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TOWARD GENDER EQUITY IN HEALTH SECTOR REFORM POLICIES

The recent impetus given to reforms in health and social security policies throughout the Region has given rise to intense debate on the effects of these policies on equity in health and human development. So far, this debate has been focused on concerns relating to geographic location and social stratum, without considering gender. The absence of this concern has resulted in a lack of corrective policies with respect to the gender inequities created or exacerbated by health sector reform that cannot be dealt with by using the same measures employed to reduce the gaps between socioeconomic strata and geographic regions.

This document has two objectives. The first is to call attention to certain implications of health sector reform for gender equity in the field of health, with specific regard to: a) the health situation; b) access to, use, and financing of health care; and c) the contribution/benefit ratio for health-related work. The second objective is to propose an unified set of strategies to identify problems, provide opportunities, and reduce obstacles to achieving the goals of equity and development through health sector reform.

The Subcommittee is requested to consider and support the contents of the present document. The recommendations of the Subcommittee with regard to this topic will be of particular importance in moving forward in the search for equity through the introduction of gender criteria in the formulation, execution, and effective monitoring of the health sector reform policies being implemented in the Region.

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Introduction

The recent impetus given to reforms in health and social security policies throughout the Region has given rise to intense debate in governments, civil society, and multilateral agencies with regard to the effects that such policies are exerting or are capable of exerting on equity in health and human development. So far, this concern has been focused, however, on geographical location and social stratum without considering how these policies impact differentially on women and men. The absence of this concern in the public discourse on reform has been reflected in a lack of corrective policies with respect to the gender inequities associated with health sector reform that cannot be dealt with by using the same measures employed to reduce the gaps between geographic locations and socioeconomic strata.

This document has the dual purpose of calling attention to the implications of the current health sector reform policies for gender equity and proposing strategies for dealing with them. The emphasis on gender does not reflect a segmented vision of reality. On the contrary, this analysis stems from the recognition that gender interacts with other social inequalities that affect both health risks and opportunities. Any strategy designed to reduce gender inequities must accordingly consider all the pertinent class, ethnic, and age differences involved. The emphasis on gender simply reflects the need for bringing to light a dimension of inequity that is frequently ignored. It underscores, first of all, that any concept that fails to take gender into account cannot accurately reflect reality. Secondly, that from the perspective of social justice, it is in no way sufficient to examine and deal with the effects of the reforms on various socioeconomic, ethnic, and/or geographical subpopulations without also addressing the differential impacts of such policies on the women and men making up these populations.

The presentation has been divided into four parts. The first refers to the institutional mandates underlying the plan to incorporate the gender perspective into the reform processes, as well as the specific antecedents that led to the formulation of the plan. The second part briefly outlines the conceptual framework of the proposal. The third section discusses some of the most important implications for gender equity contained in the most frequently applied sectoral reform policies in the Region of the Americas. The fourth segment points out the principal challenges posed by the objective of incorporating the gender equity perspective into sectoral reform policies, accompanied by a proposal for a pluralistic strategy to document and contribute to the elimination of gender inequities in health sector reform.

1. Background and Rationale

1.1 *The Institutional Policy Framework*

The present proposal is founded on the search for equity and for active and joint participation by the countries in formulating strategies to achieve this purpose. Specifically, it aims at operationalizing gender equity in health sector reform policies.

The search for equity constitutes the central and distinctive element of the Organization's mandate. Consistent with this principle, reduction of the inequities in health and human development has been declared the fundamental objective of PAHO technical cooperation. In his last quadrennial report, the Director of PAHO unequivocally stated that "*the overarching problem for health in the Americas continues to be inequity. It is this concern for equity that links all our activities to the global goal of Health for All, which holds as its essential value system.*"[1]

Within this context, one of the key values set forth in the new WHO policy of Health for All in the twenty-first century is "*the incorporation of a gender perspective into health policies and strategies*." The strategic and programmatic orientations for the next quadrennium, which were approved by the 25th Pan American Sanitary Conference in 1998, stipulate that technical cooperation should place emphasis on *"developing the capacity to use the gender perspective as a tool for analyzing the impact of globalization on the development process and on structural, macroeconomic, and social policies, with special emphasis on their relation to health*"[2] The Director, in turn, has just reaffirmed the institutional commitment to "*focus attention on the importance of women's health, the interaction among women, health, and development, and the development of gender awareness at all levels.*"[3]

The topic of health and social security reform is assuming particular regional importance due to their linkage with transnational economic integration and State reform policies, in which considerations of efficiency all too frequently prevail over equity and human rights. This trend is of special interest for a region that, like the Americas, is characterized by the greatest economic and social inequalities in the world and where these kinds of reforms have already in one way or another permeated all the countries.

