

CICRED'S SEMINAR

**Gender equity and health policy reform in
latin America and the Caribbean**

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GENDER EQUITY AND HEALTH POLICY REFORM
IN LATIN AMERICA AND THE CARIBBEAN

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INTRODUCTION

“The pursuit of development, the engagement with the globalization and the management of change must all yield to human rights imperatives rather than the reverse”

(Koffi Anan, Secretary-General of the United Nations)

The recent impetus achieved by health sector reforms policies throughout the Region has given rise to an intense debate in governments, civil society, and multilateral agencies about the actual and potential effects of these policies on health equity and human development. Up to now, however, this concern has focused almost exclusively on geographical and income considerations without taking into account the differential impact of these policies on women and men. The absence of this concern in the public debate has translated into a lack of policies to correct the gender inequities associated with these reforms that cannot be combated with the same measures employed to reduce the gaps between geographic locations and socioeconomic strata.

This new health sector reform “movement” is not indigenous to each country. It is usually part of a larger package of development assistance in support of health sector programs. Therefore, along with government and national institutions, it involves external multi-lateral actors and, along side with national specificities, it exhibits common denominators strongly linked to global processes.

Globalization is understood here as the increased integration of national economies stimulated by the liberalization of trade and capital markets, and rapid technological advances in the field of communication. Liberalization policies are cornerstone to this process. They call for deregulation of world and domestic markets, while restricting individual countries’ ability to protect their own industries (pharmaceutical, insurance, for instance), and limiting government’s scope for intervening in markets in order to support national priorities.¹

Ideally, health sector reform has been conceived as a “a process directed at introducing substantive changes into the various functions of the sector, with the purpose of increasing equity in the provision of health services, efficacy in its management and efficiency in the satisfaction of the health needs of the population”². However, translating principles to practice has not always worked in favor of equity in a broad sense, let alone of gender equity.

¹ Evers, B., and Juárez, M., *Globalization, health sector reform, gender and reproductive health*. Ford Foundation, Santiago de Chile, 2001.

² Panamerican Health Organization, *Cooperation of the Panamerican Health Organization in the Health sector reform Processes*. Washington D.C., PAHO, 1998, p.13.

The present paper has two objectives. First, to call attention to the most important implications of health sector reform for gender equity, with specific regard to: (a) access to, utilization, and financing of health care; and (b) apportioning of health care work and rewards. The second objective is to propose a series of strategies to identify problems, mobilize resources and institutionalize mechanisms to achieve the goal of health for all.

The emphasis on gender does not reflect a reductionist vision of reality. On the contrary, the analysis starts out from the essential recognition that gender inequities interact with other types of social inequalities to affect risks and opportunities in health. Thus, any strategy to reduce gender inequities must inevitably consider the differences in class, ethnicity, and age that influence the nature and magnitude of gender inequities. The emphasis on gender reflects the need to shed light on an important dimension of inequity that is frequently ignored and whose consideration is critical to achieving objectives of knowledge, social justice, efficacy and sustainability of interventions.

The paper is divided into four sections. The first one outlines the conceptual framework for the analysis. The second identifies major areas of gender inequity in health. The third examines some key repercussions of health sector reforms on gender equity in Latin America. And the final fourth discusses the main challenges posed by incorporating a gender equity perspective into health sector reform policies and proposes a pluralistic strategy to document, prevent, and contribute to eradicate gender inequities in health sector reforms.

I. FRAME OF REFERENCE

The concept of gender mainstreaming in health policy rests on four key concepts: health, equity, gender, and democratic participation.

1. Health

According to the definition adopted by the Pan American Health Organization / World Health Organization (PAHO/WHO), health “*is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.*” Health, then, is a positive concept that emphasizes both physical capacities and personal and social resources. It is therefore neither the exclusive province of the health sector nor limited to individual healthy lifestyles.³ Achieving the highest attainable level of health is a fundamental *human right*, enshrined in the WHO Constitution since 1946.

By extension, **reproductive health**, a central concern of this work, has been defined as a

*“state of complete physical, mental and social well- being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, **reproductive health care** is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases” (ICPD)⁴.*

Reproductive health is also an *approach*,

“when we use the language of ICPD, we talk about health needs, but we also talk about rights, equity, dignity, empowerment, self- determination and responsibility

³ *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, 21 November, 1986.

⁴ Programme of Action of the United Nations International Conference on Population & Development, (ICPD), 5-13 September 1994, Cairo, Egypt, Paragraph 7.2.

in relationships. Reproductive health is an approach to analyzing and then responding comprehensively to the needs of women and men in their sexual relationships” (ICPD + 5, 1999).

2. Equity in health

Equity is not the same as equality, and not all inequality is considered inequity. The concept of inequity adopted by PAHO/WHO is reserved for inequalities that are ***avoidable, and unjust***⁵. Equity implies that need rather than socioeconomic advantage is considered in decisions about resource allocation⁶. Thus, while equality is an empirical concept, equity is an ethical imperative grounded in principles of ***social justice and human rights***.

Different societies approach the concept of equity differently. In some, equity goals are seen in terms of the commitment to achieve a *minimum* level of health and health care for all, without attempting to reduce disparities once the most disadvantaged groups have attained that minimum level. This so-called “libertarian” approach focus on the extent to which people are free to purchase the health care they want. For other societies, achieving the levels of well-being attained by the most privileged groups is the goal. In this regard, the advances made by the better-off groups are used as the parameters of what can be achieved in that particular society, and equity is viewed as requiring a sharing of progress. This “egalitarian” approach judges equity by assessing the extent to which health resources are distributed according to need, and are financed according to ability to pay)⁷.

For analytical purposes it is useful to distinguish between the broad notion of *health* and the more restrictive concept of *health care*. Health generally refers to *health status*, that is, physical, psychological, and social well-being. *Health care*, one of the many determinants of health status, refers to health services and their characteristics: access, utilization and quality, formal and informal provision, and health care resource allocation and financing.

- Equity in *health status* refers to the attainment by *all people* of the *highest* level of well-being that is possible in specific contexts.

⁵ Whitehead, M., *The concepts and principles of equity and health*. Document EUR/ICP/RPD/414., WHO Office for Europe, Copenhagen, 1990

⁶ Braveman, P., *Monitoring equity in health: A policy oriented approach in low- and middle-income countries*. Geneva, WHO, 1999, p.2

⁷ Braveman, P., Ibid.; Wagstaff, Adam and van Doorslaer, E., Equity in the finance and delivery of health care: concepts and definitions. In: *Equity in the financing and delivery of health care: An international perspective*. Edited by van Doorslaer, E., Wagstaff A., y Rutten, F., Oxford, Oxford University Press, 1993; Gilson L., In defense and pursuit of equity. *Soc. Sci. Med.* 47 (12) p.p. 1891-1898, 1998.

- Equity in health care means that health resources are allocated according to *need*, services are received according to need, and contributions to health care financing are made according to *economic capacity*.⁸

Therefore, as an ethical imperative, equity demands that needs be matched to resources, that is, giving more to those with greatest need.

3. Gender

Gender is not synonymous with sex. The term “sex” refers to the biological differences between men and women, while “gender” involves the social constructs of “masculine” and “feminine” and the way in which they come together in power relationships. Gender does not mean *women*, either. The focus of gender is not women *per se*, but the *social relations of inequality* between women and men and the impact of this inequality on people’s lives.

In the past two decades, the social sciences have begun to recognize gender as one of the primary elements in the organization of social life. Beyond its micro psychological importance in the formation of subjectivity and the structuring of interpersonal relationships, **gender—together with class and race**--occupies a central place at the macro social level in the allocation and distribution of resources in a hierarchical society.

The importance of gender at the macro level lies in its integrative function of two complementary dimensions of the economy. On the one hand, gender guarantees the existence of a realm of *unremunerated* work, known as **reproductive** work, which reproduces the workforce, disciplines it and puts it into circulation; on the other, gender conditions people’s alternatives in the world of remunerated or **productive** work.

In the majority of societies, reproductive work falls predominantly to women. Productive work is performed by both men and women but within markets that are profoundly segmented by sex. The socioeconomic experience specific to women is found at the intersection of those two worlds --that is, in the interaction between their reproductive and productive roles. This interaction, plus the preeminence ascribed to the reproductive roles, subordinates women and places them at a disadvantage in terms of access to and control of certain material and nonmaterial resources necessary for attaining a high level of well-being.

Gender is also an *approach* that involves:

- Identifying and understanding the specific health **needs** of men and women that derive not only from biological sex differences, but also from differing socioeconomic conditions, gender prescribed roles, access to and control of resources, and decision making power. It departs from the approach of taking the

⁸ Braveman, Op.Cit, p. 3

family as homogenous analytical unit, but rather identifying intra-household asymmetries in access to and control of resources.

- Considering the interdependence between the formal and informal sectors of health care, which causes the policies affecting the supply of services to simultaneously affect the informal burden of care that falls predominantly on women.
- Acting **intersectorially** to promote the **empowerment** and active **participation** of women—especially from the most disadvantaged groups—in changing the conditions that stand in the way to the fulfillment of their health rights and the achievement of health for all.

4. Democratic Participation

As just stated, democratic participation plays a critical role in effectively and sustainably meeting objectives of equity, social justice and health rights defense. This participation is conceived as the democratic exercise by women and men of their right to influence the processes that affect their health, and not as the simple partaking in actions prescribed by others, or as an instrument for cutting costs in service delivery. In this context it is important to underscore that, as highlighted by the United Nations Development Program, “*in exercising real power or decision-making authority, women are a distinct minority throughout the world.*”⁹ The health system is no exception to this rule. On the contrary, it is in this sector that women are more frequently active participants in the execution of community programs while remaining excluded from the formulation, design, and resource allocation phases of these programs.

Women with their interests, needs, viewpoints, and demands, have not received recognition as a social group that merits representation and that must be accounted to. Decisions are usually made on behalf of women under the presumption of both their consent and a commonality of interests with men. This presumption, however, does not reflect reality, for when women are consulted, the priorities that they indicate for themselves and their families have been very different from those expressed by their closest male relatives, or distant politicians and bureaucrats.¹⁰ It has been observed, for instance, that health is a higher priority for women that reflects in the ways in which men and women spend the household income that they respectively control,¹¹ and in the fact that women more frequently organize themselves to deal with health issues than do men.¹²

⁹ UNDP, Human Development Report 1995, New York, PNUD, 1995, p.86.

¹⁰ Ashworth, Georgina. *Gendered Governance: An Agenda for Change*. New York, UNDP. Gender in Development, Monograph Series #3, 1996, p.10.

¹¹ The World Bank. *World Development Report 1993*, Washington DC., Oxford university Press, 1993..

¹² Beall, Jo. *Urban Governance. Why Gender Matters*. New York, UNDP. Gender in Development, Monograph Series #1, 1996, p.12

Consideration of the particular needs of the various social groups both in policy making and in the accountability of policy executors—whether the State or the private sector—is not feasible without a civic culture that demands it. Given the special needs of women and their under representation in political decision-making, promoting the participation of women’s organizations is an inherent requirement of any democratic system. It is also essential for giving higher priority to health on political agendas and ensuring the sustainability of human development.

II. GENDERED DIMENSIONS OF HEALTH INEQUITY

Gender equity in health translates into the absence of unjust, remediable health disparities between women and men that are associated with systematic socioeconomic disadvantages affecting either sex.

In analyzing health from a gender equity perspective, it is important to distinguish between *health status*, *health care use* (one of many determinant of health status), and *health development work*. It is also essential to address the distribution of the socioeconomic determinants of health.

Gender equity in these health-related dimensions may be understood as follows:

- in terms of the *social and economic determinants* of health, gender equity means equal access to and control of the resources that enable individuals and groups to exercise the right to health (food, housing, a healthy environment, education, information, work, wages, technologies, services, etc.).
- in terms of *health status*, gender equity would be reflected in the attainment by *all women and men* of the highest possible level of health and well-being.
- in terms of *health care use* gender equity implies that
 - ✓ resources are allocated according to the specific needs of men and women
 - ✓ health services are received according to the particular needs of each sex, regardless of the ability to pay
 - ✓ contributions by men and women to health care financing are based on their economic capacity, and not on the particular risks or needs faced by each sex at each stage of the life cycle
- in terms of *participation in health care work*, gender equity demands a just balance between the sexes in the distribution of responsibilities (remunerated and unremunerated), rewards, and power.

1. Gender Equity and Health Determinants

As already stated, gender is pivotal to the way societies operate. **Gender** is a stratifying force that, along with **class and race** determines how work is divided, how resources are allocated, and how benefits are shared among a population. Its influence translates into systematic differentials between women and men in terms of risks and opportunities, access to and control of resources necessary to attain and preserve optimal levels of health. Among these resources are education, information, income, food, housing, basic sanitation and drinking water, social protection, leisure time, and political power. For its central importance in ensuring other resources, work, education and political power are highlighted here.

