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

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

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Summary

The recent impetus given to the reform of health and social security policies throughout the Region has given rise to an intense debate on the impact of these policies on equity in health and human development. Up to now, this debate has focused on concerns with respect to geographic location and social stratum, without considering gender. The absence of this concern has resulted in a lack of policies to correct the gender inequities created or exacerbated by health and social security reform that cannot be addressed with the same measures employed to reduce the gaps between socioeconomic strata and geographic regions.

This study has two objectives. The first is to call attention to the most significant implications of health and social security reform for gender equity, with specific regard to: a) the health situation and its determinants; b) access to, use, and financing of health care; and c) the contribution/reward ratio for health-related work. The second objective is to propose a series of strategies with the stakeholder participation to identify problems, mobilize resources and institutionalize responses.

The study has been divided into four parts. The first discusses the institutional history and mandates of the Pan American Health Organization that underlie the plan to incorporate the gender perspective into the reform processes. The second briefly outlines the conceptual framework of the proposal. The third indicates some of the most serious implications for gender equity of the most common sectoral reform policies in the Region of the Americas. Finally, the fourth lays out the principal challenges posed by incorporating the gender equity perspective into sectoral reform policies and proposes a pluralistic strategy to document, prevent, and help to eliminate gender inequities in health and social security reform.

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Introduction

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

This study has two objectives. The first is to call attention to the most important implications of health and social security reform for gender equity, with specific regard to: a) the health situation and its determinants; b) access to, use, and financing of health care; and c) the cost/benefit ratio for health-related work. The second objective is to propose a series of strategies to identify problems, mobilize resources and institutionalize mechanisms to achieve the goal of health for all.

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

The study has been divided into four parts. The first discusses the institutional history and mandates of the Pan American Health Organization (PAHO) that underlie the plan to incorporate the gender perspective into the reform processes. The second briefly outlines the conceptual framework of the proposal. The third indicates some of the major implications for gender equity of the most common sectoral reform policies in the Region of the Americas. Finally, the fourth notes the main challenges posed by incorporating the gender equity perspective into sectoral reform policies and proposes a pluralistic strategy to document, prevent, and help to eliminate gender inequities in health and social security reform.

1. Background

1.1 *Institutional Policy Framework*

The present proposal is founded on two guiding principles of PAHO: the search for *equity* and *active, joint participation by the countries* in formulating strategies and taking action to improve health for all in the Region.

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

Within this context, the new policy of Health for All in the Twenty-first Century adopted by PAHO/WHO emphasizes "*the incorporation of a gender perspective into health policies and strategies*" as one of its fundamental values and underscores that technical cooperation should stress development of *"the capacity to use the gender perspective as a tool for analyzing the impact of globalization on the development process and on structural, macroeconomic, and social policies, with special emphasis on their relation to health*"[2] Reiterating institutional commitments that date back to 1985, the Director also emphasized the need to "*focus attention on the importance of women's health, the interaction among women, health, and development, and the development of gender awareness at all levels.*"[3]

The topic of health and social security reform is becoming especially relevant in the Region due to the linkage of such reforms with transnational economic integration and State reform, in which efficiency considerations all too frequently prevail over those of equity and human rights. This trend is of particular interest for a region that, like the Americas, is characterized by the greatest economic and social inequalities in the world and where these kinds of reforms have already in one way or another permeated every country. As the Director of PAHO has noted: "*Health must not be a victim of this restructuring and reform ... gaps that are unnecessary and unjust should be closed.*"[4]

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

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

[3] PAHO, *Leading Pan American Health*. p. 19.

[4] Alleyne, George A.O., Address at the 25th Pan American Sanitary Conference, Washington,

This orientation derives from the institutional goal of Health for All, the mandates of the Governing Bodies, other declarations issued by regional meetings such as the Summits of the Americas, and international agreements such as those of the World Summit for Children, the International Conference on Population and Development, the World Summit on Social Development, and the Fourth World Conference on Women. This international support is evidence that the global nature of the challenges posed by the reforms makes collective action a mutually beneficial imperative.

1.2 *Specific Antecedents*

During the past three years, the Program on Women, Health and Development (HDW) of PAHO's Division of Health and Human Development has been advancing conceptually and operationally toward incorporating the gender perspective in the contents and processes of sectoral reform policies. To this end, and with the resounding endorsement of the Subcommittee on Women, Health, and Development (a Special Subcommittee of the Executive Committee), the HDW program has promoted the following types of action:

- Development of conceptual frameworks and indicators to orient the analysis and monitoring of health and social security reform processes.
- Technical discussions and interprogrammatic work within PAHO, both at Headquarters and in countries,[5] to discuss concepts and strategies.
- Interagency[6] and intergovernmental meetings[7] to discuss frames of reference, share experiences, and design collaborative strategies.
- Bibliographical compilation on topics related to gender, equity, and public policy, with emphasis on health and social security reform.

D.C., September 1998.

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

[6] Pan American Health Organization, Regional Program on Women, Health, and Development. Report of the First Meeting of the Consultative Group on Gender and Health Sector Reform, Washington, D.C., 6-7 October 1998. PAHO/HDW, Washington. D.C., 1999.

[7] Pan American Health Organization, Final Report. Subcommittee on Women Health and Development. 18th Session, February 1999

- Sponsorship of a regional competition for research on gender and equitable access to care that will soon yield significant results in six countries in Latin America and the Caribbean (LAC).
- Identification of investigators and activists in the Region who have an interest in working on equity, gender, and health/social security reforms; and putting an electronic discussion network on gender and reform into operation to promote the dissemination of information, the exchange of ideas, advocacy, and training.
- Partnerships with regional networks of women working in defense of equity and health.
- Direct advisory support to the countries

One of the major achievements of this initiative is the inclusion of prevention and care services to address the problem of domestic violence in the new models of care that are being implemented in the Central American countries.