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1 PAHO, *Leading Pan American Health*. Quadrenial Report of the Director 1994-1997. Washington, D.C., PAHO, 1998, p.3.

2 PAHO, Strategic and Programmatic Orientations for the Pan American Sanitary Bureau, 1999-2002, 25th Pan American Sanitary Conference, Washington, D.C., September 1998. CSP25/8, p.29.

3 PAHO, *Leading Pan American Health*. Quadrenial Report of the Director 1994-1997. Washington, D.C., PAHO, 1998, p.29.

As the Director of PAHO noted: *"Health must not be a victim of this restructuring and reform,"* adding that "*…the scenario that still concerns me most is that related to the growing gaps between people…those gaps that are unnecessary and unjust should be closed.*"[4] It is worth emphasizing that despite the existence of significant common denominators, these reform processes are not totally homogeneous, but rather exhibit modalities and special characteristics derived from their political and economic context.

From the perspective of PAHO, health sector reform has been conceived of as "*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.*"[5] Equity, quality, efficiency, sustainability, and social participation are, then, the regulatory criteria for cooperation technical in this area.

These criteria are derived from the institutional goal of Health for All, from the mandates of the Governing Bodies, from other provisions formulated in regional summits, and from international agreements such as the World Summit for Children, the International Conference on Population and Development, the Summit on Social Development, and the Fourth World Conference on Women. International support of this nature demonstrates that the global character of the challenges posed by the reforms makes collective action a mutually beneficial imperative.

1.2 *Specific Antecedents*

In 1996, during the 16th Meeting of the Subcommittee on Women, Health, and Development, the National Chilean Women's Service Organization presented a paper on the impact of health sector reform on the access of women to the health services. The authors pointed out the adverse impact of the reform policies on gender equity in health care and aroused the interest of the members of the Subcommittee, who recommended further evaluation of the process in Chile and the initiation of similar analyses in the rest of the Region.

In following up the recommendation, in 1997 the WHD Program presented a work proposal to the 17th Meeting of the Subcommittee for an inventory of the technical resources and knowledge existing in the Region and for the implementation of electronic means for an intercountry exchange of information. The Subcommittee endorsed the

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4 Alleyne, George A.O., Address at the 25th Pan American Sanitary Conference, Washington, D.C., September 1998.

5 PAHO. *Cooperation of the Pan American Health Organization in the Health Sector Reform Processes*. Washington, D.C., PAHO, 1998, p.13.

proposal and recommended continuing and intensifying efforts to incorporate gender equity into sectoral reform policies.

Recently, the WHD Program has been advancing both conceptually and operationally toward incorporating the gender perspective into the contents and processes of sectoral reform policies. The Central American WHD Subregional Project, in conjunction with the Division of Health Systems and Services, has consequently implemented at the local levels and, in some cases, at the national level, a series of actions that consider gender issues in the reorganization of systems and services. These activities were discussed in a subregional workshop held in San José, Costa Rica, in 1997, in which the interprogram teams of each country participated, together with the WHD Program and the Directors of the Divisions of Health and Human Development and Health Systems and Services.[6] Among the achievements of the Subregional Program in Central America is the inclusion of preventive and domestic violence initiatives in the context of the new models of care being implemented in the countries of this subregion.

At the regional level, the WHD Program has developed conceptual guides, drawn up bibliographies, and formulated methodological guidelines to orient the analysis and monitoring of the reform processes. These materials are already being used by various audiences. In addition, with the support of the Center for Research on Women's Health of the University of Toronto (a PAHO/WHO Collaborating Center), the WHD Program is coordinating an electronic network on Gender Equity in Public Policies, whose objectives are the dissemination and exchange of information, support for the articulation of multicenter research projects, and the strengthening of national analysis and advocacy capacities. The regional program has also provided technical support for specific national initiatives, particularly the Gender and Reform Commission in the Dominican Republic.

In October 1998 the WHD Program convened a group of professionals with specific experience in the conceptual and operational articulation of the gender perspective in health sector reform policies. This meeting was aimed at sharing experiences, discussing priorities, and mapping out a collaborative strategy for incorporation of the gender equity perspective into health and social security reform policies. The discussions, supported by the documentation prepared by the WHD Program and the presentations of the participants, focused on the following topics: 1) principal implications for gender equity of the various strategies of health sector reform implemented in the Region of the Americas; 2) review of criteria and indicators for the monitoring and evaluation of health sector reform policies from the perspective of gender equity; and 3) configuration of alliances and mechanisms for the incorporation of the gender perspective into the design,

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[6] PAHO. Program on Women, Health, and Development. Report of the Interprogrammatic Meetings on the Incorporation of the Gender Perspective in Sectoral Reform. San José, Costa Rica, 18-19 August 1997. PAHO, San José, Costa Rica, 1998.

execution, and surveillance of health sector reform policies at the regional, national, and local level. This consultation produced an outline for a preliminary regional work plan to be developed at the national and subnational levels that forms the basis for the strategy to be presented for consideration by the Subcommittee.