Work

The disproportionate representation of women in impoverished sectors has its roots in two major factors:

- ❑ the preeminence given by society to “**reproductive**” **work** in the life of women, which limits women’s opportunities to engage in remunerated “**productive**” **work**;
- ❑ the lack of social value accorded to “women’s work,” which translates into **lower levels** of remuneration, autonomy, and benefits in the labor market and in **exclusion** in compensation in terms of wages, social benefits, and recognition of the economic contribution of work inside the home.

In most societies, it is women who have the main responsibility for the reproductive work of taking care of children and home--work that tends to be considered a natural feminine function of no economic value. Men, in contrast, have historically had the main responsibility for remunerated work, which is always considered productive. This arrangement has led to the economic subordination of women based on the **economic invisibility** of the contribution of reproductive work—a contribution that is not even recorded in censuses, much less the national accounts.

The economic subordination of women working exclusively at home may become dramatically evident in cases of widowhood or partner desertion, situations that also affect their children’s well-being. This loss of economic protection and social benefits does not occur because such events in themselves impoverish them, but because women do not have access *in their own right* to basic resources to ensure their well-being—and that of their children.

Women’s entry into the job market does not essentially alter the sexual division of labor; it simply involves women in two spheres of activity governed by the same hierarchical social structure, making women serve “double duty.” Women’s need to reconcile their reproductive and productive roles and the social undervaluing of women’s work give rise to profound differences in the work patterns of each sex.

The work pattern of women has the following characteristics:

- greater time devoted to work, if both reproductive and productive work are considered (Table 1)
- less participation in the remunerated workforce: Although the female labor share has been growing rapidly, more than 50% of women in the Region remain outside the remunerated labor market (Figure 1)

- higher rates of unemployment among women than men in every country in the Region (Figure 2)
- concentration in poorly paid occupations and less pay for equal work. (Figure 3). In the Americas, women's income is equivalent to 71% of men's income on average, a figure that cannot be explained by differences in educational levels¹³. The sex difference in income from wages does not correspond with the sex difference in years of education. In fact, in some countries of the Region the gender income gap increases as educational levels rise (Figure 4). Lower income not only limits access to need-satisfying resources, but also ability to pay for health services, and admittance to health insurance plans (and to a broad service coverage within accessible plans).
- In response to the pressure to reconcile their domestic and work roles, women fill the majority of part-time jobs (70%-90% in the Western world)¹⁴ and jobs in the informal sector of the economy (Figure 5). Neither group is customarily covered by social security or health insurance plans
- Pregnancy and child-rearing interrupt women's job history, making it harder to accumulate the time required to become eligible for health care coverage over the long term. This difficulty may be further exacerbated by the customary legal provisions applying to the lower retirement ages for women.

Table 1: Most of women's work remains unpaid, unrecognized and undervalued

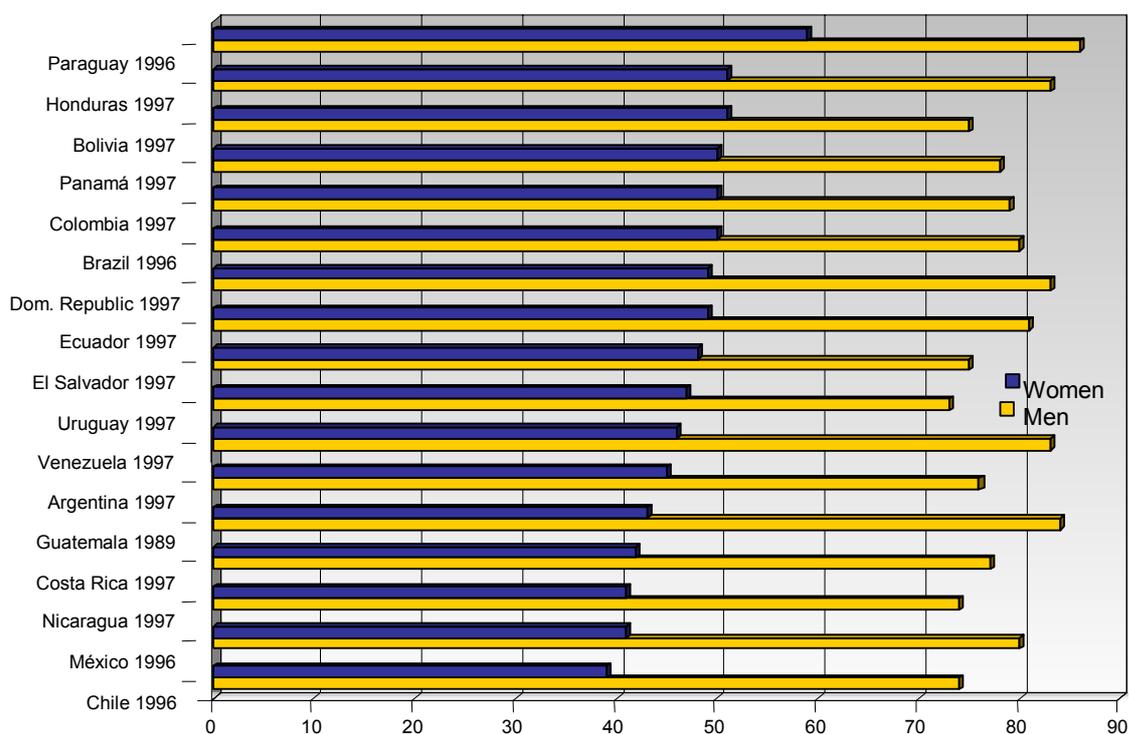
		Time Allocation and Economic Recognition of Work		
		Work Time (minutes per day)	% in National Accounts	% outside National Accounts
Colombia	Women	399	24	76
(urban)	Men	356	77	23
Guatemala	Women	678	37	63
(rural)	Men	579	84	16
Venezuela	Women	440	30	70
(urban)	Men	416	87	13

Source: UNDP – *Human Development Report 1995*

¹³ The World Bank, *Workers in an Integrating World: World Development Indicators. World Development Report 1995*, Washington, D.C., 1995.

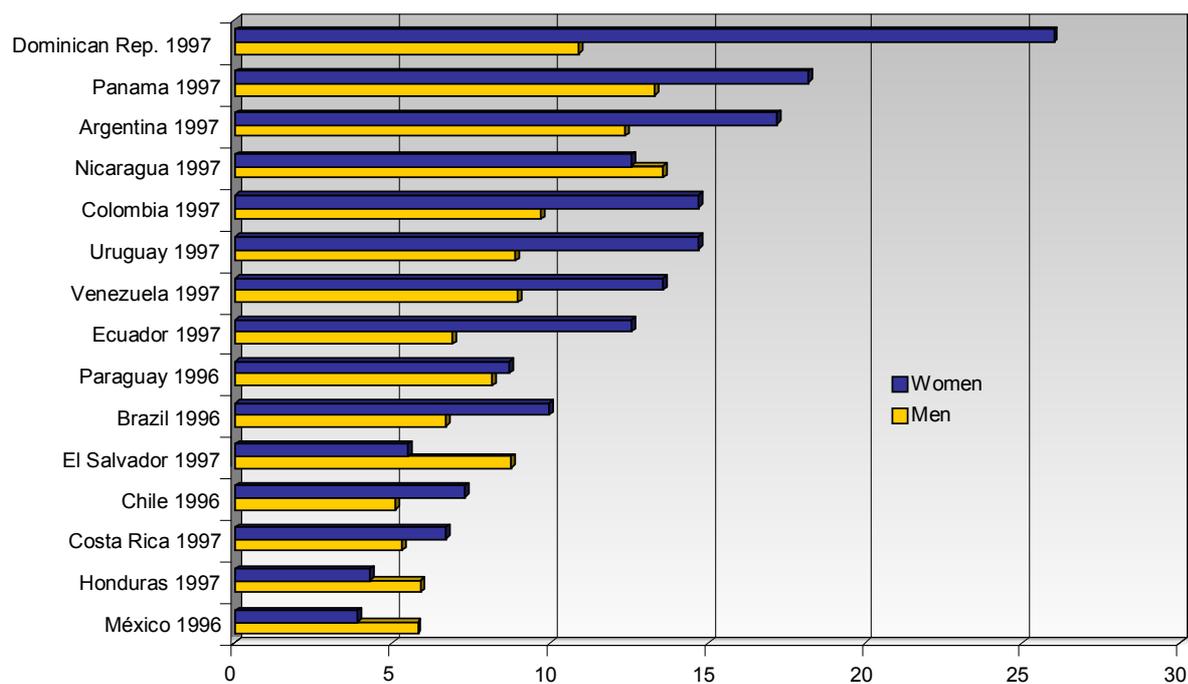
¹⁴ *The Economist*. A Survey of Women and Work. 18 July 1998.

Figure 1: Labor Force Participation Rate of Men and Women In Urban Areas



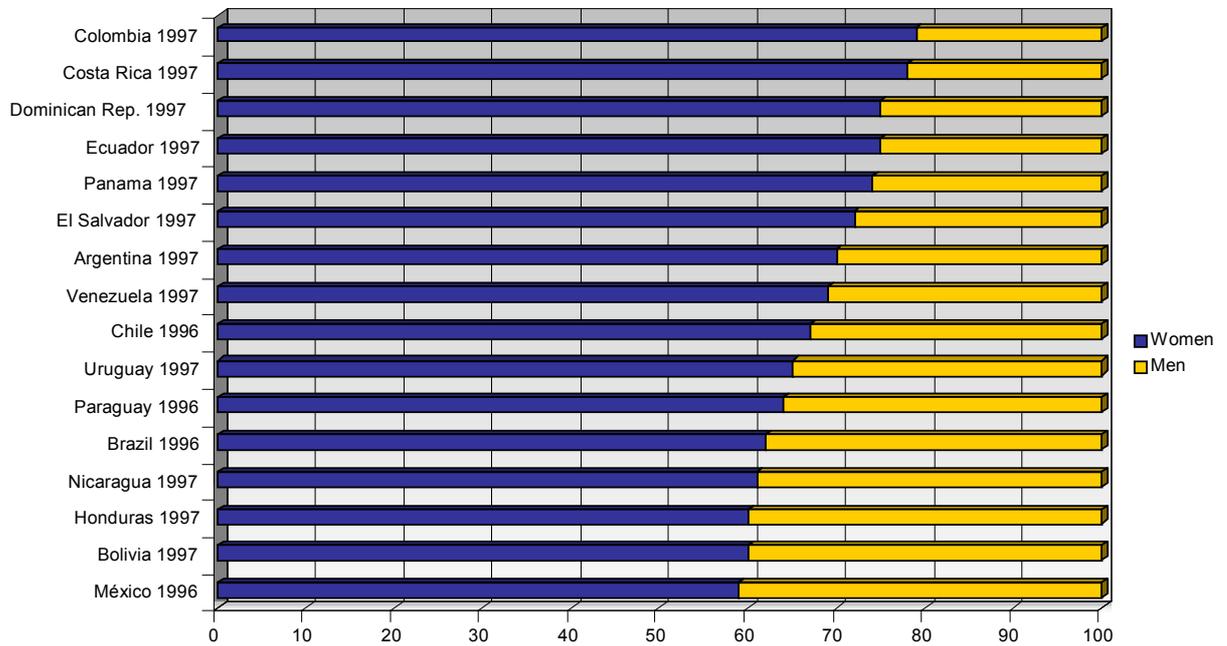
Source: CEPAL - Panorama Social de América Latina 1998

Figure 2: Unemployment Rate in Urban Areas by Sex



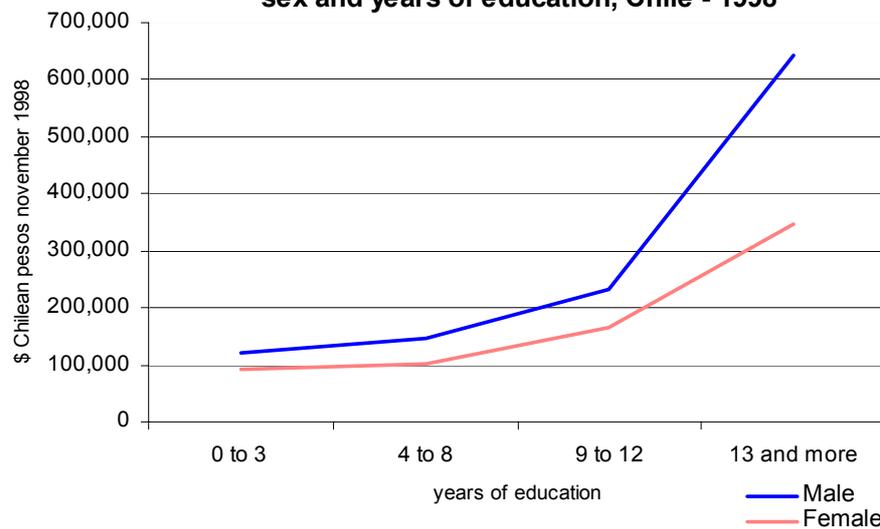
Source: CEPAL - Panorama Social de América Latina 1998