2. Frame of Reference for the Analysis of Gender Equity in Health Sector Reform

2.1 Conceptual Elements

Three related and overlapping concepts constitute the key elements of the work proposed here. These basic concepts are: gender, equity, and participation.

2.1.1 Gender

Unlike "sex", the term ordinarily used to denote the biological differentiation between men and women, "gender" refers to the social constructs that delimit and articulate in power relationships, the areas culturally defined as “feminine” and “masculine”. Gender, then, is the social and political meaning that the biological differences of sex acquire in time and space.

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

The central focus of gender approaches in development, in contrast to those of women in development, is not women *per se*, but the *social relations of inequality* between women and men. Hence, women are treated more as an integral part of any development strategy than as an isolated special interest group.

The organizational importance of gender at the macro level stems from its articulation of two complementary dimensions of the economy**.** On the one hand, gender ensures the existence of an unremunerated sphere where the work force is reproduced, disciplined, and put into circulation (reproductive work); and, on the other, it conditions an individual's alternatives in the area of remunerated work (productive work).

In the majority of societies, the reproductive work falls predominantly to women. Productive work is performed by both men and women, but within markets that are profoundly segmented by sex. The socioeconomic experience specific to women is found at the intersection of those two spheres--that is, in the interaction between their reproductive and productive roles.

The disproportionate representation of women in the poorer sectors of society has its roots in the social centrality of their reproductive role and its impact in terms of reducing their opportunities for participation in the productive sphere. This impact is manifested predominantly in the social devaluing of "women's work" both in the labor market and the home. Thus, in the formal sector of the health system, women are concentrated the occupations with the lowest pay, prestige, and decision-making power; and in the informal areas of community and family, women work without pay.

Addressing health from a gender perspective, therefore, not only includes but goes beyond a response adequate to the needs stemming from the biological differences between women and men. It demands recognition of and response to the specific needs of each sex deriving from the unequal power relationships between women and men (or between masculine and feminine social spheres). Hence, as a prerequisite, it demands a proper examination and understanding of the ways in which the differences in power over resources are manifested both in epidemiological profiles and in the social patterns of "consumption" and "production" of health.

It can be stated, then, that addressing health from a gender perspective involves the following basic elements:

a) Emphasis on the **inequalities** between men and women with respect to:
   - The distribution of **risks and needs** in health derived from biological differences, material living conditions, the sexual division of labor, and power relationships between the sexes.
   - **Access and control** of the **resources** necessary for managing risks, and for the promotion and recovery of health (including material, informational, political, service, and time resources).
   - The balance between **contributions and rewards** in the production of health within the family, the community, and the formal system
   - Representation in **decision-making** regarding the definition of priorities and the allocation of the public and private resources necessary for guaranteeing health.

b) Recognition of the **interdependence between the formal and informal sectors of health care,** which causes the policies affecting the supply of staffing in the services to simultaneously affect the informal burden of care that falls predominantly on women.

c) Promotion of "**empowerment**" and active **participation** by women--especially from the most disadvantaged groups--in the processes of change designed to achieve a more just distribution of burdens, benefits, and power in order to influence the development of health.

d) Development of intersectoral articulation mechanisms for the formulation and monitoring of policies that foster equity--mechanisms that involve representatives of civil society organizations working in defense of gender equity.

The core of the relationship between gender and development is, then, the vision of a more equitable society with a *more just distribution of the resources and benefits* of development and greater *participation* by women, especially from the less privileged sectors, in decisions that affect the common good.

2.1.2 Equity

Equity is an ethical concept linked to the principles of social justice and human rights. Equity is not the same as equality. The concept of inequity accepted by WHO refers to inequalities considered unnecessary, avoidable, and, moreover, unjust[8]. In operational terms, equity in health would result in the minimization of *avoidable* disparities in health and its determinants—including but not limited to health care—between groups of people with different levels of social privilege[9].

When talking about health it is a good idea to distinguish between health status and health care. *Health status* refers to the physical, psychological, and social well-being of people. *Health care* is only one of the many determinants of health status and is a term utilized to refer to the main characteristics of health services: access, utilization, quality, resource allocation, and financing.

Different societies approach the concept of equity differently. In some, equity goals are seen in terms of the commitment to achieve a *minimum* level of health and health care for all, without attempting to reduce disparities once the most disadvantaged groups

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[8] Whitehead, Margaret, The concepts and principles of equity and health. *International Journal of Health /Services* 22: 429-445, 1992.

[9] Braveman, Paula, *Monitoring Equity in Health: A Policy-Oriented Approach in Low and Middle-Income Countries*. Geneva, WHO/CSH/HSS/98.1, 1998, p.2

have attained that minimum level. This so-called "libertarian" approach focus on the extent to which people are free to purchase the health care they want. For other societies, achieving the levels of well-being attained by the most privileged groups is the goal. In this regard, the advances made by the better-off groups are used as the parameters of what can be achieved in that particular society, and equity is viewed as requiring a sharing of progress. This "egalitarian" approach judges equity by assessing the extent to which health resources are distributed according to need, and are financed according to ability to pay)[10].

From the perspective of PAHO/WHO, equity in *health status* is seen as the achievement by *all people* of the *highest attainable* well-being that is possible in specific contexts. And equity in health care means that health resources are allocated according to *need,* services are received according to need, and the financing of the services is made according to the *ability to pay.*[11]

Gender equity in the broader area of health would thus imply:

a) In *health status:* The elimination of unnecessary, unjust, and *avoidable* differences between men and women, in terms of the opportunities to enjoy health and the probabilities of becoming ill, disabled, or dying prematurely from preventable causes.

b) In *access to and utilization of* health *services:* The *allocation* of resources (technology, financial, and human) not equally, but differentially, according to the particular *needs* of the sexes. In addition, the actual *utilization* of quality care for men and women according to their needs.

c) In the *financing of care:* Contribution by women and men according to their ability to pay and not to their needs. Specifically, women would not have to pay more than men because of their greater need for care.

d) In the balance between *contributions and rewards* in the production of health: The work in health care--remunerated or unpaid--must be recognized, facilitated, valued, and distributed justly. Women and men must participate as equals in decisions regarding the allocation of resources in the micro and macro spheres of the health system.

