OUT-OF-POCKET EXPENDITURE IN HEALTH

THE NEED FOR A GENDER ANALYSIS

PAHO
Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

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List of abbreviations and acronyms

CCT conditional cash transfer
OPE out-of-pocket expenditure
OPP out-of-pocket payment
PAHO Pan American Health Organization
SDG Sustainable Development Goal
SIS Seguro Integral de Salud
UHC universal health coverage
WHO World Health Organization

Note to readers

This publication was conceived, prepared, and finalized in a period before the COVID-19 pandemic. Some of the situations described in this publication may have been exacerbated by the health, societal, and financial impacts of the COVID-19 pandemic. Readers may like to bear these impacts in mind as they reflect upon the findings described in this publication.

Introduction

The importance of promoting gender equality is now widely established and this is evidenced by its inclusion as one of the Sustainable Development Goals (SDGs): SDG 5 Achieve gender equality and empower all women and girls. Gender equality in health is an integral dimension of sustainable development, and it is critical to apply a "gender lens" to all aspects of the health system, including financing mechanisms in health.

Out-of-pocket payments (OPPs) are a commonly used financing mechanism in the health sector, although, as this report argues, it is more useful to employ the wider notion of out-of-pocket expenditure (OPE). OPE constitutes an essential part of health care financing, and this report starts with an overview of some of the mainstream literature on different aspects of OPE, including how it is measured. The report then goes on to discuss what a gender analysis of OPE can contribute to debates around health care financing, and in particular what it offers for wider debates around poverty and inequality.

Drawing primarily on data from Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru, the report provides an in-depth examination of the gender dimensions of OPE in Latin America before offering some final conclusions.

Out-of-Pocket Expenditure in Health

Concern about the impact of OPPs in health first emerged in the 1990s as Mexican researchers identified their impoverishing effects on households and advocated the importance of financial protection in health (Knaul et al. 2006). OPPs are considered to be the most inefficient and inequitable way of financing a health system. They place the greatest burden on households and individuals, who are often then forced to choose between satisfying other basic needs – such as education, food, and housing – or spending on health care and saving loved ones from illness, suffering, and shortened life spans (Knaul et al. 2006, p. 1829). OPPs are defined as direct payments made by individuals to health care providers at the time of service use. This excludes any prepayment for health services, for example, in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individual who made the payments (WHO 2021a).

However, for many, the broader concept of OPE is more useful and a better reflection of what occurs in practice. This encompasses direct payments for medicines, copayments, coinsurance rates, and deductibles. As evidenced in the wider literature, OPE often includes transportation costs and costs related to hospitalization; this can, for example, include the need to pay for food and bedding for hospital patients as well as any costs incurred by those accompanying the patient, especially if this involves a stay away from home (Acharya et al. 2016, McIntyre et al. 2006).

The wider literature also highlights the importance of considering the indirect costs associated with illness, such as costs due to lost labor, lost earning potential, and reduced productivity (Leatherman and Jernigan 2014, McIntyre et al. 2006). Yet, as critics argue, very few of these "hidden costs" are recorded for the provision of goods and services within health systems but often act as a significant barrier to access, even where services such as maternity care may be free (Acharya et al. 2016).

A small number of studies also highlight the importance of considering additional ad hoc "under-the-table" costs that may be imposed on health care users at the point of service delivery. For example, research in Hungary found that women were making cash payments to ensure continuity of care and the presence of a named doctor during their prenatal care and at the point of giving birth (Baji et al. 2017). Given the breadth of OPE in health, there is a clear need for more detailed empirical research that seeks to understand its impact on households and individuals, and promotes more effective financial protection mechanisms.

Financial Protection

Concern over the impact of OPPs on household poverty levels is not new, and the importance of financial protection in health, particularly for poor households, has been one of the driving factors behind the growing calls for universal health care coverage (Sen et al. 2018, WHO 2014). The importance of replacing OPPs for health care with other approaches to health care financing – such as through increasing risk pooling via social insurance schemes and prepayment for services – was a central theme in the World Health Organization (WHO) World Health Report 2010, *Health Systems Financing: The Path to Universal Coverage* (Bennett et al. 2010, p. 2). WHO defines financial protection as the point where "direct payments made to obtain health services do not expose people to financial hardship and do not threaten living standards." (WHO 2021b).

Financial protection is measured using two indicators: the incidence of catastrophic and impoverishing health expenditures. These two indicators are solely determined by the extent to which OPPs absorb households' financial resources (WHO 2021a). In 2014, the Pan American Health Organization (PAHO)/ WHO Strategy for Universal Access to Health and Universal Health Coverage was adopted in the Region of the Americas. By adopting this resolution, governments of the Region have committed to work toward eliminating direct payments in health and toward securing financial protection for all households.[1]

[1] Strategy for Universal Access to Health and Universal Health Coverage. 53rd PAHO Directing Council, 66th Session of the Regional Committee of WHO for the Americas, document CD53/5, Rev. 2 (2014).

The Limitations of Financial Protection Measures

Within the academic literature, there is a growing contention that these conventional measures of financial protection are limited and do not fully capture the multidimensional nature of what lies behind households' ability to achieve financial protection (Moreno-Serra et al. 2011, Ruger 2012). One critique is that catastrophic and impoverishing spending metrics rely on out-of-pocket medical expenditures reported in surveys. Health care expenditure is deemed catastrophic where it exceeds a certain percentage of a household's annual expenditure excluding expenditure for food. There is no consensus regarding this percentage threshold, but it has commonly been set at 40% (Dyer et al. 2013, Xu 2005). Nevertheless, this does not mean that spending under this threshold does not also jeopardize the satisfaction of basic needs for household members; and where households are surviving at subsistence levels, even a small proportion of current consumption diverted to health care might push them into, or further into, poverty (Flores 2008, p. 1398).

Moreover, the reliance on survey data is also problematic because people may underreport spending levels, particularly where these are incurred through debts or obtaining credit from health providers or other sources (Van Damme et al. 2003). Furthermore, poorer individuals often cannot afford to use health services, and therefore report very low or no health spending, and will consequently often be included among those considered protected against financial catastrophe (Moreno-Serra et al. 2011).

From a gender perspective, there are also wider concerns around how surveys themselves are conducted. As McDowell (1992, p. 405) notes, male researchers may privilege male respondents without considering whether the information so obtained is systematically biased. Moreover, feminist scholars have built on these concerns to question the limitations of what household-level surveys can reveal about the gendered nature of poverty and household expenditure (Kabeer 1997, Razavi 1999, Whitehead and Lockwood 1999). This is discussed in more detail below.

Another shortcoming of current financial protection measures is that the indicators do not reflect how these payments are financed by households, and in particular they fail to capture either the long- or short-term financial impacts of coping strategies adopted by households to pay for health care expenditure (Flores et al. 2008, Moreno-Serra et al. 2011). Coping strategies frequently include borrowing money and selling assets, and these responses are likely to have clear gender dimensions to them. Coping strategies for dealing with health expenditures are widely discussed in the health literature (see Chapter 7), but little attention has been given to the gender dimensions of these strategies. Nevertheless, studies suggest that, at least in the short term, small but frequent health shocks are found to be easier to deal with than large or persistent shocks, such as disability or chronic illness (Gertler and Gruber 2002, cited in Flores et al. 2008).

Given the prevailing gender division of labor, women are more likely to have to take on responsibility for caring for household members affected by poor health, and this will constrain their participation in the labor market. Drawing on data from a time-use study conducted in Santiago, Chile, researchers found that, in households where there were bedridden dependents, in about 50% of cases the main caregiver was female, compared to about 17% of cases where the main caregiver was male (Matamala et al. 2011). Evidence from Chile suggests that women are then either unable to participate in paid work or often take on poorly paid, part-time, "flexible" work, as they believe this will allow them to combine paid and unpaid work. However, they often face poor working conditions and potentially high levels of stress, which may in turn impact negatively on their own health (Gideon 2014). This raises clear concerns around the longer-term gendered impacts of coping strategies and the ability to pay for OPEs.

Nevertheless, the longer-term impacts will also vary, not only according to the type of coping strategy employed but also the nature of the household itself and the social identity of household members. For example, research from Peru suggests that in the absence of a fully functioning social insurance program, low-income households can be hard hit by catastrophic health care spending and, over the longer term, may divert resources intended for education costs to cover the shortfall, thus raising concerns about intergenerational transfers of poverty (Diaz and Valdivia 2012). This points to the importance of age of household members, but at the same time,

wider research highlights the importance of gender differences in terms of whether girls or boys drop out of school in resource-poor households (Rees 2017). Care must be taken to avoid overgeneralizations, and there is a clear need to consider these issues on a case-by-case basis, taking into account the specificities of each different context.

Universal Health Coverage as a Response to Out-of-Pocket Expenditure

An important response to growing concerns around OPEs and the need for financial protection in health has been the push toward universal health coverage (UHC). The drive toward improving UHC and access, particularly in the context of the 2030 Agenda for Sustainable Development and the SDGs, has focused attention on questions of financial protection in health.[2]

Given the importance of financial barriers to health care access, it was widely believed that the introduction of social insurance programs in Latin America and beyond would go some way toward eliminating OPEs in health (WHO 2010a). Across much of Latin America, there has been a range of policy initiatives aimed at incorporating larger proportions of the population into social insurance schemes, such as Seguro Popular in Mexico, and Seguro Integral de Salud in Peru, as well as the Plan AUGE in Chile, which is oriented toward ensuring financial protection for households for a specific list of health conditions that can potentially incur the highest level of cost (Atun et al. 2015). Moreover, in 2015, Chile passed Law No. 20.850, more commonly known as the Ricarte Soto Law, which expands financial protection in health to a range of high-cost medications needed to treat oncological or immunological health conditions as well as rare or infrequent diseases (Superintendencia de Salud 2021).

However, despite these important advances toward UHC in the region, there is still considerable evidence that significant inequalities in health are not being adequately addressed, and often these inequalities are particularly shaped by class, race, and gender (cf. Nigenda et al. 2015, Restrepo-Méndez et al. 2015, Rotarou and Sakellariou 2017).

[2] Strategy for Universal Access to Health and Universal Health Coverage, 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas, Agenda Item 4.3, point 13.

Has the Move Toward Universal Health Coverage Reduced Out-of-Pocket Expenditure?