Figure 3: Women's Income as a Proportion of Men's in Urban Areas



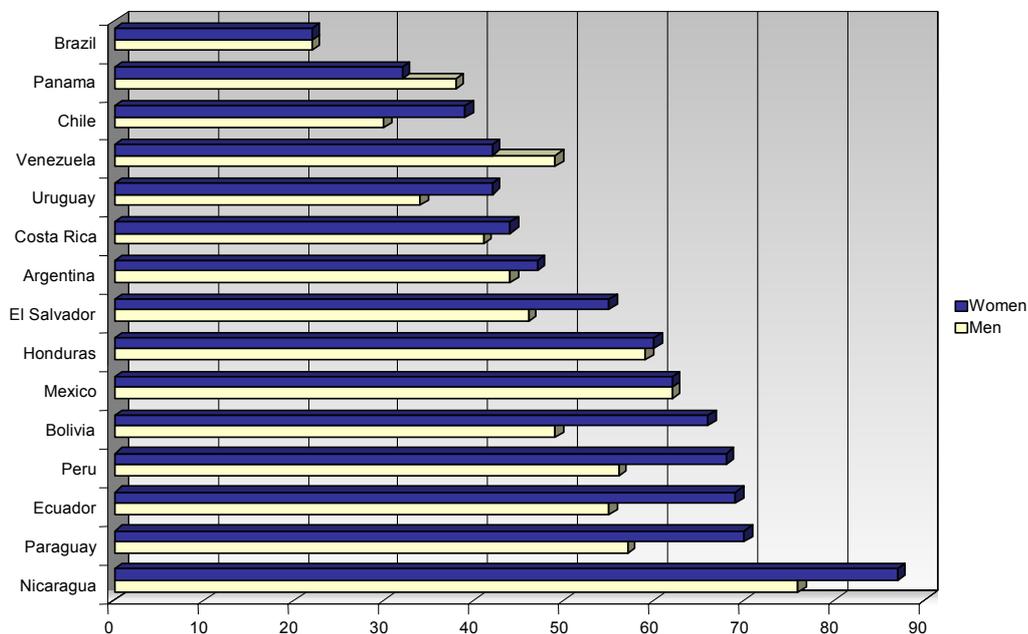
Source: CEPAL - Panorama Social de América Latina 1998

Figure 4: Average monthly income for main occupation, by sex and years of education, Chile - 1998



Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud", PAHO.

Figure 5: Male and Female Labor Force Participation in the Informal Sector, (for 25 to 45 years olds) 1995



Source: IDB. América Latina Frente a la Desigualdad 1998-1999

Education

Formal education is essential but not sufficient to ensure comparable levels of access to work, income, and social benefits for women and men. It *is*, however, a basic ingredient of empowerment, which marks profound differentials in the health behaviors of women, particularly when it comes to reproductive health.

Concerning differences between the sexes in education, it should be noted that:

- The gender gap in basic, primary, and secondary education has been closing in the Region to the extent that, with few exceptions, women in the younger cohorts have equal or higher level of education than men.
- Differences between the sexes acting against women remain in the higher education enrollment levels and in the types of disciplines in which the female population is concentrated. These disciplines, which tend to be regarded as an extension of women’s reproductive work in the public sphere, receive less social recognition and are considered to be of less economic value.

Political power.

Women's disadvantage in terms of political participation is also associated with the gender division of labor and the status accorded to their work. Women hold less than 10% of the high political posts in the institutions where decisions are made (parliaments, ministries, Supreme Courts) and are seriously underrepresented in all the national, local, and sectoral power structures responsible for setting priorities and allocating resources. These structures include those where health allocations are made.

2. Gender Equity in Health Status

Women throughout the world tend to live longer than men and to exhibit lower mortality rates at every age. This does not necessarily mean, however, that women enjoy better health. Mortality indicators reflect only the extreme deterioration of health and tend to conceal deep disparities in the well-being of those who survive.

Gender equity in health status does not mean equal mortality or morbidity rates for both sexes. It means the absence of *avoidable* differences between women and men in terms of opportunities to survive and enjoy health and the probability of not experiencing disease, disability, and premature death from *preventable* causes.

Within the general context of gender equity in health status, the following aspects should be emphasized:

☛ ***The greater longevity of women is not, nor has it always been, the norm: hostile conditions in the social environment can reduce and even nullify the female survival advantage.*** Lower mortality among women has not been a constant over time, and it is not true for all countries, age groups, and socioeconomic levels.

- Women's longer life expectancy, currently characterizing industrialized nations, did not exist in these countries at the early part of the 20th century, nor does it in certain African and Southeast Asian nations today.¹⁵ Higher female mortality has been associated not only with high maternal mortality rates during the reproductive years but also with patterns of heavy discrimination against women throughout their lives.
- In addition to the **15 to 49-year age group**, another group in which excess female mortality is found with alarming frequency is the **1 to 4-year age group**.¹⁶ Given the acknowledged female biological survival advantage at the beginning of life--even in

¹⁵ World Health Organization, *World Health Report, 2001*, Statistical Annex.

¹⁶ Ravindran, S., *Health Implications of Sex Discrimination in Childhood. A Review Paper and an Annotated Bibliography*. Geneva, World Health Organization, 986. Document WHO/UNICEF/FHE 86.2; Gómez E., "Sex discrimination and excess female mortality in childhood" In: Gómez E. (ed.) *Gender, Women and Health in the Americas, Pan American Health Organization, Scientific Publication No. 541*, 1993.

uterus--), higher mortality in girls than in boys is a serious warning sign about possible discrimination against girls, particularly in the home.

- In Latin America and the Caribbean, the pronounced mortality differential between the sexes at the expense of males that was observed during the 1990s in “non-poor” social sectors dwindled and even disappeared in the “poor” sectors of certain countries (See Figure 6). This phenomenon stems from the fact that the proportional increase in mortality associated with poverty was greater for women than for men, thus illustrating the disproportionate damage that poverty inflicts on women’s health (Figure 6a)¹⁷.

☛ ***The survival advantage does not necessarily mean better health or a better quality of life.*** The empirical evidence shows that women tend to experience greater morbidity than men throughout the life cycle, expressed in a higher incidence of acute disorders, a higher prevalence of nonfatal chronic diseases, and higher levels of disability in the short and in long term¹⁸. Also, due to their greater longevity, women have a higher probability of experiencing chronic diseases associated with advanced age.

☛ ***There are significant sex differences in the prevalence of preventable causes of premature death and disease.*** According to the report of the WHO Commission on Macroeconomics and Health (2001), mortality associated with preventable natural causes is considerably higher for women than for men in low- and middle-income countries.

“...avoidable mortality accounts for about 87 percent of the total chance of death among children up to age 5 in low- and middle-income countries. Among males aged 5 to 29, 60 percent of total mortality was calculated to be avoidable, while for females in the same cohort the figure was 82 percent, the higher level largely due to risks incurred through pregnancy and childbirth. Among women from 30 to 69, 51 percent of the mortality was avoidable; only among men in that range did avoidable mortality fall to less than half total mortality, at 43 percent”¹⁹

Some examples of preventable causes are the following:

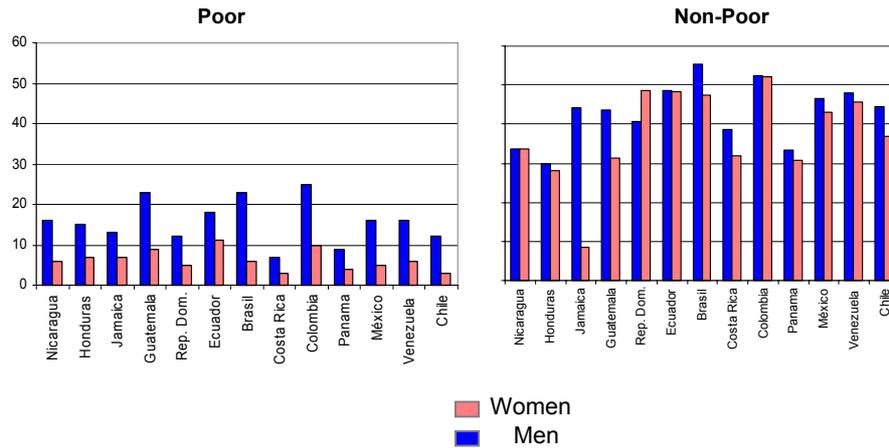
- ***Conditions that exclusively affect one of the sexes and that are highly preventable by the health sector***
 - ✓ *Complications of pregnancy and childbirth* continue to be one of the leading causes of female mortality during the reproductive ages in the Region. Because of its avoidable and unjust nature, PAHO has referred to maternal mortality as the clearest reflection of the discrimination and low social status experienced by women.

¹⁷ Gómez, E. *Equidad, género y salud: retos para la acción. Revista Panamericana de Salud Pública*, Vol. 11, Nos. 5/6, May-June 2002, pp. 457-458

¹⁸ Verbrugge, L.M., “Pathways in health and death” en: *Women, health and medicine in America*. Apple, R (ed), New York, Garland Publishing, 1990.

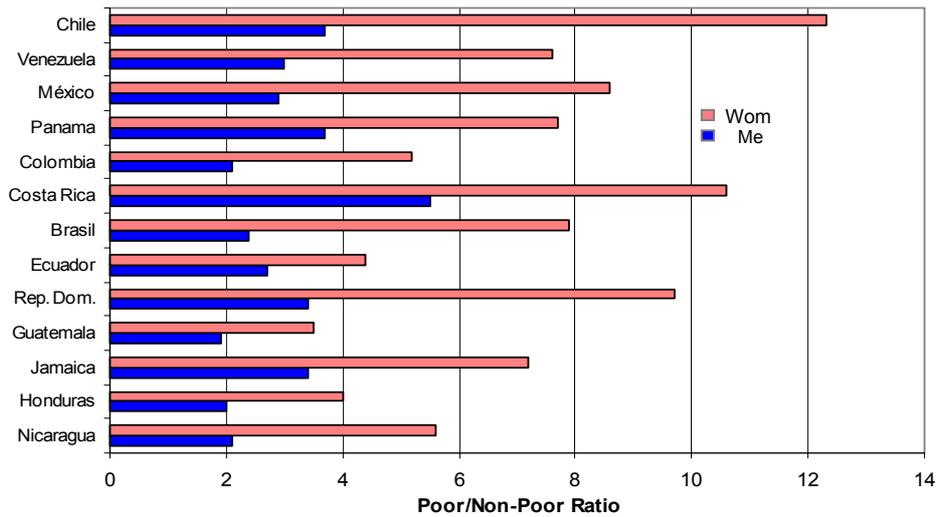
¹⁹ Sachs, J., *Macroeconomics and health: Investing in health for economic development. Report of the Commission on Macroeconomics and Health*. World Health Organization, Geneva, 2001., p. 42

Figure 6: Poverty disproportionately affects women's survival
 Probability of dying (per 1000) between the ages of 15 and 59 years
 in selected countries of the Americas, by sex and poverty status c.a. 1996.



Source: WHO - The World Health Report. 1999

Figure 6a: Being poor is more damaging to women's health than to men's.
 Poor/Non-poor ratio in the probability of dying (per 1000) between the ages 15
 and 59 years, by sex in selected countries of Americas c.a. 1996.



Source: WHO - The World Health Report, 1999

✓Mortality from *cervical cancer* is clearly avoidable, given the availability of simple economical techniques for its early detection and treatment. Still it continues to be a main public health problem in the Region.

Conditions that differentially affect the sexes and that can be prevented by a series of intersectoral measures

✓*Violence* is responsible for the greatest mortality differentials between the sexes and primarily affects men. The differential between the sexes in terms of deaths from accidents and homicides is closely related to the different roles and cultural expectations for women and men, in which “manhood” is associated with certain patterns of risk-taking, protection, and domination.

✓Violence against women is also related to patterns of domination that are tolerated and promoted primarily among men and is the crudest manifestation of the imbalance of power between the sexes.

✓Other significant differentials in terms of the mortality and disease, associated with risk behaviors that are more prevalent among men, are those linked with lung cancer, cirrhosis of the liver, and AIDS.

These examples serve to underscore that, even with different manifestations by sex, the rigid separation of roles, the unequal power relationships between men and women, and the social demands associated with the exercise of power (between and within genders) have clearly negative effects on the physical, psychological, and social integrity not only of women but men as well.

3. Gender Equity in Health Care Use

Health care is only one of the determinants of health; however, it is an important one, particularly for women. Despite the advances in knowledge and medical technology, access to and quality of health care continue to be marked by profound inequalities *between* and *within* countries. Inequities in economic, geographical, and cultural access have been compounded by those created by recent sectoral reform policies that have promoted privatization and regressive financing schemes. In addition to restricting access to care, these policies can impose “impoverishing” costs on those who receive care, thereby deepening existing inequities in living conditions.²⁰

Women’s tendency to utilize health services more frequently than men cannot automatically be interpreted as an expression of social advantage.

Gender equity in health care use does not mean that men and women receive *equal amounts* of resources and services. It means that resources are allocated and services are received *differentially*, according to the particular *needs* of each sex, life stage, and socioeconomic context—irrespective of ability to pay.