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

[11] Braveman, Op.Cit, p. 3

> *"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"*[12].

2.1.3 Democratic Participation

In the gender perspective, social participation is not a pragmatic instrumental concept, but rather an exercise in civil rights to influence the processes that affect the common good. In this context it is important to underscore that, as the United Nations Development Program notes, "*in exercising real power or decision-making authority, women are a distinct minority throughout the world.*"[13] The health system is no exception to this rule. On the contrary, it is in this sector that women are more frequently active participants in the execution of community programs; however, they continue to be excluded from the formulation, design, and resource allocation phases of these programs.

Women with their interests, needs, viewpoints, and demands, have not received recognition as a social group that merits representation and that must be accounted to. Decisions are usually made on behalf of women under the presumption of both their consent and a commonality of interests with men. This presumption, however, does not reflect reality, for when women are consulted, the priorities that they indicate for themselves and their families have been very different from those expressed by their closest male relatives or distant politicians and bureaucrats.[14] It has been observed, for example, that health is a higher priority for women; this is reflected in the ways in which men and women spend the household income that they respectively control,[15] and in the fact that women more frequently organize themselves to deal with health issues than do men.[16]

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

[13] UNDP, Human Development Report 1995, New York, PNUD, 1995, p.86.

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

[15] The World Bank. *World Development Report 1993,* Washington DC., Oxford university Press, 1993..

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

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

2.2 *Why the Emphasis on Women when Talking about Equity?*

The emphasis on women in the context of gender equity in health is frequently questioned. Why women, it is asked, when they outlive men, visit the health services more frequently, and represent the majority of health sector personnel?

Certainly, women tend to outlive men. However, historically, this survival advantage has been diminished and even annulled in hostile environments. Current and historical data suggests that the negative effects of poverty on health and survival are greater for women than for men, as illustrated by Figure 1.

Moreover, greater longevity does not necessarily amount to better health. On the contrary, the empirical evidence indicates that women tend to experience greater morbidity than men, morbidity that finds expression in higher incidences of acute disorders throughout life, higher prevalences of nonfatal chronic diseases, and higher levels of disability in the short and long term, particularly in old age. The household surveys conducted in LAC in recent years suggest a significantly higher prevalence of acute and chronic conditions among women. This difference is found across countries and the different social strata.[17]

Greater utilization of the health services by women is thus related to their greater need for health services, stemming from higher morbidity and the processes related to

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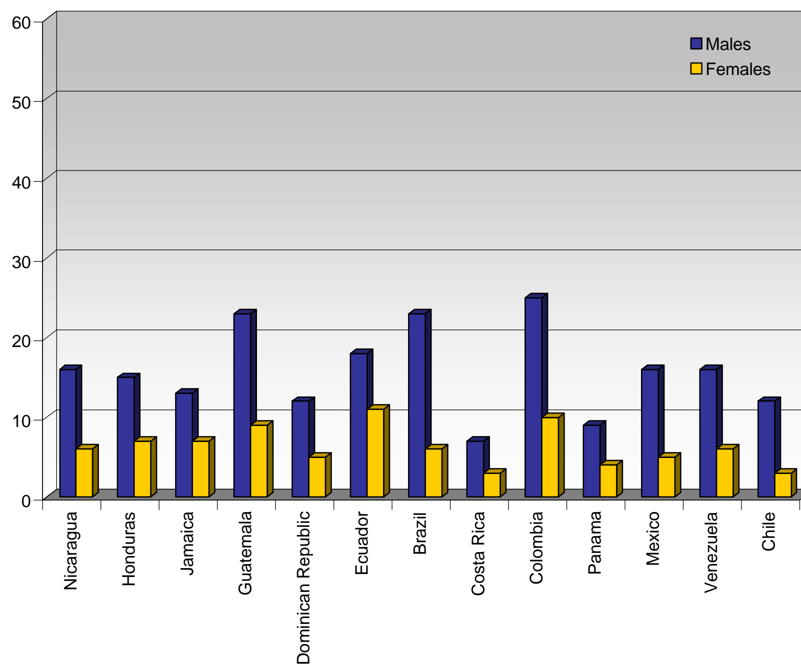
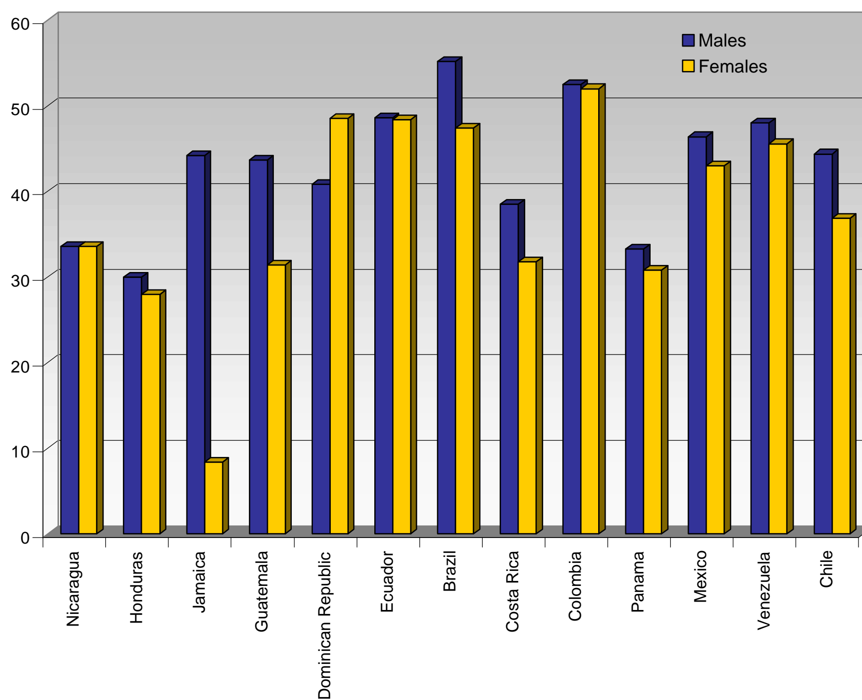
[17] Preliminary data from OPS/BID/BM study, "Access, Utilization and Private Spending on Women's Health: An analysis of household surveys in 6 countries", Washington D.C., OPS 2000.