Research from Latin America similarly reported that, despite the implementation of social insurance programs, such as Seguro Popular in Mexico and Plan AUGE in Chile, OPEs continue to be a problem for many households (Galárraga et al. 2010, Grogger et al. 2014, Koch et al. 2017, Ortiz-Rodriguez and Small 2017). This is echoed by findings from other regions, where the existence of social insurance and other financing mechanisms has not eliminated the burden of OPEs, particularly for some specific diseases and health care services. For example, a study of catastrophic health care spending for those suffering from diabetes in low- and middle-income countries found that the disease is associated with a greater chance of catastrophic spending, and that insurance is not associated with greater medication possession rates or lower rates of catastrophic spending (Smith-Spangler et al. 2012, p. 323). Other studies conducted in Ghana, India, and Nigeria also reported high levels of OPEs despite the introduction of free maternal health care services for women (Dalinjong et al. 2018, Govil et al. 2016, Kalu-Umeh et al. 2013).

The ongoing occurrence of OPE despite the apparent removal of financial barriers suggests that there is a range of other factors that continue to shape access to health care services (Dzakpasu et al. 2013). As some of the studies cited in this report suggest, the challenges in the implementation of programs to remove financial barriers to health can mean that health care users continue to endure the use of OPE.

An extensive number of studies have pointed to the importance of understanding the role of gender relations and social norms around specific health issues in order to fully understand the ways in which women and men use health care services (see studies contained within Gideon 2016). There is also a growing body of literature, much with a specific focus on Latin America, that also points to the importance of taking into account other social identity markers, particularly race and ethnicity, and how low-income, indigenous women are frequently marginalized from health care settings and are subject to multiple aspects of discrimination – on grounds of gender,

but also race and ethnicity, language, class, and location (see for example Ewig 2010 on Peru, Smith-Oka 2015, Gonçalves Martín 2016 on Venezuela [Bolivarian Republic of], Morales 2018 on Bolivia [Plurinational State of]).

However, in recent years, there has been growing recognition of the importance of intersectional analysis in health and how a failure to undertake such analysis can "seriously distort our understanding of how inequality works, and who actually bears much of its burdens" (Sen and Östlin 2008, p. 2). Springer at al. (2012, p. 1661) provide a useful explanation of what an intersectional analysis entails:

> [Intersectionality is] an approach that explores simultaneous intersections between aspects of social difference and identity (e.g. as related to meanings of race/ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and forms of systemic oppression (e.g. racism, classism, sexism, ableism, homophobia).

Out-of-Pocket Expenditure and Coping Strategies

The issue of the impact of health-related OPE on households has been an important concern within both the Global North and South[3], and there is a relatively extensive body of literature that maps different country-level and regional experiences. The literature points to a consensus across both the Global North and South on the range of coping strategies adopted by households and individuals in response to payment of OPE; although some strategies will be more commonly found in particular contexts at particular times, and care must be taken not to overgeneralize. This notwithstanding, common responses identified in the literature include:

- Cutting back on consumption (including food, clothing, and leisure activities);
- Use of savings or credit cards;
- Selling assets;
- Borrowing money from family and/or friends;
- Borrowing money from other sources;
- Family members taking on additional paid work;

[3] "The use of the phrase Global South marks a shift from a central focus on development or cultural difference toward an emphasis on geopolitical relations of power" (Dados and Connell 2012, p. 12).

- Non-compliance with medical treatments and/or prescription medicines;
- Skipping medical appointments (cf. Dalinjong et al. 2018, Head et al. 2018, Onah and Govender 2014, Ortiz-Rodriguez and Small 2017).

A large proportion of the research on OPE has tended to favor quantitative analysis, drawing on data that are available on household spending in health via existing household-level surveys. Using such an approach, research from Latin America has shown that there is considerable variability in the prevalence of catastrophic spending on health among countries. While in Costa Rica only 1% of households were affected and in Brazil this rose to 2%, in Argentina, Guatemala, Nicaragua, and urban Chile 10–15% of households were affected (Knaul et al. 2012, p. 75). The study highlights that household composition and location are also factors in determining the impact of catastrophic health care spending, with the study identifying rural households and households with children or older adults also being at risk.[4] Rural households are more likely to incur greater OPE compared to urban households because of supply-side constraints within the health system (Knaul et al. 2012).

Other country-level studies in and from the region also highlight the importance of location of households, and detect rural and urban differences in household levels of spending on OPE. Grogger et al. (2014) examine the case of Mexico, where despite the introduction of the social insurance program Seguro Popular in 2004, OPE continues to impact heavily on many households, particularly in more remote rural regions. Given the high levels of poverty within many rural communities – 27% of the rural population live in extreme poverty, and 16% are illiterate (Grogger et al. 2014, p. 597) – the impact of OPE can be particularly problematic, pushing households into downward spirals of poverty.

In the main, very little attention is given to the gender dimensions of spending on health-related OPE. In part, this relates to the lack of gender-disaggregated data available in household-level surveys (see Chapter 9 for a more detailed discussion of this), but it is also a result of the ongoing gender blindness in both health and economic research and policy-making (Gideon 2016). Even less attention is given to other social identity markers, such as age, race, and ethnicity, despite the growing acknowledgment of the importance of intersectional understandings of health (Springer et al. 2012).

[4] Although this in part depends on the ways in which catastrophic health expenditure is calculated. See Knaul et al. (2012) for a more in-depth discussion.

While not "gender-sensitive," some studies have looked at OPE relating to different health conditions, and within these studies some attention is focused specifically on the needs of women, particularly where health services are more "women-specific"; for example, maternal health care (predominantly studies conducted in Africa and Asia) and breast and cervical cancer services (predominantly studies conducted in Australia and the United States of America). Here, there is more of a focus on qualitative research and interviews conducted with small groups of service users (Head et al. 2018, McGrath 2016, Pisu et al. 2014).

Although the discussion here is not confined to research from Latin America and the Caribbean, as the analysis suggests, important correlations can be found between the experiences of the studies reported here and the available evidence from Latin America and the Caribbean. Research from Ghana has focused on women's experiences of OPE in maternal health care following the introduction of the National Health Insurance Scheme in 2008. One central objective of the policy was to eliminate OPPs in the area of maternal health, as these were considered a major barrier to women's use of formal maternal health care services. The research was conducted in Kassena-Nankana Municipal District in the Upper East Region of northern Ghana, one of the poorest parts of the country. It found that the National Health Insurance Scheme did not cover all expenses in relation to maternal health services, and that women were still expected to cover a range of OPE. In particular, women were asked to pay for drugs, especially antimalarial drugs, as well as ultrasound scan services. The research found that systemic problems contributed to the high cost of OPE for women; for example, there was a lack of well-equipped laboratories and qualified personnel, particularly in the lower-level health facilities. This meant that women were frequently referred to private laboratories for tests and scans, triggering additional OPE (Dalinjong et al. 2018, p. 15).

Similarly, research in Nepal found that, despite the introduction of free maternal health care services, women were still forced to make a range of OPEs, many of which were "hidden." The study drew on findings in a questionnaire completed by 348 postpartum women. It found that at least half of the OPE made by women and their families was attributed to food and drink consumed during the hospital stay (this included both the women and accompanying family member), but other costs included clothing and transport (Acharya et al. 2016).

The importance of focusing on intersectional inequalities when seeking to understand the gendered impacts of OPE is clear in the case of Peru. The anthropologist Marisol de la Cadena has argued that women are seen as more indigenous than men, and that as a result they suffer from different and more profound forms of social exclusion (Cadena 1992, cited in Samuel 2016). This complex relationship between gender, ethnicity, and inequalities is shown in a publication by Samuel (2016). Samuel found that women in more marginalized indigenous Andean communities were still being asked to make payments for maternal health care related services despite the implementation of Seguro Integral de Salud (SIS), a comprehensive health insurance program for the poor and workers in the informal sector. This program had been gradually expanded by the government since the early 2000s. Historically, indigenous groups were frequently excluded from the health care system, where health care entitlements were only granted to those in formal employment. However, as critics have argued, discrimination on the grounds of ethnicity remains deeply embedded within the system (Thorp and Paredes 2010, Ewig 2010). Although under SIS indigenous women were entitled to free maternal health care services, they were being asked to pay for use of the bed where they delivered their babies, as well as food for the duration of their hospital stay (Samuel 2016). Here too, the ongoing presence of OPPs has been attributed to supply-side constraints and underfunding of SIS. Following implementation of SIS, providers at the local level are often not able to keep up with the expanded demand for services and are not provided with adequate budgets to do so. Within this context, it is not unusual to find SIS backlogged with debts to hospitals and health networks (Francke 2013, cited in Samuel 2016). As a consequence, these financial problems are often passed on directly to health users.

However, a potentially more worrying cost incurred by poor families is an illegal fee charged by health workers to parents when they try to obtain certificates of live birth for their new infants. These “under-the-table” charges are especially common where the delivery did not take place in a health facility, thereby discriminating against women who delivered at home. A certificate of live birth is an essential document. It is a prerequisite for obtaining a birth certificate and is supposed to be issued free of charge. Birth certificates are the primary piece of identification needed in order to be eligible for all sorts of other benefits of citizenship, including enrollment in public health insurance.

Moreover, limiting access to citizenship in this way raises significant concerns from a human rights perspective and constrains people's ability to claim their rights and entitlements. Yet, as Samuel (2016) notes, these charges are often imposed by health care workers who try to make up the shortfall in their own budgets, which means they are forced to pay for things such as transport costs to visit patients out of their own pocket. Here too, there are important gender dimensions, given that the majority of low-paid, low-status health care workers are female. This is a pattern found across much of the world, where employment structures in health care tend to represent a pyramid with a small number of well-paid, powerful positions at the top of the pyramid dominated by men, and a growing number of women with a decreasing salary scale as one moves down the pyramid (Gideon 2014).

