. In part, this gender specific view results from neglecting gender differences in medicine and in medical education. The effects of false diagnoses have already been examined in the discipline of cardiology (Hochleitner 2002). Neglecting gender differences may result, for example, in improper dosages of medication and incorrect treatments. In terms of notions of womanhood, the image of a “hormone navigated female psyche” is possibly caused by disregarding the fact that women are at a greater socio-economic disadvantage as compared to men and are financially (very) poor, which evidently has negative effects on their health status (Doyal 1995).

In addition, medicine functions as a “social reception camp” for women. According to the concept of the female role as providing care (always) for others, women have a compensatory function within the social system. If there is a lack of national social care and health care facilities, and there usually is, women fulfil a great number of tasks in caring for others. If they themselves need support, often there is only the field of medicine to care for them. Medical care for women, who care or have cared for others for years, is often the indirect “compensation” for their provision of care for others; a task which has been or is very exhausting.

Lesley Doyal, a British public health expert, describes women’s high burdens in daily life as a “tricycle-model”, regarding their care for children, elderly parents, or other relatives, and later their partners (Doyal 995).

Though a potentially higher percentage of women subsequently requiring medical care is no “wonder” based on these circumstances, the suggestion that women are more often ill has to be re-examined with regard to further conditions specifically related to being female. One result of the so-called “sick womanhood” as model of female development is a high level of norm fulfilment. Regular doctor’s visits (once or twice a year to the gynaecologist, for
example), precautionary visits or follow-up checks, are particularly recommended to women
due to the high level of control over their reproductive organs and fertile “products”;
including prenatal care and control of embryos, etc. Reproduction as a further norm, in
addition to having a profession, career, etc., fits as another piece in the puzzle in the
hypothesis of how medical compensation functions. “Biomedicine instead of social politics”
(Ulrike Hauffe) summarizes tendencies and developments concerning the application of
reproductive medicine and genetic engineering in medical health care and the high political
support they receive (see Reprokult Frauen Forum Fortpflanzungsmedizin 2002). The norm of
bearing children is not compatible with the demands of the labour market. A satisfactory
compatibility of parenthood and child rearing along with a full-time job under conditions of
gender equality has still not been realized. This gender difference is one reason for following
special needs of women in health care. Their higher needs and costs in (private) health
insurance may increase with a liberalisation and economisation of the health market in future.

B) Applications of genetic engineering and reproductive medicine in health care – legal
regulations in Austria (with a focus on the IVF-Fonds-Law 2000)

Political junctures between demographic, family and social affairs, in combination with
health politics, are especially obvious concerning the fields of reproductive medicine and
biotechnologies.

The IVF (In-vitro-Fertilisation)-Fonds-Law (Austria, 2000) marks this relationship
very clearly, including financial regulations when an IVF or ICSI (intra-cytoplasmatic sperm
injection) is done in Austria under special conditions (for example, a woman may not be older
than 40, a man may not be older than 50 years; 4 attempts are financed). According to this
law, 70% of the costs for an IVF or ICSI are financed from public money, 50% of this 70%
coming from the Ministry of Family Affairs, 50% from the Ministry of Health. This splendid
solution is contrasted by restrictions in supporting single-parent-households, which applies
more to women. Furthermore, public money for the child is decreased at the age of 21 months
if special prenatal and postnatal examinations have not been carried out (in accordance with
the “Mother-Child-Passport” in Austria). Whereas various reductions and savings concerning
social affairs, education and public health have been realized in Austria (and other European
countries) in recent years, there is a political willingness to spend public money for
reproductive medicine though their practices have low rates of success (the “take-home-baby-
rate” of an IVF for example is lower than 20%; Reprokult 2002: 135).
The Austrian IVF-Fonds-Law and its implementation correspond with a conservative ideal of heterosexual partnership and family, and, moreover, support its re-establishment. The willingness to raise national birth-rates could be affirmed with strategies other than the support of biomedical solutions and also, for example, a different political discourse concerning nationality.

The high support of biotechnologies has further origins in terms of the aspect of “practicability” of reproduction and health. A general “genetification of medicine” includes a high amount of hopes and demands, as well as new standards of “perfect” health and bodily “equipment” and out-fit. The development of further standards, norms and, as a result, irregularities, is a result of the application of (bio)technologies in medicine – the so-called “other side of the coin”.

