

Gender Equity in Health

Women, Health and Development Program
Pan-American Health Organization



CONTENTS

I. INTRODUCTION	1
II. THE CONCEPTS	1
Equity.....	1
Gender.....	2
Participation.....	2
III. DIMENSIONS OF GENDER EQUITY IN THE HEALTH SECTOR	2
1. Health Status and its Determinants.....	3
2. Access to Care.....	5
3. Financing.....	5
4. Balance in the distribution of power and responsibility in health care.....	7
IV. FINAL CONSIDERATIONS	7

Figures

Figure 1: Probability of dying (per 100) ages 15 and 59, according to sex and condition of poverty.....	4
Figure 2: Probability of dying ratio for poor/non-poor women and men (per 100) ages 15-59	5
Figure 3: Out of Pocket Expenditures on Health for Women and Men in selected LAC countries (US\$).....	6

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

I. INTRODUCTION

The purpose of this issue paper is to present the ethical and empirical underpinnings of the effort to incorporate the gender perspective in health policies and programs. This objective emphasizes the identification and resolution of gender inequities which impede the exercise of women and men’s fundamental right to health.

The conceptualization of gender presented in this paper recognizes the crucial fact that gender inequalities interact with other inequalities (such as ethnicity, age or socio-economic class). What this paper will attempt to demonstrate is that any analysis of health which does not take gender, as well as other inequalities, into account cannot give an accurate description of reality. Moreover, from a social justice perspective, it is both insufficient and incoherent to look at inequalities between social, economic or ethnic groups without also addressing the inequalities between men and women within those groups

II. THE CONCEPTS

EQUITY

Equity is not the same as equality, and not every inequality is considered an inequity. The definition of inequity used in this paper is “**any inequality which is unnecessary, avoidable, and unjust**”² While equality is an empirical concept, equity represents an ethical imperative which is associated with the principles of social justice and human rights.

In operational terms, **equity in health** involves the minimizing of avoidable disparities in health - and its determinants - between groups with different levels of social privilege.

When discussing equity in health, we must distinguish between health status and health care. Health status refers to the physical, psychological and social well-being of a person, while health care is only one of many determinants of health status. Health care refers to certain characteristics of health services, such as accessibility, use, quality, resource distribution and financing.

Equity in health care implies that:

- Health resources are distributed according to need;
- Services are received according to need;
- Contributions to financing of health care are made according to economic capacity

¹Anand, Sudhir y Sen, Amartya, *Gender inequality in human development: Theories and Measurement*. New York, Human Development Report Office, Occasional Papers, No. 19, 1995, p.2. <http://www.undp.org/hdro/oc19a.htm>

² Whitehead, M., *The concepts and principles of equity and health*. Document EUR/ICP/RPD/414., WHO Office for Europe, Copenhagen, 1990

On the other hand, equity in health status refers to the achievement by all people of the highest state of well-being that is possible under any given circumstances.

The concept of need is at the root of the equity in health philosophy, which emphasizes a distribution of resources that is differential and not egalitarian, in order to meet the particular requirements of specific groups

GENDER

Two general misunderstandings exist about the concept of gender. The first is that gender is equivalent to sex. The second is that gender is equivalent to women.

- Gender “ Sex - While “sex” refers to the biological difference between women and men, gender refers to the social significance attributed to these biological differences, commonly called “masculinity” and “femininity”. Gender differences are fundamentally expressed in the division of power and labour which exists between women and men.
- Gender “ Women - Gender does not refer solely to women because it is a relational concept. Gender looks not at women or men, but at the unequal relations between the two, with respect to the distribution of power and resources.

Gender has begun to draw recognition in the social sciences as one of the primary axes around which social life is organized. Gender plays a central role - along with class and ethnicity - in the macro level allocation and distribution of resources in a hierarchical society.

Gender is relevant at the macro level because it defines two complementary economic dimensions. On the one hand it ensures the existence of a non-remunerated sphere of labour, in which the labour force is reproduced and put into circulation (**reproductive labour**). On the other hand, gender determines which alternatives are available to men and women in the remunerated sphere (**productive labour**).

The disproportionate number of women among the poorest social sectors is rooted, first, in the pre-eminence that society assigns to the reproductive role in women’s lives, which limits their opportunities to participate in the productive sphere. Second, and more importantly, it is rooted in the lack of social value and recognition of “feminine” labour, in the home (reproductive) as well as in the labour market (productive).