The concept of need

As already stated, the notion of *need* is at the center of the analysis of equity in health care. According to principles of distributive equity, there must be a match between needs and services. Therefore, the groups with greatest need should receive more resources.

Women have a greater need for health services than men. In addition to the health problems women share with men, virtually all sexually active women of reproductive age require health services either to avoid or assist a pregnancy. Furthermore, as already noted, women present higher rates of morbidity and disability throughout the life cycle.

Equity in the differential utilization of services by women—and men-- is a research issue that remains largely unanswered, almost unexplored. Without having need as a parameter for fairness, it is impossible to determine the extent to which lesser use of services by men –or women-- is caused by lower levels of need or shortages of care. The task of operationalizing need is certainly a difficult methodological challenge, but it is also an essential requirement for the advancement of the equity agenda.

A frequently used *proxy* for need-- taken from household surveys-- is a person’s experience of disease or accident during a given time period (whose extension varies according to the survey). This proxy has severe limitations, a main one being its

²⁰ Evans, T., Whitehead, M., Diderichsen, F., Bhuiya, A., and Wirth, M., *Challenging inequities in health*.

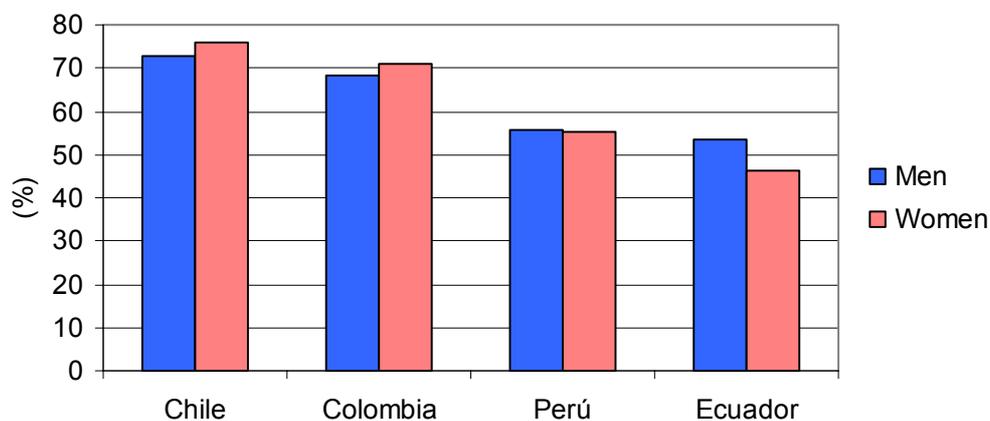
restriction to curative care. Considering that reproductive health services fall heavily within the area of prevention, the use of this proxy produces a significant underestimation of women's health care needs. Notwithstanding this limitation, the information on health service use by persons experiencing health problems shows some interesting patterns that will be discussed here. Women's higher utilization of services is not always the rule. Sex differences in the utilization of health services are influenced by income, age, ethnicity, and place of residence, as well as by variables associated with the way such services are financed and organized (The corresponding information has been taken from a PAHO coordinated research initiative on gender equity in access to health care services, that was developed in 5 countries of the region).

Patterns of health service use

- **Socio Economic Status.** On average, the trend toward greater utilization of services by women crosses all levels of income and household expenditure. This trend showed some exceptions in low-income groups. Indeed, when controlled for need, the utilization of services by low-income women was no greater than that of their male counterparts, a phenomenon that could be seen at country levels --Ecuador and Peru (Figure 7), as well as at low income quintile, as in the case of Peru (Figure 8).
- **Age:** The largest gender differential and the highest utilization of services by women take place during the reproductive years. Gender differences in service utilization tend to decrease, and even to disappear in some countries, during advanced ages. (Fig 9) In addition, studies in some developing countries²¹ suggest greater service utilization by boys than by girls during the initial years of life, and in some cases, through age 15.

²¹ Gómez, E. 1993, "Sex discrimination and excess female mortality in childhood", Op. Cit.

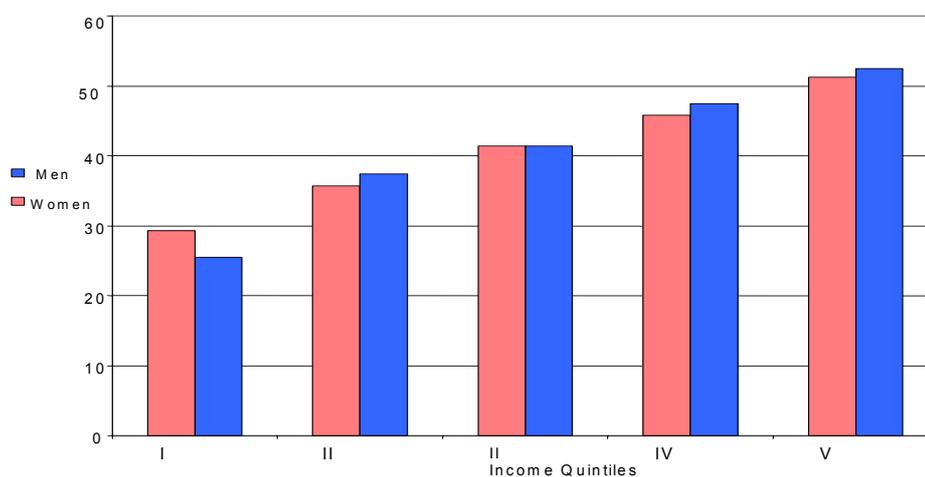
Figure 7: Percentage of persons with health problems who sought health care, by sex, in selected Latin America countries, 1997-2000.



Source: National Household Surveys.

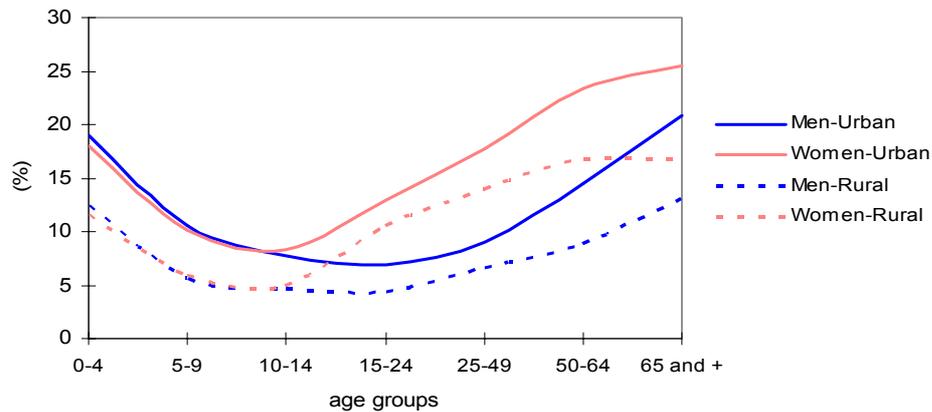
Figure 8

Percentage of persons with health problems who sought health care, by sex and household income. Selected Latin America countries, 1994 – 1996.



Source: LSMS Surveys: Bolivia, Colombia, Ecuador, Nicaragua, Venezuela, 1994 - 1996.

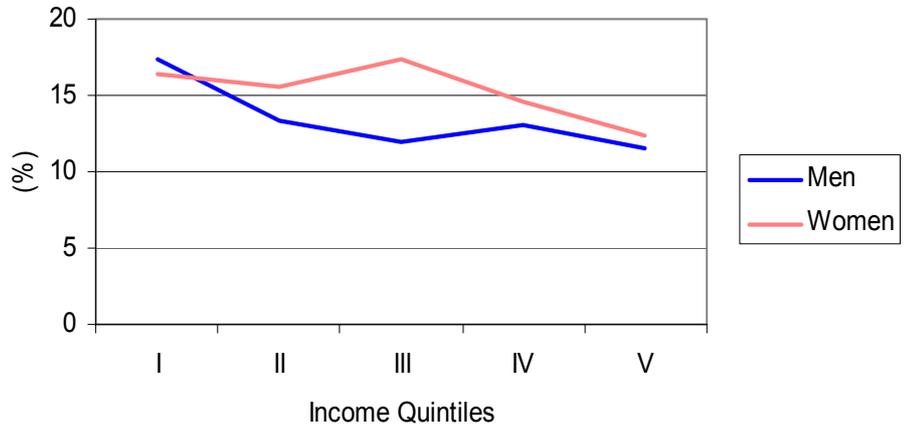
Figure 9: Percentage of persons with health problems who sought health care, by sex, age and area of residence. Brazil, 1998,



Source: National Household Survey, PNAD, 1998.

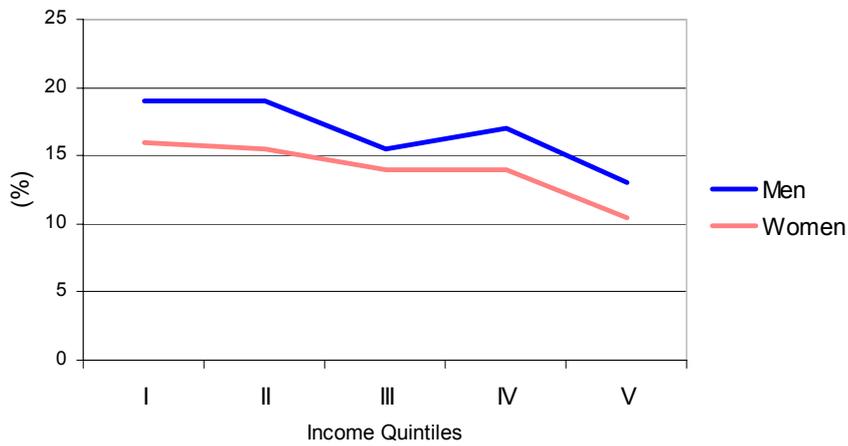
- **Type of Service.** Gender differences in the utilization of services vary according to the type of service actually demanded. Women tend to utilize health services for treatment and, particularly, for prevention, more often than men (Figure 10). Men, on the other hand, tend to utilize emergency services and, in some cases, hospitalization services more than women, as suggested by Figure 11. These trends are due primarily to the differentiated nature of women's and men's needs -- particularly, in the reproductive area, but they also may derive from gender differences in socialization with respect to health care and, possibly, from institutional factors that discourage preventive care for men.
- **Health Insurance Affiliation.** Access to and utilization of health services by sex shows substantive variations based on affiliation to different types of health insurance. Women tend to depend more than men on public insurance programs, as revealed in a study in Chile. Examination of the differential enrollment by age and sex showed that private insurance covers the groups with the least risk of illness (young men), while the public sector includes more women of childbearing age and more older adults. (Figure 12)

Figure 10: Preventive consultation rate (%) by income and sex. Chile, 1998



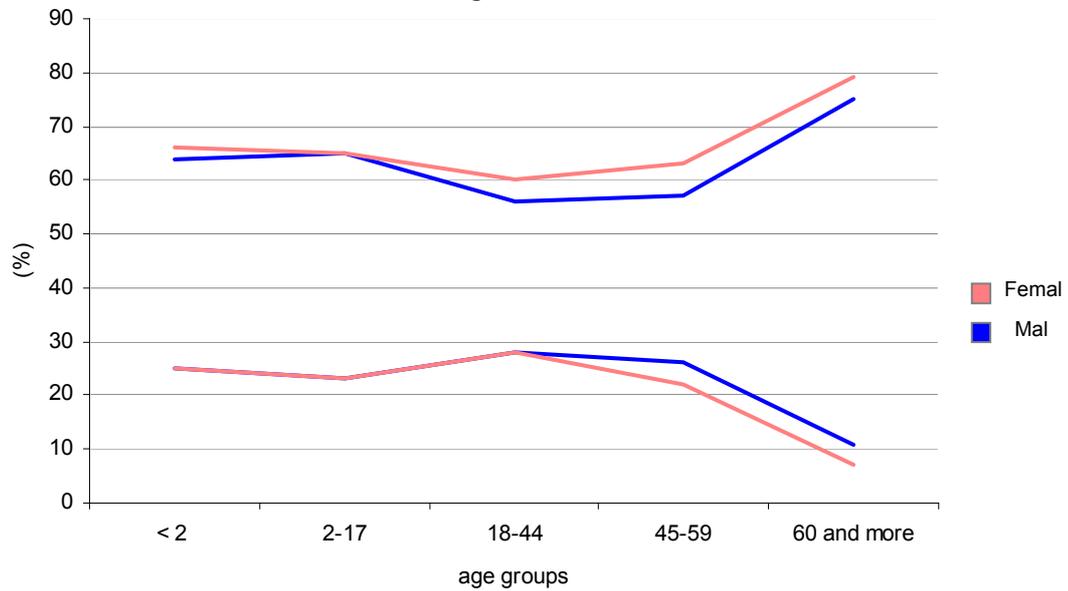
Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud", PAHO, 2001.

Figure 11: Emergency consultation rate (%) by income and sex. Chile, 1998.



Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud", PAHO, 2001.

Figure 12. Percentual distribution of population by health system affiliation, age and sex Chile - 1998



Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud", OPS, 2001.

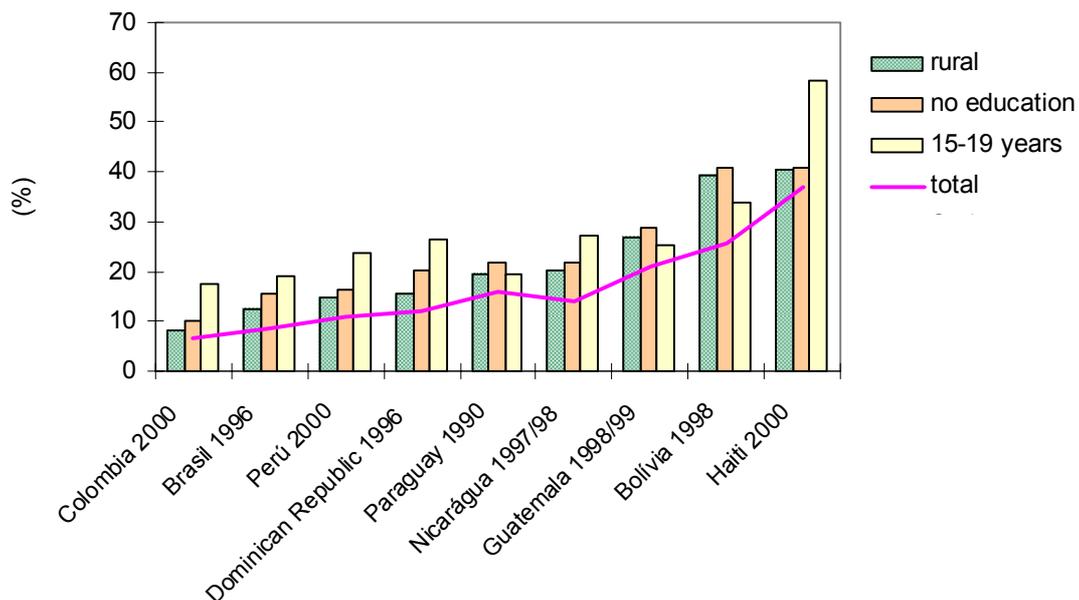
Unmet reproductive health care needs

Operationalizing needs in reproductive health care is an easier task than it is to find reliable information on the degree to which these needs are met. *All* sexually active women, who were pregnant or had a baby, *needed* fertility regulation, antenatal or childbirth services, respectively. The relative simplicity of these definitions does not apply, however, to sexually transmitted diseases, sexual violence and other dimensions of sexual and reproductive health.

The Demographic and Health Surveys (DHS)²² constitute a reliable source of information on needs and responses regarding contraception and pregnancy related services for 13 countries in the Region at specific points in time. The situation in 9 of these countries with information collected after 1990 is as follows:

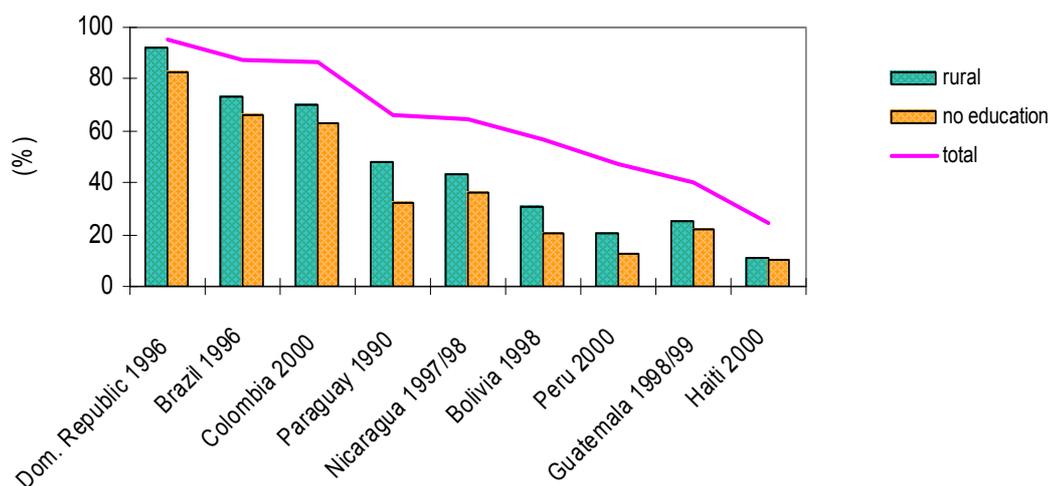
- Non-use of contraception ranges between 72% in Haiti and 23% in Colombia. However, *non-use* cannot be taken as an expression of unmet need, since it may also derive from choice. This choice element has been incorporated in the DHS indicator of unmet need for family planning, which has produced lower percentages ranging from a high of 40 in Haiti to a low of 6 in Colombia. These general averages, however, conceal profound inequities between social groups (Figure 13). Poverty, geographical distances, and sexual taboos cause adolescent, less educated, and rural women—in that order—to exhibit considerable higher than average unmet need for fertility regulation. For instance, adolescent’s unmet need is 3.5 times higher in Haiti (59%) than in Colombia (17%). And unmet need among uneducated women more than doubled that of women with secondary education in all 13 countries, except Haiti and Colombia.

Figure 13: Unmet need for family planning among currently married women in selected categories of education, residence and age. Latin America countries, 1996-2000.



1
2

Figure 14: Percentage of births assisted by trained personnel among rural and low educated women. Selected Latin America countries 1996-2000.



Source: Demographic Health Survey

- Access to professional care during pregnancy and, particularly, during childbirth is dramatically affected by socioeconomic status. In Peru, for instance, the percentage of births that were assisted by trained personnel was 5.3 times among women with secondary education (69) than among non-educated women (13).. Figure 14 illustrates the childbirth care gap between the most under-served categories of women (low educated, and rural) and the national averages for nine countries.. It is important to underscore that, as pointed out by several studies, the extent of professional assistance during childbirth is closely associated with maternal mortality levels.

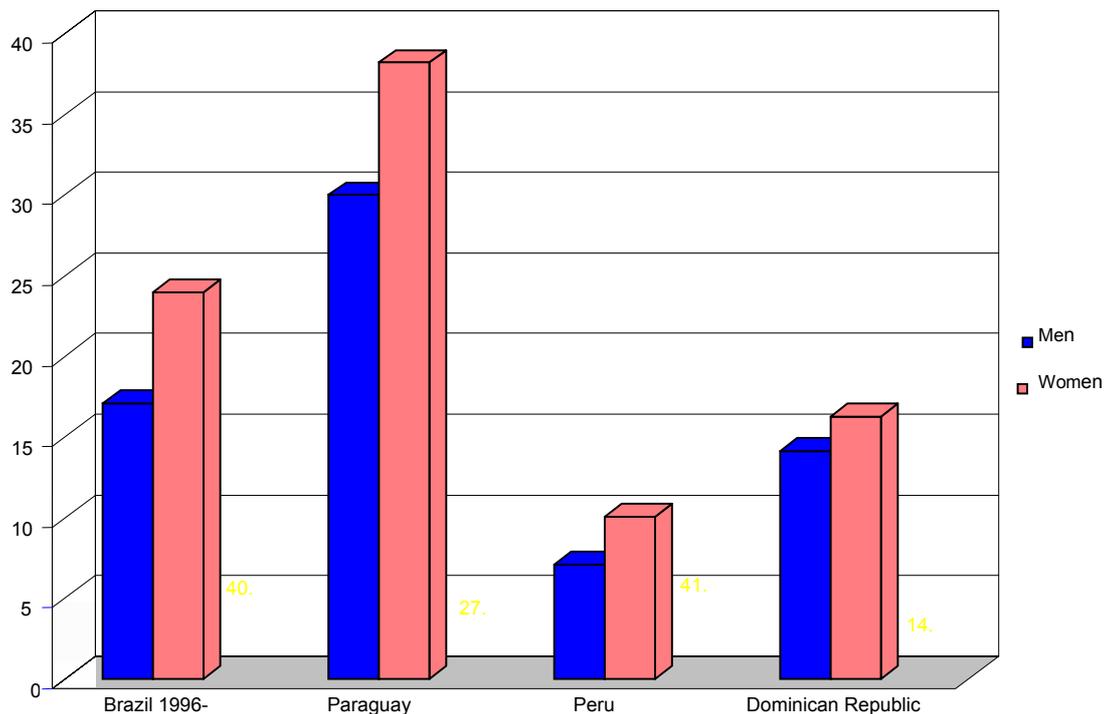
Beyond issues of access, quality of care represents a critical marker of socio-economic, ethnic and gender inequities in health care. The discussion of this subject, however, falls outside the limits of this paper.

4. Gender Equity in Health Care Financing

The principle of equity in which financial contributions are based on the economic capacity of the contributor is generally violated for women, particularly in non risk-pooling health care financing systems. Women tend to pay more than men to protect their health, not only in absolute terms--given their greater need for services-- but also proportionally, due to their lower economic capacity.

- **Higher payments in absolute terms:** In the United States, women of childbearing age pay 68% more than men in out-of-pocket health expenditures²³. In Chile, the private insurance premium during the reproductive years is 2.5 times higher for women than for men. In four LAC countries with information from household surveys, the out-of-pocket health expenditure is 16%-40% higher for women than for men (See Figure 15).
- **Higher payments in relative terms:** Women as a group are less able to pay than men. Given their prominence among unremunerated workers and their disadvantage in the remunerated job market, women have less access both to resources to pay directly for services and to insurance coverage.

Figure 15. Out-of-pocket health expenditures in health, by sex in selected Latin America and Caribbean countries (in US\$) 1996-



Source: LSMS Surveys for Brazil, Paraguay and Peru; Demographic and Health Survey (DHS) for Dominican Rep.

²³ Women's Research and Education Institute, *Women's health care costs and experiences*, Washington DC, WREI, 1994

- ❑ **Gender equity in health care financing requires that the contributions of women and men be based on their ability to pay and not on the risks or needs of each sex at each stage of the life cycle.**
- ❑ **A key requirement for gender equity in the financing of care is to collectively distribute *the cost of reproduction across society* instead of making women in their reproductive years bear the brunt of its cost.**

5. Gender Equity in health development work

Women represent more than 80% of the health workforce. More important, perhaps, and less valued is the fact that women are the **principal health managers and health care providers** in the family and community. In fact, more than 85% of the early detection and care of disease occurs outside the health services and is provided mostly by women in the home and community, free of charge. In addition women play a crucial role in vaccination campaigns, in caring for the elderly, the young, the disabled, and very importantly, for the healthy.

Despite their leading contribution to health development, women remain at a **disadvantage within the formal and informal health system.**

- they predominate in the jobs with the lowest remuneration and prestige in the formal sector, even controlling for type of profession
- they are underrepresented in the local, national, and sectoral power structures that set priorities and allocate resources for health; and
- they perform, without remuneration, most of the informal work in health promotion and health care in the family and the community.

- ❑ **Gender equity in health development work includes but goes beyond guaranteeing equal pay for equal work in the formal health sector.**
- ❑ **It demands recognition and valuation of the unpaid care provided by women in the home and the community**
- ❑ **It requires a just distribution of the actual cost of care, not only between *men and women* but among the *family or community, the State, and the market*²⁴**
- ❑ **It also requires egalitarian participation by women and men--particularly the low-income sectors --in setting priorities and allocating the public and private resources necessary for guaranteeing health.**

Informal care. As the *Human Development Report 1999* points out, studies on the impact of globalization on people have concentrated on the areas of employment, income, education.. Less visible, and frequently ignored, has been the analysis of the effects of these processes on informal care--that is, on the provision of care in the home to children, the sick, the elderly, and the rest of the population that needs to maintain or recover its health and energy for work. This care, known as social reproduction, is essential for economic sustainability.²⁵

²⁴ UNDP, *Human Development Report*, 1999, New York, Oxford University Press p. 82-83.

²⁵ UNDP, 1999, *Op. Cit.*, p. 77

This important UNDP report devotes an entire chapter to the topic of care, pointing out the disturbing impact that globalization is having on this essential function. Globalization is putting a squeeze on care and caring work: (a) Changes in the way that women and men use their time reduce the portion of time available for providing care; (b) fiscal pressures on the state result in cutbacks in public spending on care services; (c) the wage gap between tradable and non-tradable sectors puts an incentive squeeze on the supply of care services in the market.

Gender is a central factor in all of these impacts since, as this document reiterates, women carry the main responsibility for these activities, bear the greater burden, and receive the lowest rewards. Thus, care provided in the home is unremunerated; in the community, it is mostly volunteer work; and in the market, it receives low pay relative to its requirements for education and skills²⁶.