Intersectional inequalities were also highlighted as a key challenge in research conducted in a malaria endemic municipality, Tierralta, in Córdoba Department, Colombia. A study carried out among pregnant women with malaria found a high level of OPE despite malaria control interventions being provided free of charge to health care users in Colombia. The authors determined that the total median costs associated with inpatient treatment of a whole malaria episode were almost US$ 55, representing 18% of the monthly minimum salary in the country at the time of the study (US$ 307). Transportation costs and indirect costs (cost of time) were the largest components. The highest costs, of over US$ 100, were estimated for women who experienced two inpatient episodes (Sicuri et al. 2018, p. 7–9). As the authors contend, given that study participants were from the poorest households, it is likely that these OPEs constituted a significant burden on household expenses. Moreover, at least one-quarter of the participants were indigenous women and part of the Embera Katío community, who have suffered the violation of their rights to land, their economic independence, education, and their culture (Sicuri et al. 2018, p. 10).

Research from beyond Latin America also reinforces the need to look at how other forms of inequality intersect with gender. In the United States of America, a small-scale qualitative research project conducted among female breast cancer patients found that OPE could account for as much as 31% of women's monthly income, and that, within the research, racial and ethnic minority women in particular were most adversely affected (Pisu et al. 2014). The study found that many of the women interviewed reported that the financial "toxicity" of OPE had consequences for the care of survivors, potentially leading to

lower adherence to prescribed medications, forgone medical care, or reduced spending on basics such as food or clothing (Pisu et al. 2014). The research also considered age as a factor and found that older women were particularly adversely affected and concerned about the longer-term impact of reducing consumption, losing their safety net, and falling into debt.

Research in South Africa also found that black women, particularly those not in full-time employment, were most likely to be adversely affected by OPE (Dyer et al. 2013). Other studies have also highlighted the importance of age of household members in determining the impact of OPE (Koch et al. 2017). Indeed, data from Bolivia (Plurinational State of) have shown how OPPs are greatest for women and men in the 65+ years age group (averaging Bs 973 and Bs 674 per person, respectively), but it is in the age range of 45–65 years that women are likely to spend twice the amount on OPE compared to men (Bs 927 and Bs 475 per person, respectively) (Prieto and Montañez 2017, p. 15). This reinforces the importance of looking at how OPE can change across the life course.

In another study with both male and female cancer sufferers in the United States of America, many respondents reported that they were not able to deal with the financial implications of their illness early on because they were focused on the disease and its physical and emotional ramifications. Moreover, other respondents had no understanding of their personal financial responsibility or how much they would owe for treatment until they received the bills (often weeks to months after their diagnosis). These factors were disadvantages to them, as they missed opportunities to plan and offset the financial ramifications of their illness (Head et al. 2018, p. 984). One important aspect raised in this study, but often neglected in the debate around OPE, is the emotional impact these can have alongside the health implications of being ill and having to incur the costs in the first place (Head et al. 2018).

While it has not been possible to locate any analysis of intra-household decision-making around the use of or allocation of economic resources in relation to OPE, a qualitative study conducted with cancer sufferers in Australia examined gender differences in the use of credit cards to pay for OPE (McGrath 2016). The analysis found that women were no more likely than men to reject or minimize the use of credit cards for dealing with the associated OPE they had to make. However, among those respondents who did rely on credit cards as a means for paying for OPE, women were more likely to experience credit card use

(McGrath 2016, p. 54). The income profile for this group of respondents was varied and, thus, there was no clear correlation with income levels or type/regularity of income.

There is a need for further research to better understand the gender dimensions of intra-household decision-making around OPE.

The Need for a Gender Analysis

This chapter considers the importance of looking at OPE through a gender lens. It is important to locate the discussion of "engendering"[5] OPE within a broader context of the gendered nature of health systems. As the discussion presented here argues, the gender division of labor means that women carry out a large amount of unpaid care work within the household, and this unpaid work makes a significant but unrecognized contribution to the production and consumption of health care services. As a result of this "care burden," women's participation within the labor market is constrained, while at the same time, gender norms around women's care work are also used to justify paying lower wages to women (Herrera et al. 2019). As this report shows, this all has important implications for OPE.

This chapter begins with a brief overview of gender differences in OPE in Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru, before examining in more detail the importance of employing a gender lens in the discussion of OPE. This includes a range of factors, most notably the need to take into account women's unpaid care work in any discussion of health policy, including health financing mechanisms such as OPE. Attention is also given to women's unequal insertion into the labor market, as well as the gender gap in wages. Where possible, data from Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru are used to illustrate the discussion.[6]

Equality advocates have argued that, in many instances, women's OPE is systematically higher than that of men, at least in part because of the high financial burden related to and paying for delivery care and other reproductive health services (Ravindran 2012). Evidence supporting this view has been found in a range of Latin American countries, including Brazil, Ecuador, and Peru (WHO 2010b, p. 22). This is reflected in the data from the four case study countries (see Table 1).

[5] In this context, engendering refers to the need to integrate a gender analysis into the discussion of OPE.
[6] The review is mainly limited to published material in English.

Table 1. Average Out-of-Pocket Payments by Sex; Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru

	Men	Women	Total	Women/Men ratio
	(US$)			
Bolivia (Plurinational State of) (2014)	46	62	54	1.3
Guatemala (2014)	39	87	64	2.2
Nicaragua (2009)	44	66	55	1.5
Peru (2015)	66	87	77	1.3

Note: Figures converted to US$ using currency exchange values as at 8 March 2021.
Source: Prieto and Montañez 2017.

Prieto and Montañez (2017) demonstrate that there is some variation by age group but, in the main, women spend more on OPE than do men across the life course. This is illustrated below for the case of Peru (see Table 2). Yet, with few exceptions (Ewig and Hernández Bello 2009, Sen and Govender 2015, Witter et al. 2017), little attention has been given to the gender dimensions of health financing mechanisms.

Table 2. Individual Out-of-Pocket Payments as a Percentage of Household Out-of-Pocket Payments, by Age Group and Sex, Peru, 2015

Age group	Men	Women	Total	Women/Men ratio
0-4	18.5	17.7	18.1	1.0
5-14	12.5	12.9	12.7	1.0
15-44	22.5	26.6	24.6	1.2
45-65	32.1	36.9	34.7	1.2
65+	40.8	49.6	45.5	1.2
Total	23.7	27.8	25.8	1.2

Source: Prieto and Montañez 2017, p. 32.

Employing a gender lens to study OPE is about more than just determining whether women or men are more likely to incur costs in the health sector. A gender analysis involves paying attention to the role of gender relations in the production of vulnerability to ill health or disadvantage within health care systems, as well as the conditions that promote inequality between the sexes in relation to access and utilization of services (Gideon 2016). A detailed gender analysis also recognizes the importance of other forms of difference, notably race, socioeconomic status, ethnicity, and age, which interact with gender difference and can lead to differential vulnerabilities and outcomes (Springer et al. 2012).

Several recent studies have analyzed the gendered nature of Latin American health systems (Ewig 2010, Gideon 2014) and shown how women's health needs are frequently reduced to those directly relevant to their reproductive role. Moreover, women's voices are frequently excluded from decision-making processes at all levels of the health system, including from debates around economic resource allocation (Mackintosh and Tibandebage 2006, Sen et al. 2018).

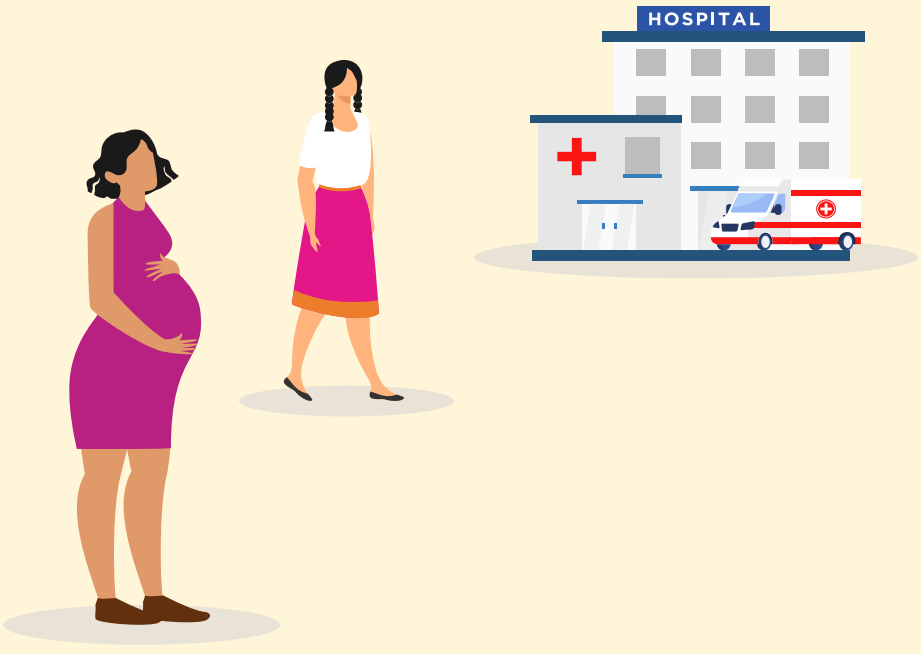
Given that an essential aspect of achieving universal coverage in health is the expansion of the share of health expenditure financed by insurance or prepayment mechanisms, it is essential that there be a better understanding of the gendered implications of resource allocations. As the studies cited Chapter 7 suggest, the introduction of UHC schemes has not always resulted in the reduction in OPE, much of which is still incurred by women. Several studies have identified gender-specific barriers to different types of insurance mechanisms, but one of the most significant constraints is that access to insurance schemes assumes that individuals are employed in the formal economy. In Latin America, both men and women are informally employed. There is evidence from across the region that women are more likely to be informally rather than formally employed and, thus, less likely to be entitled to access health insurance schemes, except as dependents.[7] Women, in turn, are also more likely not to take part in the labor market because their access is often constrained by gendered social norms. For example, research from Nicaragua has shown that strong gender norms around women's household responsibilities as well as a lack of childcare facilities keep women out of the labor market, particularly in rural areas

[7] Detailed data on gender differences in modes of employment and types of health coverage in Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru can be found in Prieto and Montañez, 2017.

(Herrera et al. 2019). Women excluded from insurance schemes are potentially more vulnerable to OPE as they may seek health care through private providers, which may require immediate payment (Gideon 2014).