Figure 1: Probability of dying (per 100) for males and females, between the ages of 15 and 59

A: Non-Poor

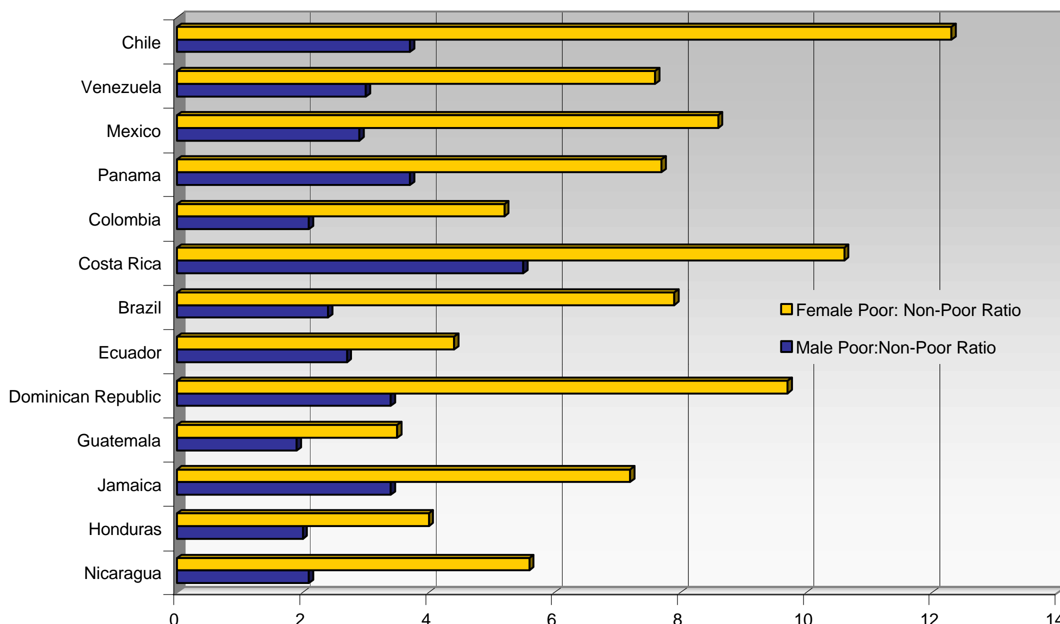


B: Poor



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

C: Poor/Non-Poor Ratio in the Probability of Dying for Males and Females (per 100) between ages 15 and 59



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

pregnancy, childbirth, and the puerperium. The recognition of these differences is essential from an equity perspective that implies a matching between needs and services.
In this regard, it is noted that there are exceptions to the general tendency of higher service utilization by women. As it will be discussed later, in some developing countries and low-income groups, utilization of services is relatively lower for women than for men.

Finally, although women constitute more than 80% of the health workers in the formal sector, they are only marginally represented at the decision-making levels.

Thus, the emphasis on women stems from the acknowledgement of the unequal positions occupied by men and women both as consumers and producers of health, and to the moral imperative to correct the ensuing imbalances of needs/resources and contributions/rewards. Recognition of women's general disadvantage in terms of access to resources and benefits is at the heart of the arguments by international agencies and governments alike to target the female population. According to the UNDP, *no country in the world treats women as well as men.*[18]

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[18] UNDP, 1995, *op. cit.*

The motives behind this emphasis, however, respond not only to the moral imperative of social justice, but to pragmatic considerations related to the efficiency and sustainability of interventions. These latter considerations are based on a wide variety of recent studies that have conclusively demonstrated that investing in women (particularly in their education, health, and nutrition) yields greater benefits in terms of efficiency, cost-effectiveness, and a positive impact on the health and well-being of the next generation.[19]

Thus, summarizing the aforementioned considerations, the emphasis on women derives from the following:

(a) Women have a **greater need for health services** than men, essentially but not exclusively because of their biological role in reproduction and their greater longevity. It has been estimated that 34% of women's burden of disease is related to reproductive health problems.

(b) Women are **overrepresented among the poor**. Therefore, in the long run, they have less access to remuneration and health resources, including health and social security services.

(c) Women are at a **disadvantaged position within the health system**, since they occupy the lowest rungs of remuneration, prestige and power in the formal health sector. They perform without payment the work of promoting and providing health care in both family and community, and continue to be underrepresented in the community power structures that set priorities and allocate resources for the development of health.

(d) Women are the **main health care providers for the family;** they bear the greatest burden in this respect and are consequently the ones most affected by any increase or cutback in public services.

(e) Women are the **principal managers of family health**, particularly that of children. Thus, women's health and the control that they can exercise over resources are key factors in achieving effectiveness, efficiency, and sustainability in health interventions.