Estimates indicate that women not only work longer hours than men, but they also spend two-thirds of those hours in unremunerated work (men spend only one-quarter their working hours), and most of this time is devoted to providing care.²⁷ (See Table 1 above)

Historically, perhaps more than in any other sector, the health system has relied on women's traditional gender roles and unpaid work. In the past, the provision of informal care was ensured with the gender division of labor, which made care an obligation for women (and an option for men).

The dubious long run effectiveness and sustainability of this type of system, as well as its possible collapse, have not yet taken seriously, due largely to the very invisibility of the unremunerated work of women. In fact, with the growing participation of women in the remunerated workforce, the continued provision of this free care will not be indefinitely available. Compounding this shortage is the growing demand for care derived from two inescapable sources: the demographic trend towards aging of the population and the epidemiological transition towards predominance of chronic diseases. This foreseeable care deficit will assume greater proportions when it is considered that health sector reforms are moving toward cutbacks in public services and privatization of care.

The failure to assign economic value to women's unpaid work is behind outwardly neutral policy concepts such as "cost cutting", "reduction of the state apparatus", "decentralization" that conceal significant gender biases. These policies are gender inequitable to the extent that they imply cost transfers from the remunerated economy to the economy based on women's unpaid work. Thus, the underlying premise of certain adjustment and reform measures is that the government can reduce costs by cutting services (decreasing, for example, hospital stays and institutional care for the elderly and the mentally ill) under the logic that these services can be provided by families. Such adjustments are based on the expectation that women are available, prepared, and morally obligated to provide home care for the dependent, sick, elderly, and disabled. Missing

²⁶ Ibid.

²⁷ UNDP, *Human Development Report 1995*. New York, Oxford University Press, 1995.

from these policies is any consideration of the impact that care provision expectations may have on women's employment status, remuneration, and physical and emotional health. Generally absent is also any proposal for home care support mechanisms, as well as any consideration regarding the efficiency and sustainability of this type of arrangement.

These trends indicate the urgency of explicitly confronting and justly distributing the real cost of care between *men and women*, and among the *family or community*, the *State*, and the *market*. The key challenge for the future lies in developing incentives and rewards that ensure a supply of health care services that recognizes gender equity and the just distribution of burdens and costs among these actors.²⁸

“Aside from looking at the state of advantages and deprivations that women and men respectively have, there is an important need to look at the contrast between (1) the efforts and sacrifices made by each, and (2) the rewards and benefits respectively enjoyed. This contrast is important for a better understanding of gender injustice in the contemporary world. The exacting nature of women's efforts and contributions, without commensurate rewards, is a particularly important subject to identify and explore”²⁹.

In short, the reasons for the emphasis placed on women in the context of gender equity in health are the following:

- ✓ due to their reproductive function, women have a greater need for health services than men
- ✓ due to their disadvantage in the labor market, women have less access to and control over the resources that determine their exercise of the right to health
- ✓ due both to their greater need for health services and their lower economic status, women pay more than men for health care in absolute and relative terms.
- ✓ due to cultural patterns with respect to the division of labor and the value placed on their work, women are granted less remuneration, prestige, and autonomy in the formal health system, assume the unremunerated responsibility for health care in the home, and have less voice in decisions affecting the allocation of resources
- ✓ due to their role as informal health care providers, women are more affected than men by increases or cutbacks in public services

²⁸ UNDP, Op. Cit., 1999, p. 82-83.

²⁹ Anand, Sudhir and Sen, Amartya, *Gender inequality in human development: Theories and Measurement*. New York, Human Development Report Office, Occasional Papers, No. 19, 1995, p.2.

III. HEALTH SECTOR REFORM AND ITS IMPLICATIONS FOR GENDER EQUITY AND REPRODUCTIVE HEALTH

Health sector reforms (HSR) throughout the region are linked to national changes driven by economic processes taking place in the world economy since the last part of the 20th century. They are usually part of a larger package of development assistance in support of health sector programs. Therefore, along with government and national institutions, they involve external multi-lateral actors, and exhibit common denominators associated with global processes

By the mid-1990s almost all the countries in LAC had begun or were considering the reform of their health and social security systems. As part of broad processes of state reform, these sector reforms have been characterized by three major trends: strengthening of private sources of financing, decentralization of services, and improvement of service delivery through private means.

Ideally, HSR reform has been conceived as a “a process directed at introducing substantive changes into the various functions of the sector, with the purpose of increasing equity in the provision of health services, efficacy in its management, and efficiency in the satisfaction of the health needs of the population”³⁰. Equity, quality, efficiency, sustainability, and social participation have been officially declared by most countries as the guiding criteria for these reforms. However, when faced with efficiency demands, equity principles have not always prevailed.

Equity concerns focus on the impact of HSR global trends that limit the ability of the state to ensure the protection of the most vulnerable and to enforce human rights. These trends refer to: the increasing reliance upon the free market to provide health care; a growing influence of international institutions in determining national health policies; cutbacks in public sector spending; privatization of government functions, particularly in terms of financing health care; and the deregulation of a range of activities with a view to facilitating investment and rewarding entrepreneurial initiative. Central to all these traits are the reduction of the role of the state in economic affairs and the strengthening of the private sector role³¹.

From the gender perspective, one might pose the following general questions with respect to HSR:

- ❑ Does HSR help to reduce, exacerbate, or perpetuate gender inequalities in health, health care, and participation in health development work? And more specifically,
- ❑ To what extent does health sector reform facilitate or hinder the exercise of health rights, particularly the exercise of women’s reproductive rights?

³⁰ Panamerican Health Organization, *Cooperation of the Panamerican Health Organization in the Health sector reform Processes*. Washington D.C., PAHO, 1998, p.13.

³¹ World Health Organization, *25 questions and answers on health and human rights*, Geneva WHO, 2002, p.24

In this kind of inquiry it is essential to reiterate that, notwithstanding the presence of certain common denominators in the socioeconomic disadvantages of women, gender-based categories are not homogeneous. There are significant differences among women themselves, based on factors such as age, class, race, and nationality--differences that demand that such factors be explicitly addressed in the analyses and interventions carried out.

Some gender equity implications of the most common components of health sector reform in the Region are outlined below. Since there is considerable overlap among these categories, some topics will be mentioned in more than one component³². These components have been classified in the following manner:

- Definition of priorities and cost effective interventions.
- Decentralization and promotion of social participation.
- Restructuring of human resource development and administration systems.
- Restructuring of financing systems, including private sector participation

These policies will be discussed from the triple perspective of their contents, process, and impact. The contents are the goals and activities--e.g., decentralization, privatization of financing, targeting. The processes have to do with the relationships among institutional actors and the manner in which they develop goals and activities. And impact alludes to the manner in which the actors react to or are affected by such activities. From the gender perspective, the emphasis on processes and impact is fundamental, since it allows to critically examining how reform is affected and how it affects the social and economic relationships between the sexes.

1. Definition of priorities and cost-effective interventions

A fundamental equity concern is related to the criteria used to determine priorities and cost-effectiveness of interventions. In this regard it is essential to find out how health needs were identified in the population at large and in special groups. This means asking what needs were considered priorities, by whom, and on the basis of what criteria. It is also important to ascertain whether the models of care and the proposed "comprehensive" care packages actually include promotional, preventive, curative, and rehabilitative services, and if the care models integrate activities that were once separate.

From a gender perspective, it is essential to consider

First to what extent the *contents* of care models and basic packages of services respond to the particular health needs and rights of women-- and men, and consider women's needs beyond those related to maternal health. Here, it is necessary to emphasize that the particular nature of these needs and rights stems not only from the biomedical dimension

³² The main elements of the discussion that follows have been adapted from the work of Hilary Standing, *Gender and Equity in Health Sector Reform Programmes: A Review*. Health Policy and Planning; 12(1):1-18, 1997.

of reproduction, but also from group's living conditions, and gender-specific roles and relations.

A gender approach to models of care implies that, in planning the content and delivery of health services³³, consideration is given to:

- ❑ all stages of the life cycle;
- ❑ exposure to specific health risks and access to resources, associated with the discharge of responsibilities socially assigned to women and men;
- ❑ growing frequency with which women are called upon to perform a dual role (paid labor and domestic work);
- ❑ unequal power relationship between women and men.

Secondly, questions should be directed to the *processes* of identification of needs and priorities. Information is needed on the nature of data sources, the extent to which women were consulted and how much they participated in determining needs and negotiating care priorities. It is relevant to ascertain whether the government agencies in charge of women's affairs, non-governmental organizations working for gender equity, and women's organizations have intervened in these processes. It is also important to investigate what methodological *instruments* were employed in setting priorities, and what gender biases may be concealed in these instruments. The DALY (Disability Adjusted Life Years) is an instrument widely used in the Region for the purpose of calculating the burden of disease and identifying intervention priorities. This methodology has been criticized, among other reasons, for its implications for gender equity and reproductive health. On one hand, it may discriminate against some women's illnesses that often are asymptomatic and undiagnosed. But more important, due to its emphasis on mortality, disease and disability, it greatly underestimates the importance of reproductive health services that do not conform to these negative criteria and which respond to a sizeable portion of women's health needs³⁴.

Third, concerning the impact of policies aimed at the reorganization of the health services, mechanisms should be sought to assess the impact of the new models and benefits packages in terms of meeting the health needs of the general population and groups with special needs, including women. The participation of civil society and, in

³³ A typical example of interventions based on such considerations would be the introduction of services to address domestic violence and obstacles to the free exercise of sexual and reproductive rights. Another example would be the organization of service delivery to take into account the constraints experienced by *certain groups of women* in terms of: information, geographical mobility, schedules, independence in decision-making about certain types of care, taboos on being examined by male professionals, and low priority assigned to their own needs versus that of their children.

Revaluing women's time is vital for the promotion of equity in the health services. Traditionally these services have operated under the assumption that women's time is both free and elastic when seeking care for themselves or their children and providing follow-up care in the home. In this regard, it would be necessary to investigate, for example, to what extent coordination has been achieved between maternal and child health services, and whether specific support is being provided for care in the home. Furthermore, it is important to determine whether interventions in reproductive health, domestic violence, and child growth and development are targeted exclusively to women or whether they include men in some way or another. Finally, with regard to cutbacks in certain services, it should be reiterated that reducing public spending on health may shift an excessively onerous burden onto the unremunerated reproductive economy by increasing the time women spend in providing necessary care for family members.

³⁴ The calculation of DALYs and their use in resource allocation have been severely criticized for their "economicist" bias and their underestimation of the burden of disease in women. For an interesting review of this criticism, see Hanson. WHO, *DALYs and Reproductive Health: Report of an Informal Consultation*. WHO/RHT/98.28, Geneva, 1999; Hanson, Kara, *Measuring up gender, burden of disease and priority setting techniques in the health sector*. Cambridge, Harvard Center for Population and Development Studies, Working Paper Series 99.12, 1999.

this particular case, of women's organizations, becomes crucial for this reform strategy to contribute to the achievement of equity and rights objectives.

2. Decentralization and Promotion of Social Participation

Decentralization is not limited to the Health sector but it cuts across other sectors. It is a strategy widely used because its potential benefits among which there are enhanced local ownership and accountability for government programs, and increased correspondence with local needs.

Equity concerns have essentially referred to inter-regional inequalities in the distribution of resources. However, there has been very little concern to date about internal community processes and the vitally important problem of identifying the circumstances in which decentralized systems improve access or further marginalize under-served groups. The possible implications of decentralization for gender equity have received almost no attention.

Depending on how it is designed and implemented, decentralization may have opposite effects on women's participation at the local levels. Thus, while decentralization may constitute a window of opportunity for increasing women's participation in local power structures, it may further exclude them and their interests, and can also give rise to a disproportionate increase in the unremunerated work performed by women³⁵.

Reproductive health services considered a priority at international and national levels may lose that rank at a local level where the role of women's rights advocates is weaker. Access to contraception--particularly by adolescent girls— emergency contraception, STD prevention, gender-based violence care, and treatment of abortion complications, may disappear altogether from the more conservative community health care settings.

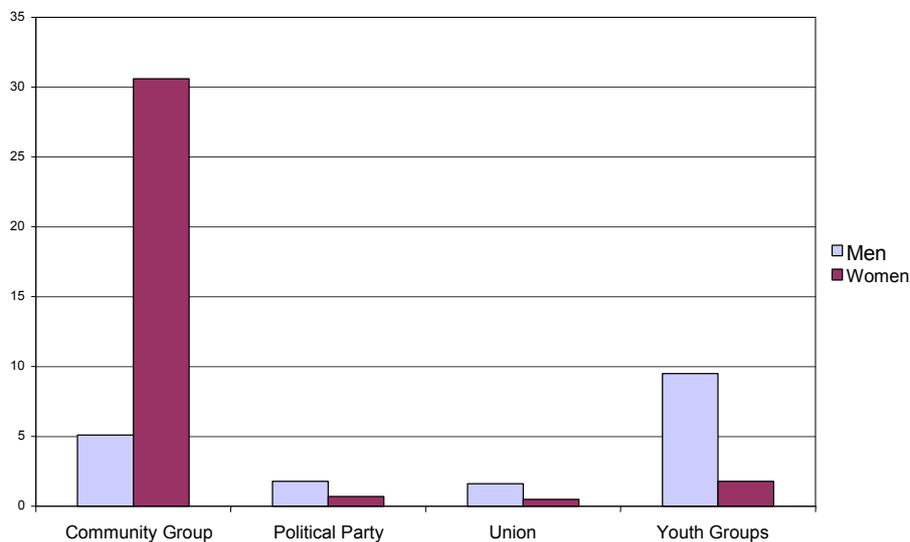
The decentralization modality that involves transferring the health care financing burden from the central government to the local community can have an adverse impact on the mitigation of poverty. A strategy of this nature "*raises the broader questions of the link with cost recovery and the use of decentralization as a tool for greater community level participation in health care delivery*"³⁶. Community participation then becomes a means to an end rather than an exercise of democratic rights. In this context, it is important to note that the unpaid health care provided by women in families and in communities has frequently been used as a structural adjustment variable.