Recognizing Unpaid Care Work

From a gender perspective, one of the most central limitations of many health policies has been the ongoing failure to acknowledge the importance of the unpaid care work that underpins the health and well-being of individuals and households (Folbre 1994). For example, Elson (1998, p. 932) highlights the invisible costs that can accompany changes in the organization of service delivery. While policy shifts may appear to improve efficiency, in reality they transfer costs from the monetary budgets of the public sector, where they are visible, to the time budgets of women in families and communities, where they are generally invisible. Feminist economists have long argued for the need to recognize the economic value of women's unpaid care work and acknowledge the contribution it makes to the wider economy and society (Folbre 1994, Himmelweit 1995, Power 2004).



Unpaid care work is primarily carried out at home. It can include tasks such as caring for sick and older people, accompanying family members to medical appointments, cooking, cleaning, and child care. All these tasks are essential in maintaining the health and well-being of individuals and households, and critics have argued that the role of household-based unpaid care work must be acknowledged in the production of health care (Doyal and Pennell 1979, Gideon 2014, Mackintosh and Tibandebage 2006).

In Latin America, as in most other parts of the world, unpaid care work is predominantly supplied by women, and gendered norms around roles and responsibilities mean that women are frequently assigned prime responsibility for the health and well-being of household members.

Gender Differences in Time Use

Several recent studies from Latin America have shown that, even when women take on paid work, they retain their responsibilities for unpaid care work at home (often referred to as women's care burden) and tend to work for longer hours in the day in an attempt to combine their paid and unpaid roles (Amarante and Rossel 2017, Campaña et al. 2018). In recent years, within Latin America, considerable progress has been made in terms of developing knowledge and a better understanding of the gender differences in time use. Regional data suggest that, on average, women are responsible for two-thirds of unpaid household work, while men report engaging in one-third of the activities related to household tasks, and women work about one and a half hours more per day compared to men (Gammage 2010). There is clear evidence that women and men's time use in Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru reflects these broader trends, and that in each country women spend more time on unpaid work than do men, and work more hours per day overall than do men (Aguirre and Ferrari 2013).

Why this All Matters for Out-of-Pocket Expenditure

This work on time use is central to a gender analysis of OPE. This is because evidence from a wide range of countries has shown that it is not just a financial burden that is placed on households when someone is ill; other indirect costs, particularly the time burden, are also critical and may in fact place a greater burden on households than do the financial costs (Sauerborn et al. 1996). While most research has failed to acknowledge the gender dimensions of these issues, McIntyre et al. (2006, p. 862)

argue that there is evidence to suggest that the indirect costs of ill health are greater when women are ill:

> More hours of productive time are lost, largely due to the long hours that women work relative to men, particularly when household maintenance activities are included.

Studies from a range of middle- and low-income countries have also found that indirect costs of ill health have a greater burden on lower-income households than on higher-income households (McIntyre et al. 2006, Neilson et al. 2008). These "invisible" costs are rarely captured in discussion of the impact of OPE, but more attention needs to be given to these aspects of the cost burden of ill health if more gender-equitable outcomes are to be achieved.

Gender and Methodological Constraints to Measuring Out-of-Pocket Expenditure and Financial Protection

Existing data on OPPs rely on household-level surveys, but this points to a number of shortcomings when considered from a gender perspective. It is important to note that household surveys also only predominantly focus on OPPs in their narrowest definition (see Chapter 2) and do not capture the full range of OPEs. Nevertheless, one immediate problem is the lack of gender-disaggregated data within such surveys. At the same time, there is also an assumption that resources are shared equally within households, when a wide body of evidence has shown that this is not the case.

As Whitehead and Lockwood (1999, p. 536) argue:

> Lying behind the aggregated household approach is an implicit assumption of pooled income and consumption within the household, despite considerable evidence to the contrary.

Moreover, female-headed households become a "proxy" for all women (Bradshaw et al. 2017). Yet, research has shown that, at least in a Latin American context, female-headed households are not necessarily "the poorest of the poor," and, in some

contexts, female-headed households may indeed be better off than male-headed households (Chant 2015, Liu et al. 2017).

Furthermore, the category of female headship lumps together categories of household, generated by different processes at different life cycle stages and for different reasons, which are likely to have a variety of socioeconomic circumstances and opportunities (Whitehead and Lockwood 1999, p. 537). As Bradshaw et al. (2017) note, a more challenging issue is to focus on the difficulties faced by single-earner household heads in accumulating assets. A recent small-scale study conducted in Peru reflects on many of the challenges faced by women who become single mothers, particularly the need to balance their paid and unpaid responsibilities (Alvarado and del Carmen Vilchez 2015). This is also highlighted in work from Nigeria, where, in many poorer communities, widowed women in particular often face greater challenges in paying off debts incurred from OPE in health. This is because they frequently lack an asset base and have more limited options to draw on than do dual-earner households, and are forced to resort to hard, manual labor to generate an income and cut down on food as strategies toward settling the debt (Onah and Govender 2014, p. 8).

An extensive body of feminist research, including from across Latin America, has documented how gender differences in access to, control over, and use of, resources within households can frequently lead to "secondary poverty" among women and children in "non-poor" households. Studies have also warned over the limitations of a sole focus on income poverty given the multidimensional nature of poverty. However, this is also not reflected in household-level surveys, which continue to rely on income poverty.

A well-established body of research has shown how, within male-headed households, women can experience both gendered "power poverty" (whereby women and girls are unable [because of fear of violence or abandonment] or unwilling [because of deeply embedded gendered norms] to contest or resist male privilege or prerogatives) or time poverty (the lack of opportunity to sleep and rest – often as a consequence of the unpaid care burden) (cf. Bradshaw 2013; Chant 1997, 2007, 2009; Gammage 2010). As Bradshaw et al. (2017, p. 4) argue, power poverty and time poverty often interrelate with one another and may be more important in perceptions of poverty than limited access to income per se. It is this type of nuance that is often missed in large-scale survey

data, and there is a clear need for such analyses to be complemented by smaller-scale analyses that draw attention to the lived experiences of those experiencing the direct impacts of OPE.

Gender and Intra-Household Decision-Making

The importance of "unpacking" the nature of intra-household relations and decision-making around resource allocation has been well established within feminist research (Agarwal 1997). Nevertheless, despite these insights, health policies, and most notably health financing strategies, often contain implicit assumptions about the unitary nature of households and assume that resources are equally allocated among all members of the household. The majority of policymakers also fail to reflect on changing social understandings and experience of women's financial dependence or autonomy within the household and their role in health care decisions (Mackintosh and Tibandebage 2006). This can have important implications for how people use health care systems and for health outcomes. It is particularly pertinent when considering the gender-differentiated impacts of OPE (i.e., how women and men are affected differently by OPE).

It is also important that intra-household relations not be oversimplified into sets of opposing and individual interests of women and men (Jackson 1996). Concern has also been expressed over the ways in which research findings have been turned into "gender myths," such as women's inherent altruism and their dedication to maintaining family well-being in the face of crisis (Cornwall et al. 2007, González de la Rocha 2007). One such example is the popular consensus that women's income is dedicated to household spending, such as food, and is primarily oriented toward maintaining household health and well-being. In contrast, it is claimed that men tend to spend their income on more personal items (Jackson 1996). While it is not the goal of this study to question the validity of such data, as Jackson suggests, it is necessary to also look closely at the specific context in which such spending occurs.

Female altruism is often shaped by women's disempowerment within the household and due to a lack of alternative choices, rather than women's "inherent" maternal instincts (Brickell and Chant 2010, Chant 2007, Kabeer 1997). In contrast, because men tend to disregard household well-being and often spend money on alcohol, tobacco, and drugs, women are therefore prevented from acting in overt self-interest (Brickell and Chant 2010, p. 149). These assumptions have shaped and permeated policy interventions such as conditional cash transfer (CCT) programs with a health component, which are designed – at least in part – to alleviate OPE on health among poorer households. Moreover, CCTs have been widely critiqued for the exacerbation of gender inequalities, most notably in relation to gender roles and responsibilities (Molyneux 2006, Cookson 2016).

Within the health literature, some attention has been given to the importance of intra-household decision-making. For example, some authors have argued that better health outcomes are linked to women's financial autonomy and have advocated increasing women's income as a means to promote better health (Adjiwanou and LeGrand 2014, Pennington et al. 2018, Singh 2015). However, some of this work has failed to fully engage with the complexities of what goes on within households. In particular, it tends to reinforce the gender myths around women's altruism and is often centered around policies focusing on women's maternal role.

In contrast, a small number of recent studies have provided more nuanced analyses of intra-household decision-making around health-seeking behavior (Tolhurst et al. 2008, Richards et al. 2013) and how this can change across the life course (Tolhurst et al. 2016). In their study, Tolhurst et al. (2008) found that, where women did earn more income and became more independent, male family members then started to shirk their responsibilities for contributing toward the cost of health care treatment, claiming that given women's "ownership" of children, they were therefore responsible for paying for treatment. Understanding the allocation of resources within the household is particularly important in the context of the increased privatization of health care and the ongoing financial burden of OPE.

A recent study from Nigeria has shown that, although decision-making around health care may be jointly made, men tend to be the custodians of household finances, particularly in rural areas. This leads to men ultimately controlling the ways in which

resources are spent on health care, and some men have reported that women spend money unnecessarily and that women's health care needs are at times considered "frivolous," and so women tend to resort to using informal health care provision (Onah and Horton 2018). Moreover, women are often considered to be more vulnerable to poor health and thus likely to incur greater expenditure in relation to health care, although the study found that men were more likely to use formal health care services when they were sick compared to women (Onah and Horton 2018). Although comparable research in the Latin America and the Caribbean region has not been identified, these findings point to the importance of considering how gendered power dynamics within the household both affect and are affected by OPE spending in health, and what this potentially means for gender-differentiated use of health care services. Within the region, there is an urgent need for more studies that seek to understand the gender dimension of economic decision-making within the household, and for policymakers to draw effectively on this knowledge.

Strong gender norms that reinforce women's gendered roles within the household remain widespread in Peru. They tend to limit women's access to decision-making processes, particularly around resources, both within the household and at community level (McNulty 2015, Nagels 2016). While important advances have been made in terms of developing "pro-gender" policies in Peru, significant constraints continue to limit their effective implementation (Boesten 2010). As long as women remain marginalized from accessing resources at all levels of the economy, this points to serious concerns around most women's ability to cope with the impact of OPE in health.