2. Referential Framework for the Analysis of Gender Equity in Health Sector Reform

2.1 *Conceptual Elements*

Three interrelated concepts make up the central elements of the work proposal presented herein: gender, equity, and participation.

2.1.1 *Gender*

Approaching health from a gender perspective means recognizing that:

(a) Beyond the biological differences between the sexes lie socially constructed differences between men and women that define risks, access to resources, decision-making power, and particular health needs. These social gender differences—together with class and ethnic differences—are key determinants of the inequality of opportunities for access to, and power over the resources and services that facilitate good health. These opportunity differentials are reflected at the micro level of the individual and the family, and also in the macrostructural level of the allocation of resources and distribution of benefits.

(b) The family cannot be considered as the smallest unit for analysis and intervention. The allocation of resources within the home must be examined in order to assess intrafamily inequalities in terms of access to and power and control over the basic resources for health. Gender is a determinant, both in society at large and within the family, of the manner in which their members contribute to and benefit from the development of health.

(c) Gender distinctions in the workplace consistently undervalue the work of women. Consequently, in the formal sector of the health system, women predominate in occupations characterized by lower pay, lesser prestige, and meager decision-making power; and in the informal community and the family, women's work is unpaid and therefore does not appear in national accounts.

(d) The formal and informal areas of health care are interdependent, and consequently the policies that affect the supply of personnel in the health services simultaneously affect the informal burden of care that falls predominantly upon women.

2.1.2 *Gender Equity*

In reiterating the foregoing considerations, it will be seen that the notion of equity in health is founded on a concept of health as a fundamental human right whose guarantee is an ethical imperative that extends beyond the delivery of services and requires action by the various sectors of society; and it is in this context of human rights that gender equity and, specifically, the rights of the women to health, have been ratified explicitly in the international conferences held in Vienna, Cairo, Copenhagen, and Beijing.

Gender equity in health implies:

(a) With regard to the state of health: the elimination of unnecessary, unjust, and avoidable differences between men and women in their potential for enjoying good health and in their likelihood of becoming ill, disabled, or dying from preventable causes.

(b) In the access to and the utilization of health services: that men and women receive care in accordance with their needs.

(c) In the financing of care: that both women and men contribute in accordance with their economic capacities and that women are not obliged to contribute more than men by reason of the biology of reproduction and their greater longevity.

(d) In participation in the development of health: that health care activities, whether remunerated or free, be recognized, facilitated, and appropriately valued, that women and men share in decision-making on an equal footing in the micro and macro spheres of the health system. "*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 ands explore*".[7]

[7] 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.

2.1.3 *Participation*

As part of the gender perspective, social participation plays a pivotal role in effectively achieving equity. Participation is not conceived in a pragmatic-instrumental manner, but rather as an exercise of the civil rights of women and men to influence the processes that affect their well-being. In this context it is important to stress that, as the United Nations Development Program notes, "*in exercising real power or Decision-making authority, women are a distinct minority throughout the world.*"[8] Indeed, and particularly in the health sector, women participate actively in the execution phase of community programs, but continue to be excluded in the stages of formulation, design, and allocation of resources.

Women, with their interests, needs, viewpoints, and demands, have not received recognition as a social group that merits representation and calls for accountability. Decisions are usually made on behalf of women, presuming both their consent and a community of interest with men. This presumption, however, does not conform to reality, for when women have been consulted, the priorities they have expressed for themselves and their families have been very different from the those expressed by their closest male family members or by distant politicians and bureaucrats.[9] Health, for example, constitutes a higher priority for women, and this tendency has been reflected in the ways in which men and women spend the family income that each controls,[10] and in the fact that women are more frequently concerned with health matters than men.[11]

Consideration of the particular needs of the various social groups in the management of policies, as well as in the accountability of their executors—State or private sector—is not feasible without the presence of a civic culture to demand them. Given the particular needs of women and their limited representation in political decision-making, the promotion of participation by women's organizations is an inalienable requisite in any democratic system and also an essential element in placing health in the forefront on political agendas and ensuring the sustainability of human development.