This emphasis on women in no way undermines the applicability of the gender approach to the health of men. On the contrary, a significant body of studies has been amassed in recent years on the constructs of masculinity and their impact on the health of

[19] The World Bank. *World Development Report 1993.* Washington D.C., Oxford University Press, 1993

men. Continuing to ignore the gender factors embedded in the male survival disadvantage would be absurd. Indisputably, the major disparities between the sexes in mortality from causes common to both are concentrated around some avoidable causes linked to risk patterns that are culturally considered masculine. Higher male mortality (5 to 10 times higher) from external causes, such as accidents, violence, suicides, and armed conflicts, has reached dramatic proportions in the Region; the figures are also markedly higher for diseases such as lung cancer (10 times higher), cirrhosis of the liver (4 times higher), and AIDS (3 times higher) The higher prevalence of substance abuse in men (tobacco, alcohol, and drugs) and the more serious impact of unemployment and retirement on the mental health and self-esteem of men should also be noted. It should therefore be underscored that--although manifested differently in the two sexes--the unequal power relationship between men and women and the social demands associated with the exercise of male power have a clearly negative impact on the physical and psychological integrity of men, and even on their conduct in terms of seeking care.

2.3 Equity, Efficiency, and Sustainability of Informal Health Care

As the *Human Development Report 1999* points out, studies on the impact of globalization on people have concentrated on the areas of employment, income, education, and other opportunities. Less visible, and frequently ignored, has been the impact of these processes on informal care--that is, on the provision of care in the home to children, the sick, the elderly, and the rest of the population that needs to maintain or recover its health and energy for work. This care, known as social reproduction, is essential for economic sustainability.[20]

This important UNDP report devotes an entire chapter to the topic of care, pointing out the disturbing impact that globalization is having on this essential function. Globalization is putting a squeeze on care and caring work: a) Changes in the way that women and men use their time reduce the portion of time available for providing care; b) fiscal pressures on the state result in cutbacks in public spending on care services; and c) the wage gap between tradable and non-tradable sectors puts an incentive squeeze on the the supply of care services in the market. Gender is a central factor in all of these impacts since, as this document reiterates, women carry the main responsibility for these activities, bear the greater burden, and receive the lowest rewards. Thus, care provided in the home is unremunerated; in the community, it is mostly volunteer work; and in the market, it receives low pay relative to its requirements for education and skills[21].

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[20] UNDP, *Human Development Report 1999.* New York, Oxford University Press, 1999, p. 77

[21] Ibid.

Estimates indicate women not only work longer hours than men, they spend two-thirds of those hours in unremunerated work (men spend only one-quarter their working hours), and most of this time is devoted to providing care.[22] (Table 1)

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

Time Allocation and Economic Recognition of Work

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

Source: UNDP – *Human Development Report 1995*

Historically, more than any other sector perhaps, the health sector has relied on the gender roles assigned to woman and their unremunerated work. More than 80% of the work in early diagnosis, health promotion, and health care occurs outside the formal health services. However, with the growing participation of women in the remunerated workforce, the continued provision of this free care is not feasible in the long run. This foreseeable deficit assumes greater proportions, when it is considered that the sectoral reforms are moving toward cutbacks in public services and privatization.

In the past, the provision of this care was ensured with the gender division of labor, which made care an obligation for women (and an option for men). The dubious effectiveness and sustainability of this health care system in the long run, as well as its possible collapse, have yet to be taken seriously, due largely to the very invisibility of the unremunerated work of women.[23] These trends, however, indicate the urgency of explicitly confronting and justly distributing the real cost of care between **men and women**, and among the **family** or community, the **State**, and the **market.** The key challenge for the future lies in developing incentives and rewards that ensure a supply of health care services that recognizes gender equity and the just distribution of burdens and costs among these actors.[24]

[22] UNDP, *Human Development Report 1995.* New York, Oxford University Press, 1995.
[23] Harrington, Mona, *Care and Equality.* New York, A.A. Knoft Publishers, 1999.
[24] UNDP, Op. Cit., 1999, p. 82-83.

3. Implications of Health Sector Reform for Gender Equity

Ideally, health sector reform has been conceived as a "*a process directed at introducing substantive changes into the various functions of the sector, with the purpose of increasing equity in the provision of health services, efficacy in its management and efficiency in the satisfaction of the health needs of the population*"[25]. Equity, quality, efficiency, sustainability, and social participation are the guiding criteria for PAHO technical cooperation in this area. The key challenge posed by these reforms is to achieve a balance between equity and efficiency without ever subordinating equity to efficiency.

By the mid-1990s almost all the countries in LAC had begun or were considering the reform of their health and social security systems. As part of the broad processes of globalization and state reform, these sector reforms have been characterized by three major trends: strengthening of private sources of financing, decentralization of services, and improvement of service delivery through private means. It should be emphasized that, despite the existence of important common denominators, the reform processes are not entirely homogeneous, but rather, have their own modalities and characteristics deriving from their political and economic context.

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

Thus, policies that on the surface are gender-neutral, for example "cost-cutting," "effectiveness," "efficiency," and "decentralization," frequently contain gender biases, because they imply transfers of costs from the remunerated economy to an economy founded on the unremunerated work performed by women. Thus, the premise of certain adjustment and reform measures is that governments can cut costs by cutting services—for example, by reducing hospital stays and the institutional care of the elderly and the mentally ill—in the assumption that these services can be provided by families. Such measures are based on the expectation that women are available, prepared, and morally obligated to provide home care for dependents, the sick, the elderly, and the disabled. Absent from these policies is any consideration of the impact that these expectations about

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

women's availability and free time in terms of their employment situation, remuneration, expenses, and physical and emotional stress. Absent, too, in the majority of cases, is any consideration of availability of support structures for providing home care. These gaps endanger not only the health of the caretakers themselves but also that of those who are supposedly under their care.