Although not specifically focused on health-related decision-making within the household, research conducted in Bolivia (Plurinational State of), Guatemala, and Peru with rural, indigenous households highlights the strong and relatively rigid gender roles and responsibilities within households. It also suggests that women often have only limited access to decision-making processes around health and resources (McNulty 2015, Nagels 2016, Wehr and Tum 2013.) Moreover, evidence from Peru has shown how women's exclusion from economic decision-making processes extends beyond the household to the community level (McNulty 2015). While men tend to be the main decision-makers, in the Guatemalan context, for example, extended family members, particularly mothers-in-law, can

also play an important role at the household level (Wehr and Tum 2013). While there is a need for further research, this suggests the potential implications in relation to OPE. Studies from India have highlighted the complexity of decision-making processes around health care spending for maternal health, where extended family members may not believe that certain costs are justified and, as a consequence, women may be denied access to certain maternal health care services (Gideon et al. 2017). Similarly, research in Ghana also sheds some light on the ways in which men question the justification of women's spending on their own health, especially in relation to maternal health care needs (Dalinjong et al. 2018). A clearer understanding of gendered power relations within households and the diverse ways in which these shape decision-making processes around health care expenditure is vital.

Gender, Households, and Poverty

If, as discussed in the previous chapter, household members do not share equal access to resources within the household and have different "fallback positions" in times of financial difficulty, then it is important that policymakers have some understanding of the gendered nature of poverty, as this will provide critical insights into women and men's differential ability to cope with making OPE in health. As the wider literature has shown, households engage in a wide range of strategies to cope with paying for health care. However, the financial burden of OPE may affect women more adversely than men if poverty is itself gendered. In order to understand the gendered dimensions of OPE, it is therefore necessary to have a better understanding of the gendered nature of poverty. The following section presents the four country case studies, to offer a better insight into the ways in which gendered norms, roles, and responsibilities shape not only the differential impact of OPE on women and men, but also their ability to pay and to cope with the increased financial burden – as well as the likelihood of them incurring costs in the first place due to ill health.

Poverty, Gender, and Inequalities in Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru

Despite the presence of pro-gender equality in all four of the case study countries, gender roles have remained relatively fixed, with women generally taking the role of primary caregiver within the household. As some of the indicators in Table 3 demonstrate, this unpaid care work has had a significant impact on shaping women's access to the labor market and also in enabling women to pursue jobs where they can earn a decent salary. There are significant gender gaps in women's income levels and labor market participation in all four countries.

Table 3. Selected Indicators for Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru

	Bolivia (Plurinational State of)		Guatemala		Nicaragua		Peru	
	Women	Men	Women	Men	Women	Men	Women	Men
Gini coefficient	48.4		48.7		47.1		44.1	
Estimated gross national product income per capita (2011 PPP US$)	4,695	7,610	5,132	9,081	3,150	6,389	8,939	13,655
Labor force participation rate (% age 15 years and older)	63.9	82.5	41.3	83.6	49.1	80.3	65.7	82.6
Urban unemployment rate (%)2013–2014, lay	4.7	3.0	3.3	3.1	7.3	9.2	4.6	3.9
Unemployment rate (total) female to male ratio	1.6		1.3		1.0		1.2	
Share of women (%) in wage employment, nonagricultural sector – 2010-2014, lay	37		40		38		37	

Source: PAHO et al. 2016, UNDP 2018.

Given the significant presence of indigenous communities in all four countries, it is also vital that any exploration of the gendered nature of poverty employ an intersectional lens. Research from Peru has found that the ethnic wage gap is much greater among women workers compared to men, and that the gender wage gap is more significant among indigenous workers compared to nonindigenous workers. Indigenous women are particularly disadvantaged. Not only are they paid the lowest absolute wages, but their relative situation in relation to the wage gaps has not improved over time, whereas this is not the case for men (Kolev and Suárez Robles 2015).

Within Guatemala, a number of studies document significant inequalities between the nonindigenous (ladino) and indigenous populations and all highlight different aspects of the marginalization of indigenous communities. Furthermore, different levels of inequality between diverse ethnic groups are frequently overlooked by researchers and policymakers, and there is an urgent need to develop a more informed picture of the ways in which indigenous groups are marginalized in different contexts (Canelas and Gisselquist 2018). Rural, indigenous populations are often doubly discriminated against, both in terms of their rural location and also in terms of their being indigenous, and this constrains their access to decent income-generating opportunities (Poder and He 2015). For example, data suggest that across Guatemala women tend to be concentrated in low-productivity activities, making up 65% of such workers compared with 53% of men. Gender gaps in pay and earnings prevail and women earn, on average, 66% of male wages (Gammage 2010). As a consequence of this discrimination, many indigenous, rural children experience negative health impacts, as they and their families are denied a decent quality of life (Poder and He 2015).

Women in rural, indigenous households are frequently highly marginalized. Several studies highlight the exclusion of these women from maternal health care services and other reproductive health care services (Castro et al. 2015, Chomat et al. 2014, Ishida et al. 2012, Taylor et al. 2015). There is a consensus within this research that women's exclusion from services, particularly those offering maternal health care services, is often not about the cost of accessing care, but about poor treatment received in public health care services and also social/cultural needs not addressed in formal health care provision. Similar findings have been identified in other parts of the region, including Bolivia (Plurinational State of)

(Morales 2018) and Peru (Ewig 2010). As these studies demonstrate, there is an urgent need to focus on the impacts of intersecting forms of (gender and ethnic) discrimination, and an important aspect of this is addressing cultural needs, which can also be considered as forming an important component of indigenous women's empowerment.

The marginalization of indigenous women from formal health care services is reflected in the available data on OPP. For example, data from Bolivia (Plurinational State of) show that individuals speaking indigenous languages besides Aymara and Quechua spent less money on OPPs[8] than did any other language group, suggesting that these groups may be most marginalized from the health system. In this category, women also spent twice the amount on OPPs compared to men. As the data in Table 4 suggest, in other language groups the differences between male and female expenditure are not as great (with the exception of foreign languages).

Table 4. Individual Out-of-Pocket Payments by Language and Sex, Bolivia (Plurinational State of)

Language	Men	Women	Total	Women/Men ratio
	(Bs)			
Spanish	338	485	412	1.4
Quechua	264	273	268	1.0
Aymara	242	238	240	1.0
Other indigenous	64	182	126	2.9
Foreign	236	559	371	2.4
No response	468	416	442	0.9
Did not specify	377	864	611	2.3
Total	320	425	373	1.3

Source: Prieto and Montañez 2017, p. 20.

[8] As these are data taken from national-level surveys, they reflect formal out-of-pocket payments and, therefore, the term OPP has been used, rather than OPE.

Research has also found strong evidence of both time poverty and gender power poverty in rural subsistence and indigenous households in Guatemala. Women often see their prime responsibility as taking care of children and the household, while men are the breadwinners (Wehr and Tum 2013). Within such households, women have been shown to be particularly time poor (Gammage 2010). This can be further exacerbated where they take on additional Research has also found strong evidence of both time poverty and gender power poverty in rural subsistence and indigenous households in Guatemala. Women often see their prime responsibility as taking care of children and the household, while men are the breadwinners (Wehr and Tum 2013). Within such households, women have been shown to be particularly time poor (Gammage 2010). This can be further exacerbated where they take on additional income-generating activities to deal with shortfalls in household-level income (Wehr and Tum 2013).

These findings raise important concerns for the debate around the gendered nature of the impact of OPE. As the discussion has shown, women are less likely to be in paid work compared to men, and, even where women are employed, they face a significant difference in wage levels compared to men. This means that they are less likely to be able to bear the cost of OPE in health. At the same time, as women are less likely to be in paid work, they are also more likely to lack access to health insurance schemes that would offer health care coverage. This means that they are more vulnerable to experiencing OPE in the first place.

Gender and Asset Ownership

One critical coping strategy employed by households when they face OPE is the sale of assets. However, the use of a gender lens can highlight important differences in asset ownership. As critics have argued, locating data on gender-differentiated assets is not an easy task, as many household surveys, given their focus on the household as a whole, do not collect information on individual-level assets (Deere and Doss 2006, Deere et al. 2012). Nevertheless, within Latin America, Nicaragua is one of the few countries where

some gender-disaggregated information on asset ownership is available. The data show that, while there is almost parity of home ownership by women and men in urban areas, stark gender differences are found in other areas of asset ownership. For example, data from the Nicaraguan household surveys show that men are more likely to be titled owners of land, be the key decisionmaker over agricultural production, and own work animals such as donkeys and cattle, while women tend to own "less valuable" livestock assets such as poultry and pigs (Deere et al. 2012). Given that sale of assets is a critical response to the need to pay OPE in health, these gender-differentiated patterns of ownership raise important questions about women's ability to cope with the impact of additional health-related payments. If there are significant gender differences in asset ownership, it is vitally important that women participate in decision-making processes within the household, particularly around economic resources.

Gender, Social Protection, and Social Policy in Latin America

Individual and household ability to cope with OPE will also in part be shaped by the wider social policy environment and the presence of social safety nets to support people in overcoming financial shocks. The social policy regime of an individual country is also important in terms of how access to services is determined, and what kinds of implicit assumptions underpin ideas of service users. A growing body of research has considered Latin American social policy from a gender perspective and, among other things, has sought to uncover many of the assumptions that are made in the financing, design, and delivery of welfare services, as well as about service users themselves.

In a pivotal piece, Martínez Franzoni (2008) developed a typology that incorporates the role of unpaid care work in welfare regimes and considers the interactions between labor markets, families, and public policy in the region. Her analysis finds that a large number of countries in the region – including Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru – have what are termed "non-state familiarist" welfare regimes. In these countries, the population

largely relies on family arrangements, as social public policies are inadequate or nonexistent (Martínez Franzoni 2008, p. 88). In fact, this means that women's unpaid care work continues to play an integral role in welfare provision and as Martínez Franzoni argues, even where women take on paid work this "comes with longer hours of unpaid household chores" (Martínez Franzoni 2008, p. 89).

In the past few decades, governments across the region have invested in expanding social protection and conditional CCTs have become a prominent feature of the Latin American social policy landscape, including in the four case-study countries. CCT programs are deliberately designed to seek to change people's health-related behavior, and to reward them with cash benefits for doing so. As has been widely documented, CCTs often target low-income women with cash payments in exchange for their carrying out a range of health-related tasks (among other things) that are aimed at ensuring better health outcomes for children (Hunter and Murray 2017).