2.2 ***Why the Emphasis on Women when Referring to Equity?***

Men and women occupy different positions with regard to the utilization and delivery of health care. The emphasis of women**,** as users and suppliers of health care

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8 PNUD, Human Development Report 1995, New York, PNUD, 1995, p.86.

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

10 The World Bank. World Development Report, 1993.

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

derives from the ethical imperative to redress the imbalance between needs and resources and between contributions and benefits. In point of fact:

(a) Women have a greater need for health services than men, essentially because of their biological role in reproduction and their greater longevity.

(b) Since women are over represented among the poor, they have, in the long run, lower access to remuneration and other health resources, including health and social security services.

(c) Women are in a disadvantageous position in the health systems, since they are among the lowest wage earners and have the least power and prestige in the formal health sector. They also perform the informal work of promoting and providing health care in the family and community without remuneration, and continue to be underrepresented in the community power structures that set priorities and allocate resources for the development of health.

(d) Since women are the principal care providers in the family**,** they bear the greatest burden in this respect and are consequently the most affected by any increase or reduction in public services.

(e) Women are the principal managers of family health, particularly with regard to children, but they have less power over the resources necessary for protecting health. For this reason the health of women, as well as the control they are able to exercise over the resources, plays a central role in the effectiveness, efficiency, and sustainability of interventions aimed at intergenerational human development objectives.

3. Implications of Health Sector Reform for Gender Equity

Certain health policy formulations that appear to be neutral with respect to gender frequently conceal significant gender biases. The foundation of such biases is the undervaluation of the work performed by women and the failure to recognize the economic contribution made by their unpaid work in the home. Therefore, while the economy is defined mainly in terms of market goods and services, the essential activities that women perform—such as raising children, carrying water and fuel, processing and preparing food, cleaning and running the home, and caring for elderly, sick, and disabled family members—are not remunerated and consequently do not figure in national accounts.

Accordingly, apparently neutral formulations, such as "cost reduction," "effectiveness," "efficiency," and “decentralization,” frequently involve gender biases because they imply transfers of costs from the remunerated economy to an economy founded on the unremunerated work performed by women. Thus, the premise sustained by certain adjustment and reform measures is that the government can reduce expenditures by cutting services—for example, by reducing hospital stays and the care of elderly people and the mentally ill—in the assumption that these services can be provided by families. Such measures are based on the expectation that women are available, prepared, and morally obligated to provide home care for dependents, patients, the elderly, and the disabled. Absent from these policies is any consideration of the impact that these expectations concerning the availability and free time of women exert on their situation of employment, remuneration, expenses, and physical and emotional stress; absent, too, is consideration of the support structures for providing home care. These lacunae endanger not only the health of the caretakers themselves but also that of those who are supposedly receiving their care.

From the gender perspective, one might pose the following general questions with respect to health sector reform: does health sector reform help to reduce or does it exacerbate gender inequalities in health, health care, and participation in the decisions that affect the health system? And more specifically, to what extent does health sector reform facilitate or hinder the exercise of citizens’ rights to health, particularly the exercise of the reproductive rights of women?

This kind of inquiry demands recognition of the fact that, in spite of the presence of certain common denominators in the socioeconomic disadvantages among women, the categories based on gender are not homogeneous. On the contrary, significant differences exist among women based on factors such as age, class, race, and nationality, differences that demand that such factors be incorporated explicitly into any analyses and interventions carried out.

It is also very important to emphasize that health sector reform cannot be reduced to administrative reform governed solely by financing and managerial efficiency criteria. Without discounting these criteria, the considerations presented below derive from a concept of health sector reform as a technical-political process directed toward the improvement of health and the search for equity as ethical principles of social justice and human rights. A major challenge posed by these reforms is achieving coexistence between equity and efficiency, and in no case whatsoever, subordinating equity to efficiency.

A few questions are presented schematically below that should be considered from a gender equity perspective with respect to the health sector reform policies or components most frequently implemented in the Region. These components have been

classified in the following manner: 1) decentralization and promotion of social participation; 2) reorganization of the health services, including the redefinition of care models and the formulation of basic packages of services; 3) restructuring of the human resources development and administration systems; and 4) restructuring of the financing systems, including participation of the private sector. Since there is considerable overlap among these categories, some topics appear in more than one component.[12]

These policies are viewed from the triple perspective of content, process, and impact. The contents refer to the goals and activities (e.g., decentralization, privatization of financing, targeting); the processes have to do with the relationships among the institutional actors and the manner in which these actors define 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 enables us to examine critically how reform is affected and how it affects the social and economic relations between the sexes.