³⁵ Wuest, Judith, Institutionalizing women's oppression: the inherent risk in health policy that fosters community participation, *Health Care for Women International*. 14:407-417, 1993.

³⁶ Standing, Hilary, 1997, Op.cit, p.7

As to representativeness, it must be noted that while women are more actively involved in health activities, community “spokespersons” tend to be predominantly men who do not necessarily consult women or represent their interests. Therefore, unless mechanisms are created to actively promote and support the participation of groups traditionally excluded from the power structures--among them, indigenous populations and women--decentralization runs the risk of reinforcing preexisting local inequalities in access to power that have traditionally excluded women. This risk is compounded by the lack of development of institutionalized mediation systems that address cases of intra-community inequalities.

Figure 16 : Community Participation
Cisne, Guayaquil, Ecuador - 1992



Source: Moser, Caroline, *Household responses to poverty and vulnerability*.

Washington, D.C., World Bank, 1997.

From a gender equity perspective it would be useful to ask the following questions:

- What kind of representation do women, particularly poor women, have in community power structures? Do they participate at the decision-making levels, that is, in priority setting, program planning, and resource allocation?
- Who gains and who loses in these decisions? What are the implications of decentralized allocation decisions for reproductive health rights?
- What are the needs for organizational support that would strengthen community decision-making structures and generate greater participation by traditionally underrepresented groups, such as indigenous populations and women?
- What mechanisms could be implemented to increase women's participation in decision-making without increasing their workload?

- Who would, and through what mechanisms, arbitrate and redress inequitable decisions regarding internal allocation of community resources?

If a transfer of responsibility for health services from the state to the community has occurred or is going to occur,

- Does this transfer imply a greater burden for women in terms of providing home care for dependents, the sick, the elderly, and the physically and mentally disabled?
- What structures are or could be in place to support home care?
- Has the impact of this additional burden on the people who provide the care and on those who receive it been considered or investigated? What effect can this work overload have on the effectiveness and sustainability of home care?

3. Restructuring health sector employment

The restructuring of human resources management systems, which includes among other elements, reductions in staffing; flexibilization of contracts; modification of remuneration, grading and evaluation systems; and redefinition of jobs, training programs, and incentive systems, has major implications for gender equity³⁷.

- a) Women's employment in this sector is particularly vulnerable to any significant reduction in staffing levels or in contractual stability, given the preponderance of women in certain occupations and in positions of less power.
- b) The experience of many developing countries suggests that women tend to use certain health services if the providers are women and, in some cases, would use them only in such circumstances. Consequently, maintaining appropriate levels of female personnel becomes a very important factor in the use of such services.
- c) As a result of the interaction between the formal and informal health care sectors, policies that have an impact on staffing in the health services simultaneously affect the magnitude of the informal care burden that devolves predominantly upon women.

From the perspective of the impact on gender equity, it would be then appropriate to ask:

- What impact has the health sector reform's human resource policies had on the composition by sex of the personnel in the various decision-making levels in the systems' public and private sectors?
- Which professions have undergone the greatest changes?
- Have these reforms had a different impact on men and women at comparable levels of occupational status, e.g., in incentives and continuing education policies?

And, turning again to the issue of interdependence between the formal and informal health sectors,

³⁷ Standing, Hilary, Op. Cit., 1997

- To what extent are the staffing reductions in health services being offset by the unremunerated work of community health workers (most frequently women) and/or women in households?

4. Expanding options for public sector health financing and private sector participation

An equitable financing system is that in which economic capacity—not need or risk-- is the parameter to determine contributions to health care financing. Progressive general taxation is the most equitable form of financing health services, while out-of-pocket payment is the most regressive and least equitable; social insurance schemes fall in between. HSRs that promote regressive financing systems and privatization of health care also generate health and economic inequities, affecting most negatively those individuals and groups with less resources and higher health risks. Financial barriers to needed care can have health damaging effects, and even when care is accessible its costs may be impoverishing. In this context, the topics that have aroused the most spirited debate on equity have been cost recovery in the public sector and privatization in health care financing.

The debate has essentially revolved around the impact of these policies on the poor, and there is sufficient evidence to determine that the poor are the losers regarding access to health care services. However “the poor” is a heterogeneous category-- particularly when they constitute a majority-- that needs to be disaggregated to facilitate the identification of the most vulnerable among them and the precise effects of different types of health financing modalities on these groups. Important markers of inequity in this respect are socioeconomic status, gender, age, ethnicity, rural-urban residence and marital status. Given the scarcity of this type of disaggregated information, it does not come as a surprise that the sex-differentiated impact of these new finance measures has been largely neglected, except in reference to MCH services.

From a gender equity perspective it is imperative to analyze health care financing policies in view of the differences between women and men in terms of roles, needs, access to and control of income, and intra-household distribution of resources. From this perspective it can be affirmed that, in general terms, the levying of user charges (public or private) generally takes a heavier toll from women-- especially the poor—due to women’s greater need for services, more limited control of income, social responsibility as principal caretakers, and increasingly frequent role of sole providers in the household.

In connection with the latter, it ought to be stressed that the cultural responsibility of women for the health care of their family members is not restricted solely to the in-kind contribution that characterizes their reproductive work. With rising frequency, it also represents monetary payments to cover medical care, particularly for their children and, increasingly, their elderly parents. This responsibility is not shared in a sizable number

of cases, since, for example, the proportion of households headed by women already exceeds 30% and even 40% in Latin America and the Caribbean. The vast majority of laws that oblige fathers to contribute to the upkeep of their children are largely ineffective. Several studies have shown that contributions from absent fathers are minimal or non-existent. Mechanisms to enforce them are very limited and time-consuming for mothers³⁸

Within this general context, more specific questions need to be asked³⁹: For instance,

- Which groups suffer most from specific health care financing modes? Are women and men differently affected within those groups, and which categories of women and men are more vulnerable? (For instance, children in poor female headed household, widows, elderly men or women without close relatives, individuals with disabilities, orphaned children and adolescents).
- What has been the impact of the various measures (community financing, exemptions, subsidies, etc.) used to mitigate the impact of these measures on the most vulnerable? How do these various measures affect access and utilization by gender?
- Who, **within a household**, gets access to health care? What **types** of services are used and **by whom**?
- How are women differentially affected by health insurance schemes tied to employment status?
- Does more spent on health, whether through preference or necessity, mean less spent on education, for instance? And which categories of individuals gain or lose?
- What is the proportion of income spent on out-of-pocket health expenditures in different groups? Does it differ by financing option and by sex? What is the proportion of women's income spent on out-of-pocket expenditures for reproductive health? Does it vary by financing option?

And specifically, with regard to the public/private sector mix in financing health care,

- Are vulnerable groups more or less likely to be served by the private sector? Are reproductive health care needs more or less likely to be met in a mixed economy of health care?
- How are reproductive health services (family planning, prenatal care, care in childbirth, maternity leave, breast-feeding) financed? On whom do such costs

³⁸ Inter-American Development Bank, Women in the Americas: Bridging the gender gap. Washington D.C., IDB, 1995, p. 36.

³⁹ The main source for this discussion is Standing, H., 1997, Op. Cit, pags. 10-13.

fall? On governments through redistributive tax mechanisms, on employers, on donors, on other actors, or on women themselves? What reproductive health services are excluded or are totally or partially subsidized in different types of insurance plans? (In this regard the Free Maternity Law in Ecuador is particularly noteworthy; this law was modeled on the experience of Bolivia).

- To what extent is the private sector providing preventive services and contributing to the achievement of public health objectives? This is a particular important question considering that, aside from being the main *users* of preventive services, women also absorb as *caretakers*, much of the additional burden imposed by, for example, infectious diarrheal diseases in children
- To what extent contractual frameworks are, or can be, devised with the private sector to improve equity or to counter existing or potential inequalities in provision, such as by explicitly addressing women's health needs or inequalities of access through the contracting process? Has the government established regulatory frameworks to set standards for service delivery by the private sector? Are these regulations aimed at improving equity or counteracting existing or potential inequities in services provision? Do they explicitly address the health needs of women and gender inequities with regard to access?

The Chilean case

The process of HSR in Chile serves as an illustration of the type of gender inequities that frequently derive from private sector participation in health care financing. (The corresponding information has been taken from a PAHO coordinated research initiative on gender equity in access to health care services, that was developed in 5 countries of the region)

Reproductive health needs are more likely to be served by the public sector. As already mentioned in relation to *system affiliation* (Section II, Figure 12), women outweighed men, and older adults outweighed the young in the public system. By contrast, the groups with the least need for health care --young males-- constituted the majority of affiliates in the private system, which simultaneously enjoyed higher per capita resources.

- The compositional difference between the two systems corresponds with the structure of insurance premiums charged by the private health system which, in effect, discriminate against old adults and reproductive age women (Table 2). Thus, in the private health system women's premiums more than doubled men's in the 18 to 44 age group, and were 1.5 times larger than men's in the 45-59 group. By contrast, the premiums for the 60+ group were five times higher for males than for females.
- In terms of effective utilization of services, it was evident that *only in the public sector*, use of services in the 18-44 age group was higher for women than for men. Clearly, privately insured women frequently resorted to the public system as a source of reproductive health services that were not included-- or included at high costs-- in

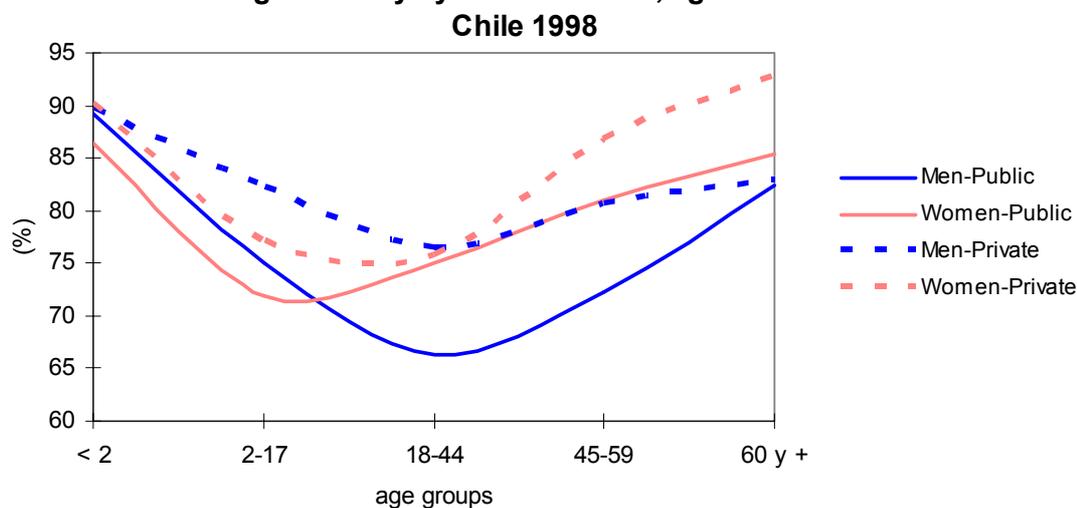
their private insurance plans (Figure 17). This pattern has been recognized as a type of cross-subsidy from the public to the private sector.

Table 2: Private Insurance premium factor, by age and sex. Chile, 1998.

	Age Groups				
	0-1	2-17	18-44	45-59	60 +
Male	97.3	32.9	42.5	84.7	214.6
Female	82.9	33.8	92.5	130.6	42.8
Ratio Female/Male	0.9	1	2.2	1.5	0.2

Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud", PAHO, 2001.