Nevertheless, CCTs have been widely critiqued from a gender perspective, most notably for their reinforcement of women's role as mothers (Molyneux 2006) and the feminization of household responsibilities and obligations (Chant 2007). However, as Johnston (2016) argues, one important shortcoming of CCT programs is that they "blame" the individual for illness, thereby ignoring the way in which illness may be produced by socioeconomic structures and overlooking the role of health systems in failing to prevent or respond to poor health. Given that CCT programs frequently assign this responsibility to women, they are subsequently blamed for not only their own poor health but also that of their families and household members. As Hunter and Murray (2017) note, many of the CCT programs across Latin America do include important components that specifically focus on antenatal care and seek to incentivize women to give birth in formal health care settings. Yet, as has been demonstrated in this report, despite policies intended to ensure free maternity care, women frequently encounter a range of additional OPEs that can act as a powerful deterrent from using services and often occur because of supply-side constraints. In Guatemala, for example, research has shown how the introduction of the CCT program undermined the already inadequate supply and quality of service, and many municipalities were unable to meet the increased demand for services generated by the program (Sandberg and Tally 2015).

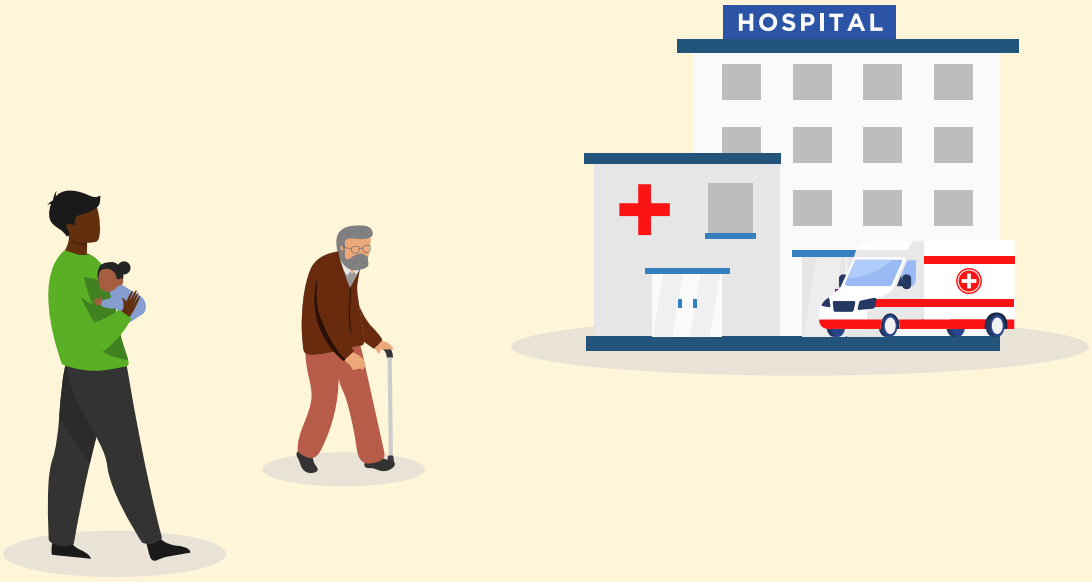
A growing number of studies in Bolivia (Plurinational State of), Nicaragua, and Peru have revealed the ways in which CCT programs also increase women's time poverty, as they are expected to perform a wide range of tasks in order to comply with program requirements (Molyneux and Thomson 2011, Nagels 2016, Neumann 2013). Moreover, Cookson's (2016) ethnographic research in Peru has also drawn attention to what she terms "shadow conditionalities." These are additional tasks that are often imposed on CCT beneficiaries but are not formally part of the program. All of these raise important concerns about women's time burden and highlight the potential challenges of responding to OPE in health. As Elson (1995) has argued, women's time is not infinitely elastic, and if women have to take on additional paid work or spend more time shopping to find cheaper produce to make up for a shortfall in income, they are likely to reach breaking point, which can in turn lead to additional health problems. Yet, as Neumann (2013) has shown in Nicaragua, women's time poverty can be further exacerbated when other social policy programs beyond CCTs also depend on women's "voluntary" participation.

Some CCT programs have also sought to address gender differences in access to financial and banking services. These can constitute a major constraint to women's economic empowerment and have potential implications for women's ability to respond to OPEs. In Peru, Proyecto Capital was introduced in 2009 as part of the Juntos CCT program with the objective of promoting formal savings for female beneficiaries. Personal savings accounts are a means of helping to mitigate the impacts of unanticipated financial shocks, such as those resulting from illness, and Proyecto Capital was also seen as a means of improving financial inclusion (Meltzer 2013). Nevertheless, the savings elements of CCT programs have also been criticized for their inherent gendered narratives, which again target women as bearing the prime responsibility for household welfare and saving sufficiently to ensure they can fulfil these responsibilities. Yet, as critics have argued, these kinds of discourses are also underpinned by specific moral and racialized narratives. As Meltzer (2013, p. 649) contends:

> Although indigenous populations are not explicitly targeted in contemporary cash transfer or savings program, they nevertheless continue to constitute the significant majority of extremely poor populations in Peru, and therefore make up the majority of targeted recipients. The

requirement not only to save but also to maintain certain standards of hygiene, cleanliness, and education as conditions of cash transfers reflect an articulation of longer standing moral-racial narratives of indigenous/poor/non-citizens as idle, dirty, and destitute.

OPE in health places the responsibility for indebtedness on individuals and fails to address the wider structural constraints in the health system that generate the initial need for households to make these OPP in the first place. As this report has demonstrated, the ability to cope with OPE is highly gendered and can exacerbate gendered vulnerabilities to poverty and ill health. This can then, in turn, further re-embed gendered and racialized narratives around "the poor," which contribute to their ongoing marginalization.



Conclusions

Drawing on a range of different bodies of literature, this report has highlighted the need to employ a gender lens when considering the differential impacts of health-related OPE on women and men. Evidence from Latin America and beyond shows that, despite progressive shifts toward UHC provision, health care users in a wide variety of contexts still face a broad range of OPEs that can contribute to the impoverishment of households.

The analysis presented has pointed to the importance of understanding the gendered nature of vulnerabilities to poor health as well as the gendered nature of pathways into poverty, as this sheds light on the constraints and challenges faced by many low-income women, in particular when coping with the impact of OPE. The report has also stressed the importance of employing an intersectional analysis to ensure a more nuanced understanding of the ways in which other aspects of social identities beyond gender intersect and shape the ability of individuals and households to respond to the different OPEs that they may encounter.

If governments in Latin America and the Caribbean are to take seriously the commitments they signed up to in the 2014 Strategy for Universal Access to Health and Universal Health Coverage, there is an urgent need to recognize the importance of engaging with these wider debates around gender and intersectional inequalities.

References

- Acharya J, Kaehler N, Marahatta SB, Mishra SR, Subedi S, Adhikari B. Hidden costs of hospital based delivery from two tertiary hospitals in western Nepal. PloS One 2016;11(6):e0157746.
- Adjiwanou V, LeGrand T. Gender inequality and the use of maternal healthcare services in rural sub-Saharan Africa. Health & Place 2014;29:67-78.
- Agarwal B. "Bargaining" and gender relations: within and beyond the household. Feminist Economics 1997;3(1):1-51.
- Aguirre R, Ferrari F. Surveys on time use and unpaid work in Latin America and the Caribbean: Experience to date and challenges for the future. Santiago: CEPAL; 2013. (Working Paper, ECLAC Series Gender Affairs No. 122). Available from: https://www.cepal.org/en/publications/35903-surveys-time-use-and-unpaid-work-latin-america-and-caribbean-experience-date-and
- Alvarado B, del Carmen Vilchez R. Single, divorced, or separated? factors that impact the lives of women who are heads of household in Lima, Peru. SAGE Open 2015;5(4):https://doi.org/10.1177/2158244015611713.
- Amarante V, Rossel C. Unfolding patterns of unpaid household work in Latin America. Feminist Economics 2017;24(1):1-34. https://doi.org/10.1080/13545701.2017.1344776
- Atun R, de Andrade LOM, Almeida G, Cotlear D, Dmytraczenko T, Frenz P, et al. 2015. Health-system reform and universal health coverage in Latin America. The Lancet 2015;385(9974):1230-1247.
- Baji P, Rubashkin N, Szebik I, Stoll K, Vedam S. Informal cash payments for birth in Hungary: Are women paying to secure a known provider, respect, or quality of care? Social Science & Medicine 2017;189:86-95.
- Bennett S, Ozawa S, Rao KD. Which path to universal health coverage? Perspectives on the World Health Report 2010. PLoS Med 2010;7(11):e1001001. https://doi.org/10.1371/journal.pmed.1001001
- Boesten J. Intersecting inequalities: women and social policy in Peru, 1990-2000. University Park, PA: Penn State University Press; 2010.
- Bradshaw S. Women's decision-making in rural and urban households in Nicaragua: The influence of income and ideology. Environment and Urbanization 2013;25(1):81-94.
- Bradshaw S, Chant S, Linneker B. Gender and poverty: what we know, don't know, and need to know for Agenda 2030. Gender, Place & Culture 2017;24(12):1667-1688.
- Brickell K, Chant S. 'The unbearable heaviness of being': Reflections on female altruism in Cambodia, Philippines, The Gambia and Costa Rica. Progress in Development Studies 2010;10(2):145-159.
- Cadena M de la. Las mujeres son más indias: Etnicidad y género en una comunidad del Cuzco. Revista Isis Internacional, Ediciones de las Mujeres (Santiago de Chile), 1992;16.
- Campaña JC, Giménez-Nadal JI, Molina JA. Gender norms and the gendered distribution of total work in Latin American households. Feminist Economics 2018;24(1):35-62.
- Canelas C, Gisselquist RM. Human capital, labour market outcomes, and horizontal inequality in Guatemala. Oxford Development Studies 2018;46(3):378-397. https://doi.org/10.1080/13600818.2017.1388360