PARTICIPATION

Social participation plays a crucial role in the effective and sustainable achievement of equity objectives in general, and more particularly of gender objectives. This participation is conceptualized, not as a way of lowering costs, but as the exercise of the human right to participate in those processes which affect our own well-being.

It is clear that the effective consideration of the particular needs of distinct social groups in policy-making and budget planning is impossible without the existence of a political culture which demands it. It is important to emphasize therefore, the active participation of civil society, particularly women’s organizations, not merely in the implementation of actions prescribed by others, but in the formulation and monitoring of public policies. Emphasis must be placed on women in order to eliminate the instrumentalist focus which has predominated with respect to women’s participation in the health system, with a view to developing greater equity in the distribution of power and responsibilities in health production.

Equity in health status does not imply equal levels of mortality and morbidity among women and men, but the elimination of avoidable differences between them with respect to opportunities to enjoy health, vulnerability to illness or disability and premature death.

III. Dimensions of Gender Inequity in the Health Sector

Adopting the gender perspective in health involves linking the division of power and labour within a society to the epidemiological profiles of a population, and the accessibility, financing and management of the health system.

Studying gender inequities in health signifies looking at one or more of the following dimensions:

1. Health status and its determinants
2. Access to health care which is in accordance with need
3. Financing of health care which is in accordance with the ability to pay
4. Balance in the distribution of power and responsibility in health care.

1. Health Status and its Determinants

Why place the emphasis on women when they live longer than men?

It is true that women have a longer overall life-expectancy than men, which is partly a result of genetic factors. It is also true that male mortality exceeds female mortality at any age, including in utero, and particularly during the peri-natal stage. However, it is important to note that:

- **The survival advantage does not necessarily indicate better health.** On the contrary, empirical evidence indicates that women experience higher morbidity than men throughout the life cycle. This morbidity is expressed in a higher incidence of serious disorders, in a greater prevalence of non-fatal chronic illness, and in higher levels of short and long-term disability.
- **The causes of illness and premature death, and by association the opportunities to avoid them, are different for women and men.** Though it seems inconceivable in this day and age, women continue to die in the non-pathological process of reproducing the species. In the Americas, complications with pregnancy and birth remain one of the primary causes of mortality for women of reproductive age. Maternal mortality, because it is both avoidable and unjust, has been defined as one of the most glaring reflections of discrimination against women, and women's low social status.

At the same time, it would be absurd to ignore the gendered causes behind men's increased mortality. The major sex differences in mortality are linked to avoidable risk behaviours which are commonly considered "masculine", particularly among certain social groups. Increased male mortality reaches dramatic proportions (5 to 50 times greater) with respect to accidents, violence, suicide and armed conflict. It is also notable with respect to lung cancer, cirrhosis and AIDS.

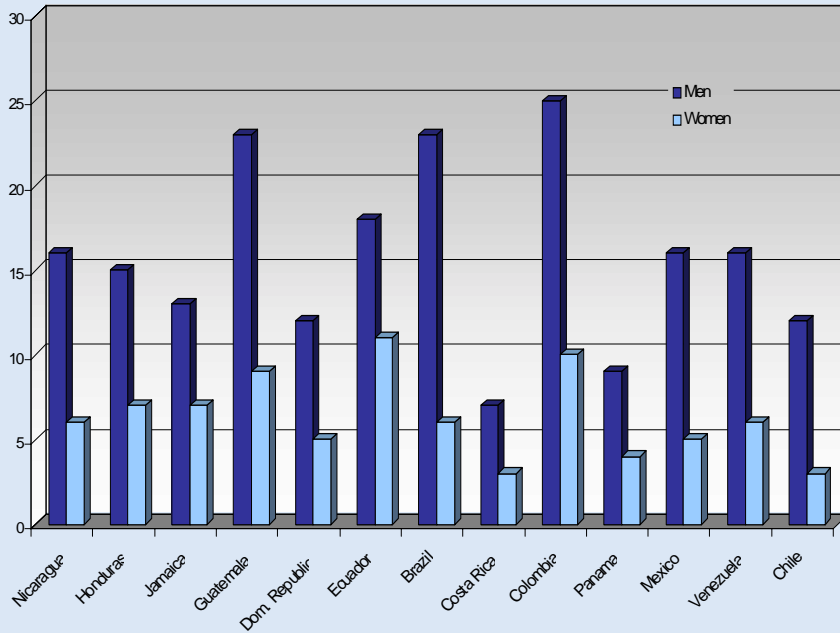
It is therefore worth noting that - even with different manifestations according to sex - the unequal power relations between women and men, and the social demands associated with the exercise of power, have clearly negative effects on the physical integrity of men as well as women.