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

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

Some gender equity implications of the most common components of health sector reform in the Region are outlined below. These components have been classified in the following manner: 1) Decentralization and promotion of social participation. 2) Reorganization of the health services, including the redefinition of care models and the formulation of basic packages of services. 3) Restructuring of human resources development and administration systems. 4) Restructuring of the financing systems, including participation of the private sector. Since there is considerable overlap among these categories, some topics will be mentioned in more than one component[26].

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

3.1 *Decentralization and Promotion of Social Participation*

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

With regard to decentralization, equity concerns have essentially targeted inequalities originating in or supported by preexisting geographical inequities in the distribution of resources. However, there has been very little concern to date about internal community processes and the vitally important problem of identifying the circumstances in which decentralized systems improve access or further marginalize underserved groups.

Decentralization has many implications for gender equity in health. This section will confine itself to indicating that, depending on how it is designed and implemented, decentralization may have opposite effects on the amount and characteristics of women's participation at the local levels. Thus, while decentralization may constitute a window of opportunity for increasing women's participation in local power structures, it may also result in greater marginalization of groups traditionally excluded—including women—and even result in a disproportionate increase in the unremunerated work performed by women.[27]

As to representativeness, while women are more actively involved in health activities, community "spokespersons" tend to be predominantly men who do not necessarily consult women or represent their interests. (See Figure 2). Therefore, unless mechanisms are created to actively promote and support the participation of groups traditionally excluded from the power structures--among them, indigenous populations and women--decentralization runs the risk of becoming the simple transfer of power from the national to the local elite. This risk is compounded by the lack of development of institutionalized arbitration systems to handle cases of inequity at the local level.

The decentralization modality that involves transferring the health care financing burden from the central government to the local community can have an adverse impact on the mitigation of poverty. A strategy of this nature raises the broader questions of the link with cost recovery and the use of decentralization as a tool to increase community participation in the delivery of health services[28]. In this context, it is important to note that the unpaid health care provided by women in families and in communities has frequently been used as a financial adjustment variable.

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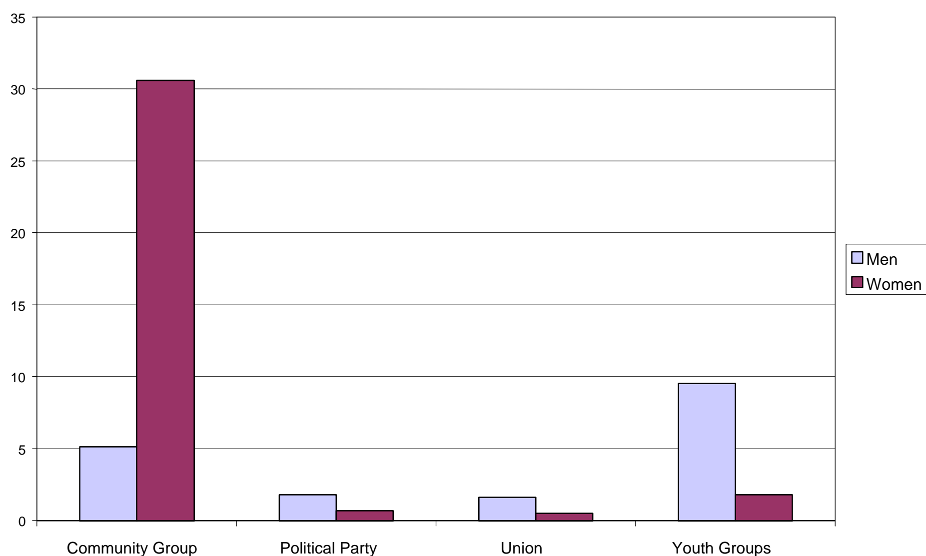
[27] Wuest, Judith, Institutionalizing women's oppression: the inherent risk in health policy that fosters community participation, *Health Care for Women International*. 14:407-417, 1993.

[28] Standing, Hilary, 1997, Op.cit



Source: Moser, Caroline, Household responses to poverty and vulnerability. Washington, D.C., Banco Mundial, 1997.

From a gender equity perspective it would be useful to ask the following questions: What representation do women have in community power structures? Do they participate at the decision-making levels—that is, in the setting of priorities, in the planning of programs, and in the allocation of resources? Who gains and who loses in these decisions? What are the needs for organizational support that would strengthen community decision-making structures and generate greater participation by traditionally underrepresented groups, such as indigenous populations and women? What mechanisms could be implemented to increase women's participation in decision-making without increasing their workload? Who would, and through what mechanisms, arbitrate and redress inequitable decisions regarding internal allocation of community resources?

In the event that a transfer of responsibility for health services from the state to the community has occurred, has it implied a greater burden for women in terms of providing home care for dependents, the sick, the elderly, and the physically and mentally disabled? What structures exist to support home care? Has the impact of this additional burden on the people who provide the care and on those who receive it been considered or investigated? What effect does this work overload have on the effectiveness and sustainability of home care?

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

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

From the gender perspective, it is essential to determine *first of all* to what extent the *contents* of care models and basic packages of services respond to the particular health needs and rights of women-- and men. Here, it is necessary to emphasize that the particular nature of these needs and rights stems not only from the biomedical dimension of reproduction. Incorporating a gender approach into models of care also implies that in planning the content and delivery of health services, consideration be given to: a) all stages of the life cycle; b) risks and resources for health that are associated with the discharge of responsibilities socially assigned to women and men; c) the growing frequency with which women are called upon to perform a dual role (paid labor and domestic work); and d) the unequal power relationship between the sexes.