- Castro A, Savage V, Kaufman H. Assessing equitable care for Indigenous and Afrodescendant women in Latin America. Revista Panamericana de Salud Pública 2015;38(2):96-109.
- Chant S. Female household headship as an asset? Interrogating the intersections of urbanisation, gender, and domestic transformations. In: Moser C, ed. Gender, asset accumulation and just cities: Pathways to transformation. Oxford and New York: Routledge; 2015:33-51.
- Chant S. Gender, generation and poverty: exploring the feminisation of poverty in Africa, Asia and Latin America. Cheltenham: Edward Elgar Publishing; 2007.
- Chant S. The 'feminisation of poverty' in Costa Rica: To what extent a conundrum? Bulletin of Latin American Research 2009;28(1):19-43.
- Chant S. Women-headed households. Houndmills, Basingstoke: Macmillan; 1997.
- Chomat AM, Solomons NW, Montenegro G, Crowley C, Bermudez OI. Maternal health and health-seeking behaviors among indigenous Mam mothers from Quetzaltenango, Guatemala. Revista Panamericana de Salud Pública 2014;35(2):113-120.
- Cookson TP. Working for inclusion? conditional cash transfers, rural women, and the reproduction of inequality. Antipode 2016;48(5):1187-1205.
- Cornwall A, Harrison E, Whitehead A. Gender myths and feminist fables: The struggle for interpretive power in gender and development. Development and Change 2007;38(1):1-20.
- Dados N, Connell R. The global south. Contexts 2012;11(1):12-13.
- Dalinjong PA, Wang AY, Homer CSE. Has the free maternal health policy eliminated out of pocket payments for maternal health services? Views of women, health providers and insurance managers in Northern Ghana. PLoS One 2018;13(2):e0184830. https://doi.org/10.1371/journal.pone.0184830
- Deere CD, Alvarado GE, Twyman J. Gender inequality in asset ownership in Latin America: Female owners vs household heads. Development and Change 2012;43(2):505-530.
- Deere CD, Doss CR. The gender asset gap: What do we know and why does it matter? Feminist Economics 2006;12(1-2):1-50.
- Diaz JJ, Valdivia M. The vulnerability of the uninsured to health shocks in Peru. In: Knaul FM, Wong R, Arreola-Ornelas H, eds. Household spending and impoverishment. Volume 1 of Financing health in Latin America series. Cambridge, MA: Harvard Global Equity Initiative, Mexican Health Foundation, International Development Research Centre; 2012.
- Doyal L, Pennell I. The political economy of health. London: Pluto Press; 1979.
- Dyer SJ, Sherwood K, McIntyre D, Ataguba JE. Catastrophic payment for assisted reproduction techniques with conventional ovarian stimulation in the public health sector of South Africa: frequency and coping strategies. Human Reproduction 2013;28(10):2755-2764.
- Dzakpasu S, Powell-Jackson T, Campbell OM. Impact of user fees on maternal health service utilization and related health outcomes: A systematic review. Health Policy and Planning 2013;29(2):137-150.
- Elson D. Male bias in the development process. Manchester and New York: Manchester University Press; 1995 (2nd Edition).

- Elson, D. Integrating gender issues into national budgetary policies and procedures: some policy options. Journal of International Development: The Journal of the Development Studies Association 1998;10(7), 929-941.
- Ewig C. Second-wave neoliberalism: Gender, race, and health sector reform in Peru. University Park, PA: Penn State University Press; 2010.
- Ewig C, Hernández Bello A. Gender equity and health sector reform in Colombia: Mixed state-market model yields mixed results. Social Science & Medicine, 2009;68(6):1145-1152.
- Flores G, Krishnakumar J, O'Donnell O, Van Doorslaer E. Coping with health-care costs: Implications for the measurement of catastrophic expenditures and poverty. Health Economics 2008;17(12):1393-1412.
- Folbre N. Who pays for the kids? Gender and the structures of constraint. New York: Routledge; 1994.
- Francke P. Peru's comprehensive health insurance and new challenges for universal coverage. Universal Health Coverage (UNICO) studies series, no. 11. Washington, DC: World Bank; 2013.
- Galárraga O, Sosa-Rubí S, Salinas-Rodríguez A, Sesma-Vázquez S. Health insurance for the poor: Impact on catastrophic and out-of-pocket health expenditures in Mexico. European Journal of Health Economics 2010;11(5):437-447.
- Gammage S. Time pressed and time poor: Unpaid household work in Guatemala. Feminist Economics 2010;16(3):79-112.
- Gertler P, Gruber J. Insuring consumption against illness. American Economic Review 2002;1:51-76.
- Gideon J. Gender, Globalization and health in a Latin American context. Basingstoke and New York: Palgrave Macmillan; 2014.
- Gideon J, ed. Handbook on gender and health. Cheltenham: Edward Elgar; 2016.
- Gideon J, Hunter BM, Murray SF. Public-private partnerships in sexual and reproductive healthcare provision: Establishing a gender analysis. Journal of International and Comparative Social Policy 2017;33(2):166-180.
- Gonçalves Martín J. Walking to the health post, flying to the hospital. Yanomami people's approaches to a gendered reproductive health system. In: Gideon J, ed. Handbook on Gender and Health. Cheltenham: Edward Elgar; 2016:351-374.
- González de la Rocha M. The construction of the myth of survival. Development and Change 2007;38(1):45-66.
- Govil D, Purohit N, Gupta SD, Mohanty SK. Out-of-pocket expenditure on prenatal and natal care post Janani Suraksha Yojana: A case from Rajasthan, India. Journal of Health, Population and Nutrition 2016;35(1):15. https://doi.org/10.1186/s41043-016-0051-3 PMID: 27207164
- Grogger J, Arnold T, León AS, Ome A. Heterogeneity in the effect of public health insurance on catastrophic out-of-pocket health expenditures: the case of Mexico. Health Policy and Planning 2014;30(5):593-599.
- Head B, Harris L, Kayser K, Martin A, Smith L. As if the disease was not enough: Coping with the financial consequences of cancer. Supportive Care in Cancer 2018;26(3):975-987.
- Herrera C, Dijkstra G, Ruben R. Gender segregation and income differences in Nicaragua. Feminist Economics 2019;25(3)144-170.
- Himmelweit S. The discovery of "unpaid work": The social consequences of the expansion of "work". Feminist Economics 1995;1(2):1-19.

- Hunter BM, Murray SF. Demand-side financing for maternal and newborn health: what do we know about factors that affect implementation of cash transfers and voucher programmes? BMC Pregnancy and Childbirth 2017;17(1):262.
- Ishida K, Stupp P, Turcios-Ruiz R, William DB, Espinoza E. Ethnic inequality in Guatemalan women's use of modern reproductive health care. International Perspectives on Sexual and Reproductive Health 2012;38(2)99-108.
- Jackson C. Rescuing gender from the poverty trap. World Development 1996;24(3):489-504.
- Johnston D. Cost-cutting, coproduction and cash transfers: Neoliberal policy, health and gender. In: Gideon J, ed. Handbook on gender and health, Cheltenham: Edward Elgar; 2016:98-116.
- Kabeer N. Tactics and trade-offs: Revisiting the links between gender and poverty. IDS Bulletin 1997;28(3):1-13.
- Kalu-Umeh NN, Sambo MN, Idris SH, Kurfi AM. Costs and patterns of financing maternal health care services in rural communities in Northern Nigeria: Evidence for designing national fee exemption policy. International Journal of MCH and AIDS 2013;2(1):163-172. Epub 2013/01/01. PMID: 27621969; PubMed Central PMCID: PMCPMC4948141.
- Knaul FM, Arreola-Ornelas H, Méndez-Carniado O, Bryson-Cahn C, Barofsky J, Maguire R, et al. Evidence is good for your health system: Policy reform to remedy catastrophic and impoverishing health spending in Mexico. The Lancet 2006;368(9549):1828-1841.
- Knaul FM, Wong R, Arreola-Ornelas H, Méndez O, Bitrán R, Campino ACC, et al. Household catastrophic health expenditures: A comparative analysis of twelve Latin American and Caribbean Countries. In: Household spending and impoverishment. Volume 1 of Financing health in Latin America series. Cambridge, MA: Harvard Global Equity Initiative, Mexican Health Foundation, International Development Research Centre; 2012.
- Koch KJ, Cid Pedraza C, Schmid A. Out-of-pocket expenditure and financial protection in the Chilean health care system—a systematic review. Health Policy 2017;121(5):481-494.
- Kolev A, Suárez Robles P. Ethnic wage gaps in Peru: What drives the particular disadvantage of indigenous women? International Labour Review 2015;154(4):417-448.
- Leatherman T, Jerrigan K. The reproduction of poverty and poor health in the production of health disparities in southern Peru. Annals of Anthropological Practice 2014;38(2):284-299.
- Liu C, Esteve A, Treviño R. Female-headed households and living conditions in Latin America. World Development 2017;(90):311-328.
- Mackintosh M, Tibandebage P. Gender and health sector reform: Analytical perspectives on African experience. In: Gender and social policy in a global context. London: Palgrave Macmillan; 2006:237-257.
- Martínez Franzoni J. Welfare regimes in Latin America: Capturing constellations of markets, families, and policies. Latin American Politics and Society 2008;50(2):67-100.
- Matamala M, Eguiguren P, Díaz X. Tensiones y silencias en la reforma de la salud. Género y derechos ausentes. Santiago: Observatorio de Equidad de Género en Salud; 2011.
- McDowell L. Doing gender: feminism, feminists and research methods in human geography. Transactions of the Institute of British Geographers 1992;17(4)399-416.
- McGrath P. The use of credit cards in response to the crisis of serious illness. Illness, Crisis & Loss 2016;24(1):46-56.