- **Poverty has a greater negative impact on the health and survival of women.** In fact, the longer female life-expectancy which is characteristic of industrialized countries is not the norm in poor countries, or among low-income groups. Adverse social conditions can diminish and even eliminate the female survival advantage. For example, recent data for 13 countries in Latin America indicates that in higher-income groups, the risk of premature death is clearly more elevated for men than for women (figure 1). However



among poor groups, this sex differential is considerably reduced and in some cases disappears. While poverty raises the risk of premature death for men from two to five times higher, the risk for women is raised 4 to 12 times higher (see figure 2).

A. Non-Poor



B. Poor

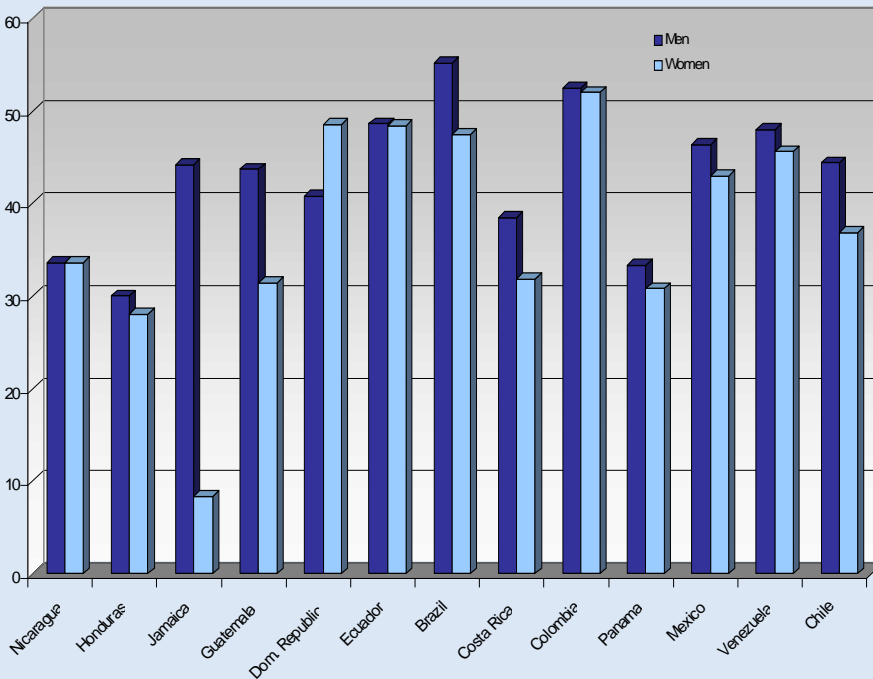
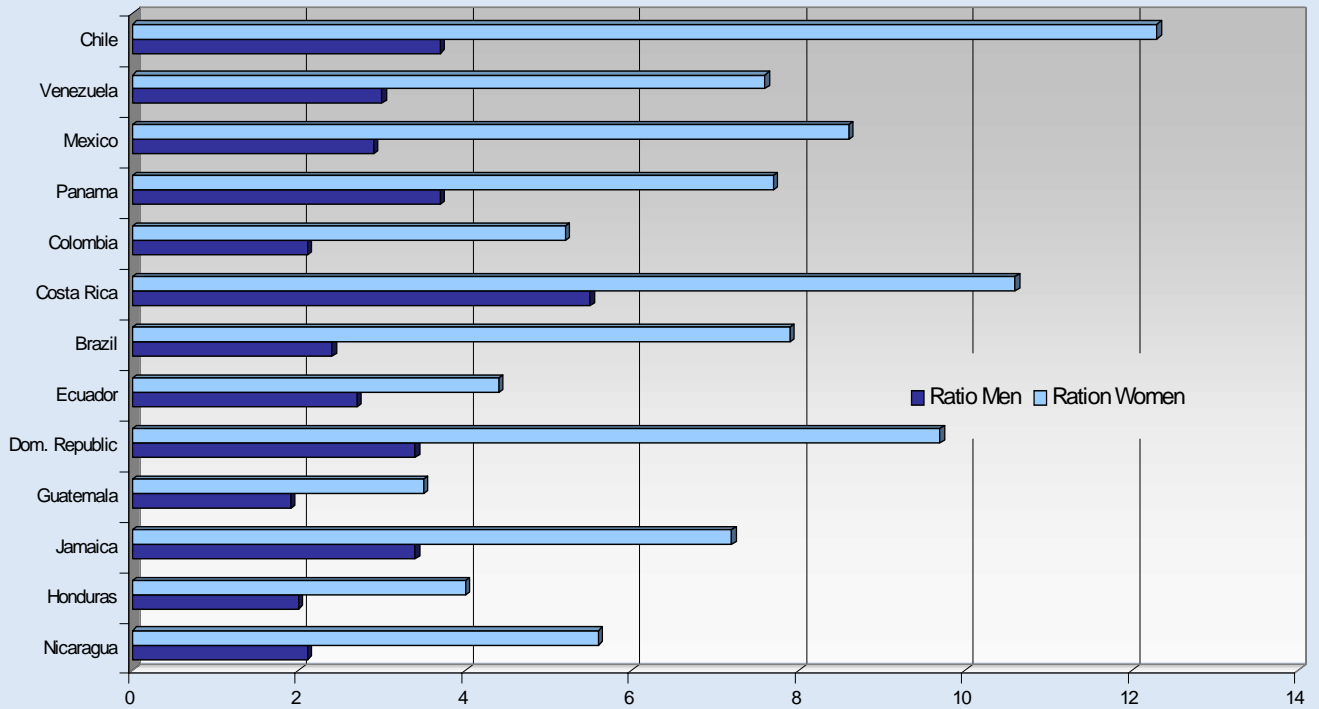