3.1 *Decentralization and Promotion of Social Participation*

With regard to decentralization, the concern over equity has essentially been directed toward interregional inequalities originated or supported in preexisting territorial inequities concerning the distribution of resources. There has been very little concern to date regarding the internal processes of the community and the vital problem of identifying the circumstances in which decentralized systems either assist in improving access by vulnerable groups or marginalize them to an even greater degree.

The topic of decentralization has multiple implications for equity and gender in the area of health. This section will be limited to indicating that decentralization, depending on how it is designed and implemented, may have opposite effects on the amount and characteristics of women's participation at the local levels. Thus, while decentralization may become a window of opportunity for increasing the participation of women in local power structures, it may also result in greater marginalization of groups traditionally without power—including women—and even result in a disproportionate increase in the proportion of unremunerated work performed by women.

With respect to representativeness, although women are more actively involved in health activities, the "spokespersons" of the community tend to be predominantly men, who do not necessarily consult with women or represent their interests. For this reason, 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 becoming a simple transfer of power from

[12] Standing, Hilary. *Gender and Equity in Health Sector Reform Programmes: A Review*. Health Policy and Planning; 12(1):1-18, 1997.

national to local elite. This risk is compounded by the lesser development of institutionalized arbitration systems to handle cases of inequity at the local level.

The modality of decentralization that involves transfer of the burden of financing health care from the central government to the local community is capable of producing adverse effects 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 to increase community participation in the delivery of health services. In this context, it is important to note that the unpaid work of health care performed by women in families and in communities has frequently been used as a financial adjustment variable.

From a gender equity perspective it would be useful to ask the following questions: What representation do women have in community power structures? Do they participate at the decision-making levels—that is, in the identification of priorities, in the planning of programs, and in the allocation of resources? Who benefits and who loses in these decisions? 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 the participation of women in decision-making without increasing their workload?

In the event that a transfer of responsibilities for health services has taken place from the State to the community, has this transfer implied an increase in the burden for women in the home care of dependents, the sick, the elderly**,** and the physically and mentally disabled? What structures exist to support home care? Has the effect of this additional burden on the people who provide care and on those who receive it been considered or investigated? What is the effect of this overload on the effectiveness and sustainability of home care?

3.2 *Reorganization of the Health Services, Including the Redefinition of Care Models and the Formulation of Basic Packages of Services*

A basic concern for equity is related to the criteria used to define priorities and cost-effectiveness of interventions. In this regard it is essential to determine how health needs were identified in the population at large and in special groups and what kinds of needs were identified as being of a priority nature and in accordance with what criteria. It is also important to ascertain if the care models and the “comprehensive” care packages effectively include promotional, preventive, curative, and rehabilitative services, and if they integrate previously separate activities.

From the gender perspective, it is essential to determine first of all to what extent the redefinition of care models and the formulation of basic packages of services respond to the particular health needs and rights of women. It is necessary here to emphasize that the particular nature of these needs and rights refers not only to the biomedical dimension of reproduction, but also encompasses all stages of the life cycle and the diverse dimensions of existence, in addition to incorporating the social dimension of gender.

The incorporation of gender issues into care models implies that in planning the content and delivery of health services, consideration should be given to sex-differentiated health risks, responsibilities, and restrictions that are socially created. These derive from the roles differentially assigned to women and men**,** together with the growing frequency with which women are called upon to perform a dual role (paid labor and domestic work), and the inequitable relations of power between the sexes. Typical examples of such considerations would be the introduction of services that respond to needs deriving from domestic violence and the obstacles preventing the free exercise of sexual and reproductive rights. Other provisions would aim at compensating for the limitations of certain groups of women with regard to information, geographical mobility, availability of time, independence in making decisions concerning certain interventions, free choice in being examined by male professionals, and the low priority assigned to their own needs.

The valuation of women's time is a key element in the promotion of equity in the health services. Traditionally these services have operated under the assumption of the gratuity and elasticity of women's time, both in seeking care for themselves or their children and in follow-up care in the home. In this regard, it would be necessary to investigate to what extent, for example, articulation has been achieved between reproductive and child health services, and if specific supports are being provided for care provided 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 if they include men in some way or another. Finally, with regard to reductions in certain services, it is worth reiterating that the cuts in public spending on health may shift an overly onerous burden onto the unremunerated reproductive economy by increasing the time women spend in providing care for family members who demand it.

Second**,** questions arise regarding the identification of needs and priorities. Information is required regarding the extent to which women have been consulted and how much they have participated in identifying needs and in negotiations with respect to the determination of care priorities. It is pertinent to determine if government agencies in charge of women's affairs, nongovernmental 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 determining priorities

(AVISAS or DALYS, for example), and what gender biases may be concealed in these instruments.