- McIntyre D, Thiede M, Dahlgren G, Whitehead M. What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? Social Science and Medicine 2006;62(4):858-865.
- McNulty SL. Barriers to participation: Exploring gender in Peru's participatory budget process. Journal of Development Studies 2015;51(11):1429-1443. https://doi.org/10.1080/00220388.2015.1010155
- Meltzer J. 'Good citizenship' and the promotion of personal savings accounts in Peru. Citizenship Studies 2013;17(5):641-652.
- Molyneux M. Mothers at the service of the new poverty agenda: Progresa/Oportunidades, Mexico's conditional transfer programme. Social Policy & Administration 2006;40(4):425-449.
- Molyneux M, Thomson M. Cash transfers, gender equity and women's empowerment in Peru, Ecuador and Bolivia. Gender & Development 2011;19(2):195-212.
- Morales GE. There is no place like home: Imitation and the politics of recognition in Bolivian obstetric care. Medical Anthropology Quarterly 2018;32(3):404-424.
- Moreno-Serra R, Millett C, Smith PC. Towards improved measurement of financial protection in health. PLoS Med 2011;8(9):e1001087. https://doi.org/10.1371/journal.pmed.1001087
- Nagels N. The social investment perspective, conditional cash transfer programmes and the welfare mix: Peru and Bolivia. Social Policy and Society 2016;15(3):479-493.
- Neilson C, Contreras D, Cooper R, Hermann J. The dynamics of poverty in Chile. Journal of Latin American Studies 2008;40:251-273.
- Neumann PJ. The gendered burden of development in Nicaragua. Gender & Society 2013;27(6):799-820.
- Nigenda G, Wirtz VJ, González-Robledo LM, Reich MR. Evaluating the implementation of Mexico's health reform: The case of Seguro Popular. Health Systems & Reform 2015;1(3):217-228.
- Onah MN, Govender V. Out-of-pocket payments, health care access and utilisation in south-eastern Nigeria: A gender perspective. PLoS One 2014;9(4):e93887. https://doi.org/10.1371/journal.pone.0093887
- Onah MN, Horton S. Male-female differences in households' resource allocation and decision to seek healthcare in south-eastern Nigeria: Results from a mixed methods study. Social Science & Medicine 2018;204:84-91.
- Ortiz-Rodriguez J, Small E. The financial burden of healthcare cost: Coping strategies for medical expenses in Mexico. Social Indicators Research 2017;133(1):275-284.
- PAHO, WHO, ECLAC, UN Women, UNFPA, UNICEF. Gender, Health and Development in the Americas, Basic Indicators, 2016. Available from: https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=data-statistics-8724&alias=47095-gender-health-and-development-basic-indicators-2016&Itemid=270&lang=en
- Pennington A, Orton L, Nayak S, Ring A, Petticrew M, Sowden A, et al. The health impacts of women's low control in their living environment: A theory-based systematic review of observational studies in societies with profound gender discrimination. Health & Place 2018;51:1-10.
- Pisu M, Martin MY, Shewchuk R, Meneses K. Dealing with the financial burden of cancer: Perspectives of older breast cancer survivors. Supportive Care in Cancer 2014;22(11):3045-3052.

- Poder TG, He J. The role of ethnic and rural discrimination in the relationship between income inequality and health in Guatemala. International Journal of Health Services 2015;45(2):285-305.
- Power M. Social provisioning as a starting point for feminist economics. Feminist Economics 2004;10(3):3-19.
- Prieto AL, Montañez VA. (2017) Estudio de gasto de bolsillo desde una perspectiva de igualdad de género, Informe Final. Washington, DC: Pan American Health Organization; 2017. (Unpublished document).
- Ravindran TS. Universal access: making health systems work for women. BMC Public Health 2012;12(1):S4.
- Razavi S. Gendered poverty and well-being: Introduction. Development and Change 1999;30(3):409-433.
- Rees G. Children's activities and time use: Variations between and within 16 countries. Children and Youth Services Review 2017;80:78-87.
- Restrepo-Méndez MC, Barros AJD, Requejo J, Durán P, Serpa LA, França GVA, et al. Progress in reducing inequalities in reproductive, maternal, newborn, and child health in Latin America and the Caribbean: An unfinished agenda. Revista Panamericana de Salud Pública 2015;38(1):9-16.
- Richards E, Theobald S, George A, Kim JC, Rudert C, Jehan K, et al. Going beyond the surface: Gendered intra-household bargaining as a social determinant of child health and nutrition in low and middle income countries. Social Science & Medicine 2013;95:24-33.
- Rotarou ES, Sakellariou D. Neoliberal reforms in health systems and the construction of long-lasting inequalities in health care: A case study from Chile. Health Policy 2017;121(5):495-503.
- Ruger JP. An alternative framework for analyzing financial protection in health. PLoS Medicine 2012;9(8):e1001294.
- Samuel J. Citizen monitoring: Promoting health rights among socially excluded women in Andean Peru. In: Gideon J, ed. Handbook on gender and health. Cheltenham: Edward Elgar; 2016:419-435.
- Sandberg J, Tally E. Politicisation of conditional cash transfers: The case of Guatemala. Development Policy Review 2015;33(4):503-522.
- Sauerborn R, Adams A, Hien M. Household strategies to cope with the economic costs of illness. Social Science and Medicine 1996;43(3):291-301.
- Sen G, Govender V. Sexual and reproductive health and rights in changing health systems. Global Public Health 2015;10(2):228-242.
- Sen G, Govender V, El-Gamal S. Universal health coverage, gender equality and social protection: A health systems approach. UN Women background paper for the Sixty-third session of the Commission on the Status of Women (CSW 63). New York: UN Women; December 2018 (EGM/SPS/BP.2). Available from: http://dawnnet.org/wp-content/uploads/2019/01/Sen-Gbackground-paperdraftEGMSPSBP2.pdf
- Sen G, Östlin P. Gender inequity in health: Why it exists and how we can change it. Global Public Health 2008;3(Suppl 1):1-12.
- Sicuri E, Bardají A, Sanz S, Alonso S, Fernandes S, Hanson K, et al. Patients' costs, socio-economic and health system aspects associated with malaria in pregnancy in an endemic area of Colombia. PLoS Neglected Tropical Diseases 2018;12(5):e0006431. https://doi.org/10.1371/journal.pntd.0006431
- Singh K, Bloom S, Brodish P. Gender equality as a means to improve maternal and child health in Africa. Health Care for Women International 2015;36(1):57-69.

- Smith-Oka V. Microaggressions and the reproduction of social inequalities in medical encounters in Mexico. Social Science & Medicine 2015;143:9-16.
- Smith-Spangler CM, Bhattacharya J, Goldhaber-Fiebert JD. Diabetes, its treatment, and catastrophic medical spending in 35 developing countries. Diabetes Care 2012;35(2):319-326.
- Springer KW, Hankivsky O, Bates LM. Gender and health: Relational, intersectional, and biosocial approaches. Social Science & Medicine 2012;74(11):1661–1666.
- Superintendencia de Salud. Ley Ricarte Soto. 2021. Available from: https://www.supersalud.gob.cl/difusion/665/w3-propertyvalue-6088.html
- Taylor TM, Hembling J, Bertrand JT. Ethnicity and HIV risk behaviour, testing and knowledge in Guatemala. Ethnicity & Health 2015;20(2):163-177.
- Thorp R, Paredes M. Ethnicity and the persistence of inequality: The case of Peru. London: Palgrave MacMillan; 2010.
- Tolhurst R, Amekudzi YP, Nyonator FK, Bertel Squire S, Theobald S. "He will ask why the child gets sick so often": The gendered dynamics of intra-household bargaining over healthcare for children with fever in the Volta Region of Ghana. Social Science & Medicine 2008:66(5):1106-1117.
- Tolhurst R, Richards E, MacPherson E, Kamuya D, Zalwango F, Theobald S. "Capacities to exercise strategic decision-making agency: Exploring the gendered production of health within intimate partnerships and households". In: Gideon J, ed. Handbook on gender and health. Cheltenham: Edward Elgar; 2016:394-418.
- UNDP. Human Development Reports 2018; http://hdr.undp.org/en/indicators/140606
- Van Damme W, Meessen B, Por I, Kober K. Catastrophic health expenditure. (Correspondence) The Lancet 2003;362(9388): 996.
- Wehr H, Tum SE. When a girl's decision involves the community: The realities of adolescent Maya girls' lives in rural indigenous Guatemala. Reproductive Health Matters 2013;21(41):136-142.
- Whitehead A, Lockwood M. Gendering poverty: A review of six World Bank African poverty assessments. Development and Change 1999;30(3):525-555.
- Witter S, Govender V, Ravindran TS, Yates R. Minding the gaps: Health financing, universal health coverage and gender. Health Policy and Planning 2017;32(Suppl 5):v4-v12.
- World Health Organization (WHO). The World Health Report: Health systems financing: The path to universal coverage. Geneva: WHO; 2010a. Available from: https://www.who.int/whr/2010/en/
- World Health Organization (WHO). Gender, women and primary health care renewal: A discussion paper. Geneva: WHO, Department of Gender, Women and Health; 2010b. Available from: http://www.who.int/gender-equity-rights/knowledge/9789241564038/en/
- World Health Organization (WHO). The global push for universal health care coverage. 2014. Available from: https://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf
- World Health Organization (WHO). Out-of-pocket payments, user fees and catastrophic expenditure. 2021a. Available from: http://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

- World Health Organization (WHO). Health financing: financial protection. 2021b. Available from: https://www.who.int/health_financing/topics/financial-protection/en/
- Xu K. and World Health Organization. Distribution of health payments and catastrophic expenditures methodology (EIP/FER/DP. 05.2). Geneva: WHO; 2005.

The main purpose of this publication is to advocate for the need to understand the gendered nature of vulnerabilities to poor health. Gender equality in health is an integral dimension of sustainable development, and it is critical to apply a "gender lens" to all aspects of the health system, including financing mechanisms in health.

The impact of health-related out-of-pocket expenditure (OPE) on household poverty has been a significant factor driving the move toward universal health coverage across much of Latin America and beyond. However, not only do health care users still face a broad range of health-related OPEs that can contribute to the impoverishment of households, but the gender dimensions of OPEs have received very little attention.

Drawing primarily on data from Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru, this report offers an in-depth analysis of the gender dimensions of health-related OPEs in Latin America. It highlights the limitations of survey data in determining levels of household spending on health as well as the potential failure of indicators to capture the impacts of coping strategies that households adopt to pay for OPEs.

This publication calls for the application of an intersectional analysis to ensure a more nuanced understanding of the ways in which other social identity markers, such as race and ethnicity, alongside gender shape the ability of individuals and households to respond to the different OPEs they may encounter.

Until policymakers consider the issue through a gender lens, OPE will continue to limit the potential of universal health care coverage to effectively address health inequalities.

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