Figure 2: Probability of dying ratio for poor/non-poor women and men (per 100) ages 15-59



Prepared by HDW/HDP/PAHO with data from WHO - The World Health Report 1999

Advocating gender equity in health does not mean insisting that women and men receive equal quotas of resources and services. On the contrary, it means that resources are assigned and received differentially, according to the needs of each sex within their socio-economic context.

2. Access to Care

It is often argued that, in terms of equity in access to health services, women use services more often than men. Though women do in fact tend to use health services more frequently, this does not necessarily give them an advantage since:

- **Women have a greater need for health services** than men, particularly derived from their biological reproductive role, but also as a result of their higher levels of morbidity and longer life-expectancy. In terms of need for health care, the widest gap is again observed among the poor.
- **Poverty disproportionately restricts women’s access to health services.** When need is controlled for, the use of services is often lower among women, than men from lower-income sectors, in the public as well as the private sectors. Paradoxically, this reduced use of services occurs in situations where women’s need is highest in relation to men’s.

3. Financing

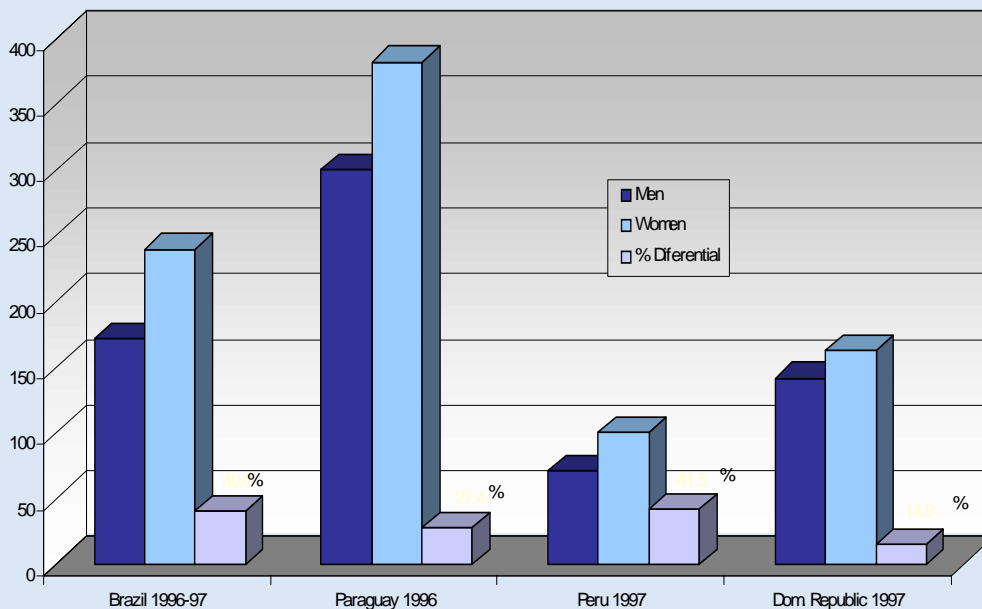
The principle of equity which demands that payment for health services be made according to economic capacity is doubly violated for women within health care systems that are not based on the principle of solidarity. Women end up paying more than men to maintain their health as a result of needs created by their reproductive function and higher morbidity. This absolute inequality is exacerbated by the fact that women as a group have less economic capacity than men.