> A typical example of interventions based on such considerations would be the introduction of services to address domestic violence and obstacles to the free exercise of sexual and reproductive rights. Another example would be the organization of service delivery to take into account the constraints experienced by *certain groups of women* in terms of: information, geographical mobility, schedules, independence in decision-making about certain types of care, taboos on being examined by male professionals, and low priority assigned to their own needs versus that of their children.
>
> Revaluing women's time is key to the promotion of equity in the health services. Traditionally these services have operated under the assumption that women's time is both free and elastic when seeking care for themselves or their children and providing follow-up care in the home. In this regard, it would be necessary to investigate, for example, to what extent coordination has been achieved between maternal and child health services, and whether specific support is being provided for care in the home. Furthermore, it is important to determine whether interventions in reproductive health, domestic violence, and child growth and development are targeted exclusively to women or whether they include men in some way or another. Finally, with regard to cutbacks in certain services, it should be reiterated that reducing public spending on health may shift an

excessively onerous burden onto the unremunerated reproductive economy by increasing the time women spend in providing necessary care for family members.

Secondly, questions should be directed to the *processes* of identification of needs and priorities. Information is needed on the extent to which women have been consulted and how much they have participated in the determination of needs and in negotiations on setting care priorities. It is relevant to ascertain whether the government agencies in charge of women's affairs, nongovernmental organizations working for gender equity, and women's organizations have intervened in these processes. It is also important to investigate what methodological instruments were employed in setting priorities (DALYS, for example)[29], and what gender biases may be concealed in these instruments.

Third, concerning the impact of policies aimed at the reorganization of the health services, mechanisms should be sought to assess the impact of the new models and benefits packages in terms of meeting the health needs of the population in general and groups with special needs, including women. The participation of civil society and, in this particular case, of women's organizations, is also crucial in complying with the principles of equity.

3.3 *Restructuring of Human Resources Management*

The restructuring of human resources management, which includes reductions in force, modification of remuneration systems, staffing hierarchies and personnel evaluation, reclassification of jobs, and training, has major implications for gender equity,[30] for three main reasons.

a) Women's employment in this sector is particularly vulnerable to any significant reduction in staffing levels, given the preponderance of women in certain occupations and in positions of less power.

b) The experience of many developing countries suggests that women tend to use certain health services if the providers are women and, in some cases, would use them only in such circumstances. Consequently, maintaining appropriate levels of female personnel becomes a very important factor in the use of such services.

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

[30] Standing, Hilary, Op. Cit., 1997

c) As a result of the interaction between the formal and informal health care sectors, policies that have an impact on staffing in the health services simultaneously affect the magnitude of the informal care burden that devolves predominantly upon women.

From the perspective of the impact on gender equity, it is appropriate to ask, then, What impact has the health sector reform's human resource policies had on the composition by sex of the personnel in the various decision-making levels in the systems' public and private sectors. Which professions have undergone the greatest changes? Have these reforms had a different impact on men and women at comparable levels of occupational status, e.g., in incentives and continuing education policies? And, turning again to the topic of the interdependence between the formal and informal health sectors, to what extent are the reductions in force in the health services being offset by the unremunerated work of community health workers (frequently women) and/or women in the home?

3.4 *Expanding the Options for Health Financing and Private Sector Participation*

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

The debate has essentially revolved around the impact of these measures on access by the poor to the health services. The evidence indicates that access to and use of the services by low-income groups is affected by the various financing modalities. It is an established fact, for example, that most health insurance systems in the developing countries tend to benefit disproportionately the urban middle classes and certain groups of workers.[31] It has also been seen that strengthening private financing of care, in detriment of public financing systems, has negative repercussions on low-income groups in terms of access to, and affordability of health care.

However, in spite of the evidence of some general trends, there is a scarcity of studies that identify the most affected groups and evaluate the differential impact of various financing modalities on them.

From the gender perspective it is imperative to remember that cost recovery measures can particularly affect women, given their greater need for services, their limited access to remuneration, and their social role as the principal caretakers of their children's health.

a) Needs and Expenditure

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[31] Standing, Hilary, 1997, Op. cit., p.12.

Women have a greater need for health services than men, particularly because of their reproductive role. This need is frequently associated, with greater health expenditure, especially in privatized systems geared to individual care. Consequently:

- In some countries, given their potential for pregnancy, women of childbearing age must pay higher insurance premiums than men of the same age; such is the case, for example, in Chile, where insurance premiums for individuals 15-44 are more than twice as large for women than for men[32].

- In this same age group, women's out-of-pocket expenditure in health is often considerably higher than that of men. In the United States, for example, women pay 68% more in out-of-pocket expenditures for their health than men in same age group.[33] In the Region of the Americas, household surveys suggest that out-of pocket expenditures in health may be 15% to 43% higher for women than for men of all ages (Table 2).

- Spending on reproductive health services represents one-third of all health expenditures by women in this age group. This is basically due to the high cost of obstetric care and to the emphasis on curative care, since insurance plans do not always cover family planning services[34] and other preventive measures.

- Women's greater longevity exposes them to a larger share of exclusions from private health insurance plans by reason of chronic diseases and catastrophic conditions, having then to resort to publicly financed care[35].

b) Access to Services and Ability to Pay

This higher level of need and expenditure contrasts with women's more limited ability to pay by virtue of their social and economic subordination, especially their disadvantaged insertion in the job market. Consequently:

- Due to the cultural centrality of their domestic role, most women (more than 50% in

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[32] See: Base de gastos en ISAPRES; and Ramírez, Apolonia. *Situación de la mujer trabajadora en el sistema ISAPRES*. In: Fernández, Margarita (Ed.), *Economía y trabajo en Chile*. Informe Annual No. 7, 1997-1998, Santiago, 1998.

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

[34] Women's Research and Education Institute. 1994, Op. cit. P.3.