Third, concerning the impact of policies for reorganizing the health services, mechanisms should be sought to evaluate the impact of the new models and packages on satisfaction of the health needs of the population and of groups with particular needs, including women. The participation of civil society and, in this particular case, of women's organizations is also crucial in complying with the principles of equity.

3.3 *Restructuring of Human Resource Management*

Restructuring of the management of human resources, which, inter alia, includes reductions in force, modification of remuneration systems, staffing tables and personnel evaluation, revision of job descriptions, and training, has important implications for gender equity for three main reasons.

First, the employment of women in this sector is particularly vulnerable to any significant reduction in personnel levels, given the preponderance of women in certain specific occupations and in positions of less power.

Second, 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, the maintenance of appropriate levels of female personnel becomes a very important factor for the use of such services.

Third, as a consequence of the interaction between the formal and informal health care sectors, the policies that exert an impact on the supply of personnel in the health services simultaneously affect the extent of the informal care burden that devolves predominantly upon women.

From the perspective of the impact on gender equity, it is appropriate to determine the effects human resource policies in health sector reform have had on the composition by sex of the personnel in the various decision-making levels in the systems' public and private sectors. What professions have undergone the greatest changes? Have these reforms had different impacts on men and women at comparable levels of occupational status, e.g., in incentive and continuing education policies? How have the relationships between predominantly "male" and "female" health professions (e.g., between medicine and nursing) been affected by human resource policies? And, turning again to the topic of the interdependence between the formal and informal health care sectors, to what extent are the reductions in personnel in the health services being offset by the unremunerated work of community health workers (frequently women) and/or of women in the home?

3.4 *Expansion of the Options for Health Financing, and Participation by the Private Sector*

With regard to the component of financing of health care, the topics that have aroused the most vigorous debate on equity have been cost recovery in the public sector and the privatization of health care financing.

The debate has essentially revolved around the impact of these measures on access of the poor to the health services. Evidence indicates that access to and the use of the services by low-income groups is affected by the various payment modalities. It is an established fact, for example, that most of the medical insurance systems in the developing countries tend to benefit disproportionately the urban middle classes and certain groups of workers.[13] However, in spite of the evidence of some general trends, there is a scarcity of studies that identify the most affected groups and evaluate the differential impact of various payment modalities on these groups.

From the gender perspective it is imperative to consider that cost recovery measures can particularly affect women, in view of their greater need for services, their reduced access to remuneration, and their social role as principal caretakers of the health of their children.

3.4.1 *Needs and Expenditure*

Women experience a greater need for health services than men, particularly, but not exclusively, due to their reproductive role. This greater need is frequently associated, with greater expenditure on health, particularly in privatized systems. Consequently:

(a) In some countries, women of childbearing age, owing to their potential for pregnancy, have to pay higher insurance premiums than men of the same age; such is the case, for example, in Chile.[14]

(b) At these same ages the health expenditure of women is frequently considerably higher than that of men. In the case of the United States, for example, women pay 68% more in out-of-pocket expenditures for their health than men in same age group.[15]

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13 Standing, Hilary, 1997, Op. cit., p.12.

14 Ramírez, Apolonia. *Situación de la mujer trabajadora en el sistema ISAPRES*. In: Fernández, Margarita (Ed.), *Economía y trabajo en Chile*. Informe Annual No. 7, 1997-1998, Santiago, 1998.

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

(c) Spending on reproductive health services represents a third of all the health expenditures by women in this age group. These expenditures represent most of the differential by sex in health expenditure, due basically to the high costs of obstetric services and to the emphasis on curative care, since insurance plans do not always cover family planning services[16] and other preventive measures.

(d) Women's greater longevity exposes them to a larger share of exclusions in health insurance plans for chronic diseases, as borne out by the situation in Chile, for example.[17]

3.4.2 *Payment Capacity and Access to Services*

This greatest level of need and expenditure contrasts with women's lesser capacity for payment by virtue of their social and economic subordination, and particularly of their disadvantageous situation in the job market. Consequently:

(a) Due to the cultural importance of the woman's role in the family, most women (more than 50% in the Region) remain outside the job market, and when they are employed, they receive lower wages than men. In the Americas, women's wages average 71% of men's.[18] This tendency constitutes in itself a barrier to direct access to health insurance plans and to broad service coverage within those plans.

(b) In response to the pressure to reconcile their domestic and labor roles, women fill the majority of part-time jobs (70%-90% in the Western world),[19] and in the informal sector of the economy. Neither category is customarily covered by social security or health insurance plans.