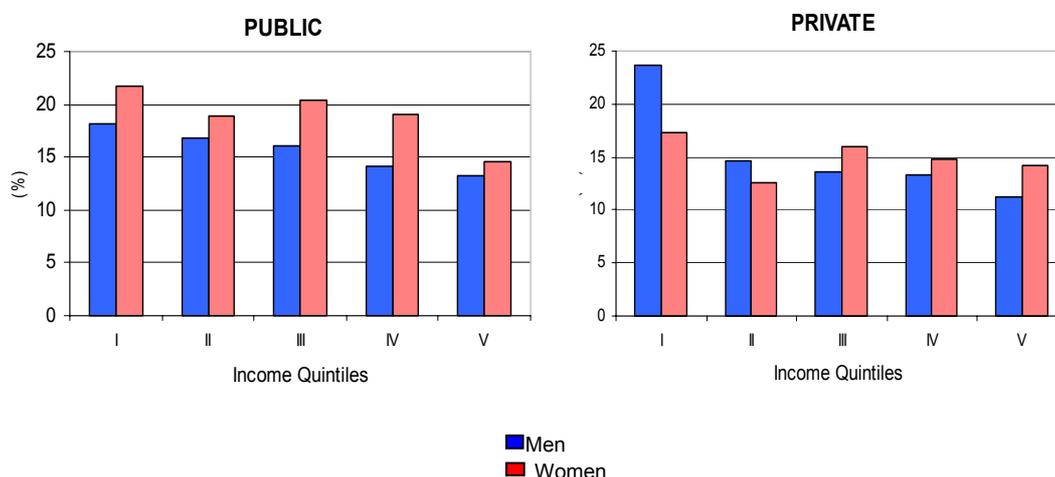
Figure 17: Percentage of persons with health problems who sought care by system affiliation, age and sex.



Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud", PAHO, 2001.

- When conditions favor general access to health care, women tend to use preventive health services more frequently than men. However, when socioeconomic status limits such access, the relationship between gender and use of preventive services is less clear. In Chile, women's use of preventive care services was on average, much higher than men's use (Figure 10 in Section II). However, when type of affiliation was considered, the tendency toward higher women's utilization was maintained across all income levels in the public sector, but only among higher quintiles in the private sector. In fact, women's use of preventive services was lower than men's among the poor affiliated to private systems (Figure 18).

Figure 18: Preventive consultation rate by public/private system affiliation, Income, and sex. Chile, 1998.



Source: Vega, J. et al. "Equidad de género y acceso a servicios de salud". OPS. 2001.

To complement the Chilean information it is useful to recall the USA case, where reproductive-age women were found paying 68% more on out-of-pocket health expenditures than men in same age group.⁴⁰ As in Chile, USA women's higher health expenditure was linked to their reproductive health needs. In fact, the spending on reproductive health services represented one-third of all health expenditures by women in this age group. Such high portion was basically due to their more frequent use of services, high co-payments for obstetric care, and lack of family planning coverage⁴¹ by most insurance plans.

In the majority of countries, access to health insurance--and to specific services within that insurance-- depends not only on income but also on being employed in the formal sector. Logically, the distribution of men and women around income and employment categories differentially affects their access to insurance. It must be noted that women's indirect access to insurance as dependents (and not subscribers) puts them—and their children—in a vulnerable position in the event of widowhood, marital separation, changes in the spouse's employment status, or changes in the regulations governing coverage for dependents. In this context it is important to note that more than 30% of households in this region are headed by women.

⁴⁰ Women's Research and Education Institute. *Women's Health Care Costs and Experiences*. Washington, D.C., 1994, p.2.

⁴¹ Women's Research and Education Institute. 1994, Op. cit. P.3.

Given the gender division of labor, remuneration, and social benefits, it is clear that as long as social security and insurance plans remain employment-based, the majority of women will not enjoy access to health care in their own right.

IV. CHALLENGES AND STRATEGIES FOR INCORPORATING THE GENDER PERSPECTIVE INTO HEALTH SECTOR REFORM

1. Challenges

Incorporating the gender perspective into health and social security reform policies requires a response to three major challenges:⁴²

- Generating knowledge about gender inequalities in health and their relation to reform policies at the national and sub-national levels in the Region;
- Facilitating access to this information by the pertinent stakeholders in governments and civil society;
- Promoting evidence-based advocacy to support priority interventions leading to greater equity in health;
- Supporting key stakeholders in government and civil society for developing institutional mechanisms that will permit these priorities to be incorporated and sustained into the policy management process.

Generation and Dissemination of Information

At present, the discussion of gender equity and reform is supported only by fragmentary empirical evidence and general conceptual "principles". The lack of a solid information base as a foundation for policy formulation is a particularly urgent problem when discussing the impact of the reforms. This deficiency is not limited to the gender dimension, but extends to the entire sphere of social inequalities. However, in the case of gender it is exacerbated by the scarcity of routine information in the health sector with a breakdown by sex. It is important to emphasize, nevertheless, that although the health sector does not systematically obtain or publish sex-disaggregated—except with regard to mortality—relevant health information from household surveys is available in a sizable number of countries in the Region. This information, which is currently underutilized, would facilitate the measurement and monitoring of inequalities in health, access to care, and health financing.

The first need with respect to the generation of information is the development of gender-sensitive indicators and gender inequity indicators,⁴³ together with evaluation and monitoring instruments. Some of these indicators will be applicable regionally, whereas others will be context-specific. Parallel with such development, it is essential to promote and support research to document the differential impact of reforms on various social groups and on the women and men in these groups.

⁴² Adaptation of the classification proposed by Standing, Hilary, in *Reflections on Gender and Health Reforms in the Context of Severe Health Inequalities*. Paper presented at the Meeting of the Consultative Group on Gender Equity and Reform, Washington, D.C., PAHO/HDW, October 1998.

⁴³ Anand and Sen, *op. cit.*, 1995.

The information thus generated will be translated into appropriate languages for different audiences, will emphasize its relevance for human rights, and will be made easily accessible to orient political and technical decision-making, empower the civil society groups involved, and raise general awareness among the public.

Political Advocacy and Institutionalization of Changes

Generating information, obviously, is not enough to produce changes in policy. Utilizing knowledge to bring about change will require the sensitization of policymakers and the strengthening of technical capacity at the planning level regarding gender issues and gender analysis. This “training” component is essential for providing the state with the technical support needed to exercise its steering role in policy development and the establishment of regulatory frameworks for private sector participation.

Even more decisive for achieving these objectives to improve gender equity in policies is bolstering the technical capacity and advocacy of civil society, particularly of organized women's groups. Experience shows that the distribution of public resources in a society reflects the distribution of power among the groups that make up this society. Political articulation and “empowerment” of the groups that work in defense of gender equity are essential for moving in the direction of a more just distribution of resources and benefits, and more importantly, for ensuring the sustainability and social control of the changes achieved.

The work program that PAHO is attempting to implement has been designed to address these challenges and promote gender equity in HSR, taking advantage of their institutional incorporation in two types of scenarios: First, the national scenarios, where it engages in technical cooperation to strengthen local capacity for the analysis, evaluation, and monitoring of HSR policies; and second, the international scenario, where the sharing of experiences and joint efforts is facilitated through promoting the production, adaptation, and application of the knowledge generated in the countries. Collaboration between countries in this effort is particularly important, because of the opportunity that it offers to evaluate various policy alternatives, learn from each other's successes and failures, and foster changes that are regional in scope.

2 Strategies

PAHO's basic strategy in this respect is to promote dialogue and coordinated activities among technical teams and advisory groups representing relevant sectors of government and civil society. The joint efforts of these actors revolve around diagnostic studies, identification of priorities, formulation of corrective policies, and implementation of mechanisms to monitor compliance with and impact of such policies.

In the initial stage, the activities are taking place at the regional level and in two countries, Chile and Peru, that were selected on the basis of one or more of the following criteria: a) sustained development of health and social security reform processes that facilitate impact assessment; b) national authorities' interest in integrating the gender

equity perspective in the contents and processes of reform; and c) presence of an organized women's movement interested in participating in public policy-making. An extension of this initiative is planned for four countries in Central America during 2004-2005.

Activities at the regional level consist basically of the following:

- Development of basic indicators and analytical guidelines for identifying, measuring, and monitoring inequities associated with HSR, with special emphasis on gender inequities;
- Construction of a regional database on women's health and health related sex-differences.
- Coordination with other international agencies to complement and reinforce common lines of work, mobilizing financial and technical resources to achieve the proposed objectives;
- Dissemination of useful information for advocacy and planning;
- Technical and logistical coordination of multi- country activities;
- Facilitation of mechanisms for sharing knowledge and experiences among countries;
- Consolidation of research findings and recommendations for action;

The main activities at the country level consist of the following;

- Review and adaptation of regional basic indicators and development of new specific country indicators
- Workshops on gender and health for politicians, planners, and nongovernmental organizations;
- Establishment of cross-sectoral partnerships involving, at the very least, the ministries of health, departments of women's affairs, bureaus of planning and statistics, research institutions, and organized women's groups.
- Carrying-out situation analysis and evaluation of HSR policies.
- National forums to discuss the findings of the analysis;
- Identification of needs and setting of priorities for action, with the participation of stakeholders;
- Concerted policy formulation
- Creation of government/civil society mechanisms for monitoring compliance with policies

SUMMARY AND CONCLUSIONS

This paper attempted to identify, from a gender perspective, the most important equity implications of HSR in the Region. Specifically it examined the relations between health sector reforms and a) health situation and its determinants; b) access, utilization, and financing of care; and c) balance between contribution and rewards with respect to health work.

The conceptual tripod of equity, gender, and participation constituted the basis for the health policy discussion, which underscored the interrelation of these three concepts. Health was presented from the human rights perspective, as a positive concept that includes both physical capacities and personal and social resources, therefore not constituting neither the exclusive province of the health sector nor limited to individual healthy lifestyles. Regarding *equity*, it was pointed out that not all differences constitute inequity and that this term is reserved to designate those differences considered avoidable, unnecessary and unjust. In relation to gender, it was emphasized that the focus of the gender approach is one of the sexes but the *relations of inequality* between women and men. It was called attention to the fact that the guiding vision of this approach is that of an equitable society in the *distribution of the resources* and benefits of development and in the *participation* of its members in the decisions that shape that development. It was further emphasized that the meaning assigned to participation is not instrumental, but referred to the citizens' right to influence and demand accountability regarding the political processes that affect their well-being. It was also accented, that a gender approach is not reductionist: It does not restrict its aim to the analysis of inequalities between women and men, but points to the systematic interaction of these inequalities, with those of class, race, age, and geographical residence.

Four types of reform policies frequently implemented in Latin America and the Caribbean were examined from the perspective of their implications for gender equity. These policies were: (a) decentralization and promotion of social participation. (b) Reorganization of services, including redefinition of care models and determination of basic service packages. (c) Restructuring of the systems of development and administration of human resources. (d) Restructuring of the systems of financing, including the participation of the private sector.

The analysis of these health sector reform policies highlighted the following elements:

1. The conceptual bias that permeates the economic policies causing women's work to be severely undervalued: the economic contribution of their "reproductive" work is ignored and their "productive" work is underpaid.
2. The importance of recognizing the interaction existing between the spheres of formal and informal provision of health care, and the unequal impact of this interaction on men and women.

3. The need for understanding the different positions of women and men as producers and consumers of health goods, and the inequities ensuing from this difference..
4. The sex-differentiated effects of the policies of allocation of resources, public spending, and financing of care, on the physical and economic well-being of society, and the distribution of its care burden.
5. The implications for society's health, of gender inequalities in access to and control of resources and decision-making.

The goal of minimizing avoidable, unnecessary and unjust differences in health and its determinants encounters three main constraints: (a) Lack of adequate information that permits the identification of the effects of policies and also the groups most affected. (b) Preponderance of economic efficiency interests in the current health sector reforms, and absence of gender considerations in the equity debate of these reforms. (c) Lack of representation of the less privileged groups, women among them, in the power structures that define priorities and allocate public and private resources for health.

For the purpose of confronting these obstacles and seeking the incorporation of the perspective of gender equity into the processes of RSS, a cross-sectoral strategy with stakeholder participation is being piloted in two countries. Its main elements are the following:

1. Improvement of the availability and quality of routine information on health and its determinants, and breakdown of this information by sex, age, and socioeconomic criteria.
2. Analysis of existing inequalities between men and women regarding the production and consumption of health. Emphasis is placed on differences in needs, risks, contributions, access to, and power over health resources. Groups most affected will be identified and measurement and monitoring of the impact of the different types of reforms on these groups will be assessed.
3. Targeted dissemination of the knowledge thus acquired, with a view to inform policy formulation at decision-making and planning levels, "empower" stakeholders in civil society, and shape public opinion.
4. Fostering active participation of the *less heard* groups in society--particularly women--so that they can have voice in the generation, planning and monitoring of solutions.
5. Promotion and support of cross-sectoral institutional mechanisms that address the multiple determinants of health and inequity, and actively involve gender equity advocates from civil society.

In short, and recognizing the importance of the achievement of objectives not only of equity but also of efficiency in the health sector, the preeminence of the ethical values of social justice and human rights is upheld. Within this context, it is further reaffirmed that the right to access and enjoy the resources that ensure health is one that the state (the public sector) directly or indirectly should guarantee. In addition, it is emphasized that this guarantee should be extended, not to a theoretical community-- in terms of statistical averages-- but to the real groups that form that community, and to the women and men in those groups. Finally, attention is called on the urgency to make operational the principle of equity so that it abandons the rhetoric level to be translated into policy proposals and transforming actions.