- **In financing systems which are not based on solidarity**, women pay more for health care than men.
 - In the United States, women of reproductive age pay 68% more in out-of-pocket health expenditures than men.
 - In Chile, private insurance premiums are 2.5% higher for women of reproductive age than for men.
 - In 4 LAC countries for which household data is available (Figure 4), out-of-pocket health expenditures for women are 16-40% higher than for men.

- **Women have less capacity to pay than men because:**
 - They make up the majority of the poor.
 - Due to their predominance among unremunerated workers and their disadvantaged position within the remunerated labour force, women have less access to resources to pay directly for health care and less access to health insurance plans. Women's pattern of labour is distinguished by the following characteristics:
 - Less participation in the remunerated labour force
 - Higher levels of unemployment
 - Concentration in lower-paying occupations. (Women's employment income represents 70% of men's income in the region).
 - Over-representation in occupations, such as part-time and informal employment, which do not provide social security.
 - Lack of continuity in work history as a result of child-bearing and care, which limits women's access to the long-term benefits of health insurance.

Figure 3: Out of Pocket Expenditures on Health for Women and Men in selected LAC countries (US\$)



Source: LSMS Surveys for V=Brazil Paraguay and Peru. DHS Surveys for Dominican Republic

Gender equity in the management of health goes beyond guaranteeing equal pay for equal work within the formal health sector. It also implies that the real costs of the provision of care must be addressed and evenly distributed between men and women, and among the family, the community, the state and the market.

It also requires men and women's equal participation, particularly in low-resource sectors, and in decision-making about the definition of priorities and the allocation of public and private resources necessary for ensuring health.



4. Balance in the distribution of power and responsibility in health care

Women represent 80% of the health labour force. More important, yet less valued is that women are the principal managers and providers of health care within the family and community. In fact, more than 85% of early detection and treatment of illness occurs outside formal services, and this care is provided principally by women within the home and community, and without cost (vaccination campaigns, early detection and treatment of illness, care for the elderly, children, the sick and the healthy).

Despite this critical contribution to health production, women remain in a disadvantaged position within the health system given that:

- They are concentrated in the lowest-paid and least prestigious positions within the formal health sector.
- They remain under-represented in the local and national power structures which define health priorities and assign resources.
- They perform, without remuneration, informal health promotion and care work within the family and community.

Ostensibly “neutral” policies such as “cost-reduction”, “reduction of the state apparatus”, and “decentralization”, tend to conceal wide gender gaps because they involve the transfer of labour from the remunerated economy to the sector which is centred around women’s unremunerated work.

The premise sustaining adjustment and reform measures is that the government can reduce spending by cutting back services - for example, shortening the duration of hospital stays and reducing care services for the elderly and the mentally ill - under the supposition that these services can be provided by families. These measures are based on the assumption that women’s time is free and infinitely flexible, and the expectation that women will be available, willing, and morally obliged to provide care and assistance to the dependant, the sick, the elderly and the disabled within their homes. Any consideration of the impact these expectations about women’s availability, obligation and free time will have on their employment situation and their physical and emotional health is absent from these policies. Also absent is any consideration of the presence of support structures for the provision of care within the home. Moreover, these policies give no consideration the long-term efficacy and sustainability of this arrangement.

IV. Final Considerations

The basis of the relationship between gender and the development of health is the vision of a more equitable society, with a more just distribution of the resources and benefits of this development and with greater participation of women, especially those from less privileged sectors, in those decisions which affect the common well-being.

To recapitulate, the inequity of the gendered division of power and labour in society is reflected in unjust and unnecessary inequalities between men and women in at least four aspects of health:

- Health status and its determinants
- Access to health care which is in accordance with need
- Financing of health care which is in accordance with the ability to pay

- Balance in the distribution of power and responsibility in health care.

Confronted with this reality, the need to move from discussion to action becomes obvious. This move will involve four fundamental components³:

- The generation of information about the status and determinants of gender equity in health.
- Translation of this information into a comprehensible language for policy-makers, planners and activists.
- Political mobilization of support for priorities and actions which are conducive to greater equity in health.
- Definition of institutional mechanisms through which these priorities can be democratically and sustainably incorporated into the policy-making and management process.

³ Standing, Hilary, Reflections on Gender and Health Reforms in the Context of Severe Health Inequalities. Paper presented at the Meeting of the Consultative Group on Gender Equity and Reform, Washington, D.C., PAHO/HDW, October, 1998.