C) Effects of the application of genetic engineering and reproductive medicine on health insurance

Besides gender specific calculations, “life style” factors such as smoking, obesity, or performing extreme sports become more and more important in their influence on contribution rates in health insurance. Furthermore, the calculation of genetic risks, which is actually possible and of growing importance in medicine, provides information about potential unseen risks. Genetic risks are considered irreversible. In the extreme case, they could possibly cause exclusion from private health insurance in the future. Actually, the concern is with monogenetic illnesses, but it is obvious that the practical application of screening for genetic risks will be expanded in the future (Feuerstein/Kollek/Uhlemann 2002: 96).

In terms of the reproductive field, family stigmatisation may arise in the future with the determination of genetic risk potentials. Concerning the (health) political aspect of responsibility for one’s own health, this tendency is and will be of even greater importance in the future, depending on the possibilities of early diagnosis of illnesses (routine checks for those with a particular genetic defect, such as BRCA1 or BRCA2, for example).

Due to this development, pressure is put on social and health policies as well as health economics, which is even implemented with regard to “prenatal life”. Pregnant women are regarded as the prenatal responsible persons for the health of their future child, though there are no cures for illnesses arising before a child’s birth. The only possible “measures” are prenatal risk calculations. This discrepancy between pre-testing of illnesses and (im)possible
medical (prenatal) treatment even results in women, parents or doctors being regarded as “guilty” when a child is born handicapped or otherwise “non-perfect” (Reprokult 2002: 130f).

D) So-called “Autonomy of Giving Birth”

The so-called autonomy of giving birth is often strained to legitimate the application of biotechnologies in reproductive medicine. The limitation of this “autonomy”, which is signified in age limits regulated in the IVF-Fonds-Law in Austria, for example (women get financial support until the age of 40, men until the age of 50), shows the cultural dimension of so-called “biological limits”. Whereas women and couples do get financial support for the “production” of children, social and financial regulations to raise them are insufficient, and still bring financial disadvantages, mostly for women. Even if their lack of demand of equal income (through part-time-regulations, for example) seems to be voluntary, female role conceptions include this voluntary “lack of demand”, with the result, that there are generally less paid work opportunities for women due to the fact that they “are a woman” (and perhaps bearing children).

In general, actual political tendencies of a re-privatisation of care issues, concerning care for children as well as for the elderly, ill and handicapped, may even involve increased burdens for women as a future effect. Due to the lack of equal opportunities for entry into the labour market, they are often still the ones who provide care, either non-paid or low paid. One final example is the possibility of taking time off from paid labour to care for terminally ill relatives in Austria (“Sterbekarenz” for 3 months, with the possibility of extending this period for a further 3 months). Though it is not a women’s issue, it is obvious that more women than men will be taking this opportunity and task.

“Autonomy of birth” as well as “autonomy of death” involve gender specific issues. Women, who still represent the other to the male norm (of “bread-winner” income), may once again be discriminated against even more so in the future by taking on the provision of care and taking advantage of opportunities to “stay at home”.

Moreover, returning to the general focus of health care, an analysis of ethical questions from the perspective of the natural sciences, whose base is in a consideration of the human body as an object for medical examination, include precarious relations to the self. To avoid further development and re-production in this area, biopolitical “solutions” and the results of genetic engineering must necessarily be regarded, examined and discussed as social and socio-economical issues before further steps in the direction of a quick adoption of
biotechnological “healing” and “creation of reproduction” are carried out: measures, moreover, which do not correspond with the real-life circumstances of women and men and awaken false hopes.

E) Summary and Outlook:

In general, unisex rates in health insurance are possible. Counter arguments have mostly an origin in patriarchal thinking, with the addition of taking a risk-calculation for women outside a family system (family contributions in private health insurance do exist as well). Insurance companies develop their risk calculation according to male bread-winners, who are likewise the probationers of medical testing. Women are the “special model” in this calculation, with the result, that they differ from the norm, and their specification results in higher costs.

This specification is not primarily one of health insurance contributions, but is an important social and general economic question as well. Therefore, a claim for unisex-rates in health insurance is only a single factor which requires the co-reflection of various factors to prohibit the financial discrimination of women.

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