(c) When conditions favor broad access by the population to health care, women tend to use the health services more frequently than men. However, when economic conditions restrict such access, the relationship between gender and use of the services is less clear. For example, recent household surveys of five countries in the Region indicated that, in case of illness , the poor utilize the services less frequently than the rich, and also that among the poor, particularly in private health care systems, women use the services less than men.[20]

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

17 Ramírez, Apolonia. 1998, Op. cit.

18 Banco Mundial. *Workers in an Integrating World—World Development Indicators* en World Development Report 1995, Washington, D.C., 1995.

19 The Economist. *A survey of Women and Work*. July 18, 1998.

20 Casas, J. A. *Economic, Social and Health Inequalities in Latin America and the Caribbean*.

(d) Pregnancies and child-rearing interrupt women's job history, making it harder to accumulate the time required to become eligible for retirement benefits and ensured health care over the long term. This difficulty may be further exacerbated by the customary legal provisions applying to the lower retirement ages for women.

3.4.3 *Responsibility for Care*

The cultural responsibility of women for the health care of their family members is not restricted solely to the contribution in kind characteristic of their work in the home. More and more frequently it also represents payments to cover medical care, particularly for their children and increasingly for elderly parents. In this respect it must be recalled that 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 the Latin American and Caribbean countries.

Some pertinent questions from the gender equity perspective would accordingly be in order:

(a) Has the government developed regulations to set standards for service provision by the private sector? Do these regulations aim at improving equity or counteracting existing or potential inequities in the delivery of services? Do they explicitly address the health needs of women and gender inequities with regard to access?

(b) How are the reproductive health services (family planning, prenatal care, delivery care, maternity leave, breast-feeding) financed? On whom do such costs fall? On the governments through redistributive tax mechanisms, on the employers, the donors, other actors, or on the women themselves? What reproductive health services are excluded or are totally or partially subsidized in various types of insurance plans? (In this regard the Free Maternity Law in Ecuador is of particular note, a law that was modeled on the experience of Bolivia).

(c) To what extent do the various financing systems provide access to preventive services and contribute to achieving public health objectives? These kinds of interventions are of special importance for women for two reasons. First in view of their particular needs for family planning, prenatal care, and the detection of cervical cancer. Secondly, because as has been emphasized throughout this

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document, women absorb the additional burden of the care required for environmentally induced diseases, such as infectious diarrheal diseases in children.

It should be pointed out here that there is a basic need for information broken down sufficiently to identify the most affected groups and to measure and monitor the impact of diverse types of financing of health care.

4. Challenges, Opportunities, and Strategies for Incorporating the Gender Perspective into Health Sector Reform

Incorporation of the gender perspective into health sector reform policies has three fundamental components:[21] The first is the generation of knowledge of the situation of gender inequalities in health and its relation to reform policies at the national and subnational levels in the Region; the second is the political advocacy in support of certain action priorities leading to greater equity in health; and the third is the definition of institutional mechanisms through which these priorities may be incorporated into the policy management process.

The central element of the proposal presented here has to do with the creation, exchange, and utilization of knowledge about gender and health sector reform. Emphasis will be given to: 1) developing situation analysis that makes it possible to identify and measure health-related gender inequities; 2) evaluating the effects—current and potential—of reform policies on social inequities; and 3) identifying alternatives that can help to reduce—instead of increase—the inequalities existing in health and human development.

At the present time, discussion of gender and reform derives support from a fragmentary empirical basis and general estimates. The lack of a solid database as a basis for policy formulation is particularly evident with respect to discussion of the impact of the reforms undertaken. This deficiency is not limited solely to the gender dimension, but rather extends to the entire topic of social inequalities. However, in the case of gender this difficulty is exacerbated by the scarcity of data broken down by sex in the health sector. It is important to emphasize, nevertheless, that although the health sector does not routinely obtain or publish information broken down by sex—except with regard to mortality—relevant information is available derived from household surveys in a sizable number of countries in the Region. This information, currently underutilized, would make it possible to measure and monitor the inequalities in health, access to care, and health financing.

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[21] Standing, Hilary. *Reflections on Gender and Health Revorms in the Context of Severe Health Inequalities*. Trabajo presentado en la Reunión del Grupo Consultivo sobre Equidad de Género y Reforma, Washington, D.C., OPS/HDW, October 1998.

The first need with regard to the generation of knowledge is the development of gender-sensitive indicators and indicators of gender inequity,[22] together with evaluation and monitoring instruments. Some of these indicators will be applicable regionally, whereas others will be contextually 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.

The production of information, although necessary, is not sufficient to induce changes in policies. The utilization of knowledge in the production of such changes requires sensitization in the spheres of political decision and technical strengthening at the planning levels with regard to the topics and the analysis of gender. This "training" component is essential as part of the objective of providing technical support to the steering role of the State in formulating policies and drafting regulations for participation of the private sector. Perhaps even more important than support for the top-down formulation of policies is the strengthening of the technical and advocacy capabilities in women's organizations. This in order to put them in a position to influence and demand accountability from the State and the private sector with regard to their rights in the area of health.

The work plan presented below attempts to deal with these challenges and is founded on two basic strategies. First**,** the building of local capacity for analysis, evaluation, and monitoring of health sector reform polices, and second, the articulation of joint intra- and intercountry activities to promote the production and adaptation of knowledge in this regard. The collaborative action component between countries is a particularly important part of this effort in view of the opportunity it offers to evaluate various political alternatives and the synergy that is generated by learning from each other's successes and errors.

This initiative has the following objectives:

(a) The development of indicators and instruments for situational analysis, inequity identification, and measurement and evaluation of the impact of health sector reform from a gender perspective;
(b) Technical support for government entities in applying the gender analysis to the formulation of policies;

(c) Coordination of multicenter research activities related to the impact of health sector reform on gender equity;

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[22] Anand y Sen, Op. cit., 1995.

(d) The transmission of information and knowledge to stakeholders in ways that facilitate their utilization;

(e) The strengthening of the organizational and advocacy capacities of civil society groups that support equity, with particular emphasis on local groups and international women's networks;

(f) Pluralistic and collaborative development of proposals for action at the local, national, and regional levels.

In the initial stage, this program of work would be carried out at the regional level and in a limited number of countries, possibly three. These countries would be selected on the basis of the following criteria: sustainable development of health sector reform processes that will make it possible to evaluate their effects; the existence of PAHO technical cooperation in the area of health sector reform; and the interest of national authorities in integrating the gender equity perspective into the contents and processes of reform.

The activities that would be carried out at the regional level would essentially be the following:

- Development of basic indicators and analytical guidelines for identifying, measuring, and monitoring the inequities in health sector reform, assigning substantive emphasis to gender inequities;

- Construction of a regional sub-database on women’s health and differences by sex in the area of health;

- Articulation of activities with other technical units of PAHO that deal with topics related to inequity and to health sector reform;

- Articulation of actions with other international organizations to complement and strengthen common lines of work, and mobilization of financial and technical resources for achieving the proposed objectives;

- Dissemination of usable information for advocacy and planning purposes;

- Technical and logistical coordination of multicenter activities;

- Facilitation of the exchange of knowledge and experiences between countries;

- Consolidation of research results and recommendations for action;

The following would be the principal activities to be carried out at the country level:

- Development of workshops on gender and health directed to politicians, planners, and nongovernmental organizations;

- Review and adaptation of basic regional indicators and development of new, specific country indicators;

- Establishment of intersectoral alliances that include at a minimum ministries of health, offices of women's affairs, statistics offices, research institutions, and women's organizations;
- Elaboration of situation analyses and evaluation of health sector reform policies;

- Holding of national forums to discuss the results of the analyses;

- Identification of needs and determination of action priorities with the participation of stakeholders;

- Formulation of concerted action proposals.

5. Support Requested of the Subcommittee

The recommendations of the Subcommittee with regard to this topic will be of particular importance in moving forward in the search for equity through the introduction of gender criteria in the formulation, execution, and effective monitoring of the health sector reform policies being implemented in the Region.

Accordingly, the Subcommittee is requested to consider and support the contents of the present document, recommending that the Executive Committee call upon the Member States to:

(a) Compile and publish statistics broken down by sex, not only in the area of mortality but also in the areas of morbidity, coverage and utilization of services; characteristics of the work force in the health sector; and participation in the management of community health.

(b) Integrate the gender dimension into situational analyses, policy analysis, and instruments for monitoring health sector reform.

(c) Encourage the best utilization of the existing information and facilitate the collection of new information (e.g., health modules in household surveys) in order to monitor the differential effects of health sector reform and access to health care in accordance with criteria pertaining to gender, socioeconomic stratum, ethnic group, age, and geographical region.

(d) Stimulate and incorporate the participation of governmental offices of women's affairs and representatives of women's organizations in the formulation, execution, and monitoring of policies.

(e) Support the role of PAHO's Program on Women, Health, and Development in fulfilling its responsibility for facilitating operationalization of the gender equity mandate at the different levels of health policy management.