[35] Ramírez, Apolonia. 1998, Op. cit.

Table 2: Out-off pocket health expenditures for males and females in selected Latin American and Caribbean Countries

Country	Health Spending in Current US dollars	
	$ US	Percent Difference
Brazil 1996-97		
Women	239.51	40.0
Men	171.08	
Paraguay 1996		
Women	381.95	27.4
Men	299.77	
Peru 1997		
Women	100.31	41.5
Men	70.91	
Dominican Rep. 1996		
Women	162.52	14.9
Men	141.48	

Source: LSMS Surveys for Brazil, Paraguay and Peru. DHS Surveys for Dominican Rep.

the Region) remain outside the job market (Figure 3). Women also bear the larger share of unemployment in the Region (Figure 4). These patterns constitute a systematic barrier to direct access to health insurance and social security plans.

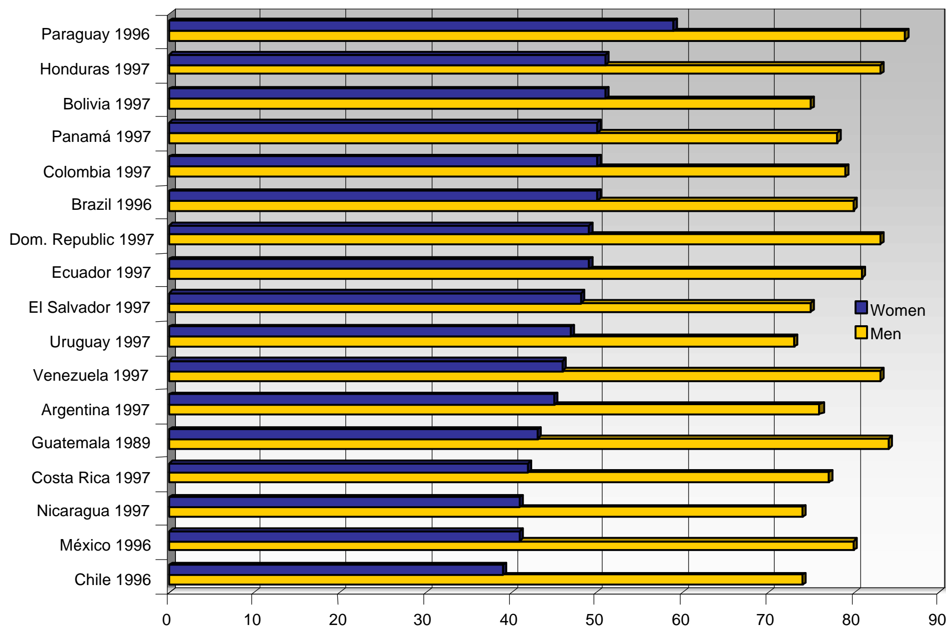
- When women participate in the job market, they systematically receive lower wages than men (Figure 5). In the Americas, women's wages average 71% of men's[36]. This difference constitutes an additional barrier to access a broad service coverage within accessible plans.

- In response to the pressure to reconcile their domestic and work roles, women fill the majority of part-time jobs (70%-90% in the Western world)[37] and jobs in the informal sector of the economy (Table 6). Neither group is customarily covered by social security or health insurance plans.

[36] World Bank. *Workers in an Integrating World—World Development Indicators* en World Development Report 1995, Washington, D.C., 1995.

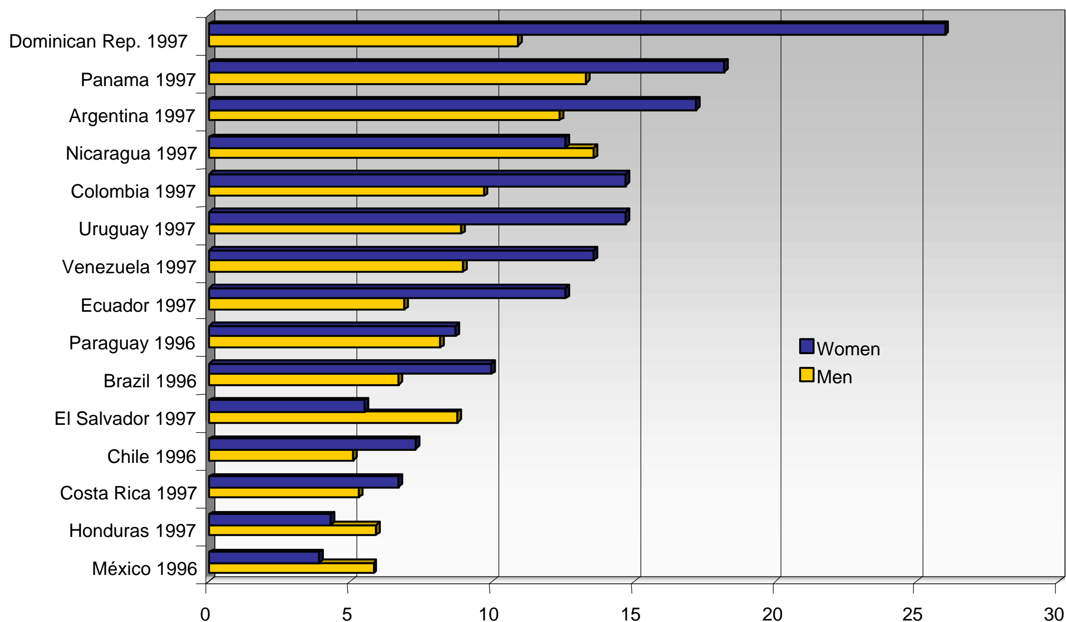
[37] *The Economist*. A Survey of Women and Work. 18 July 1998.

Figure 3: Labor Force Participation Rate of Men and Women In Urban Areas



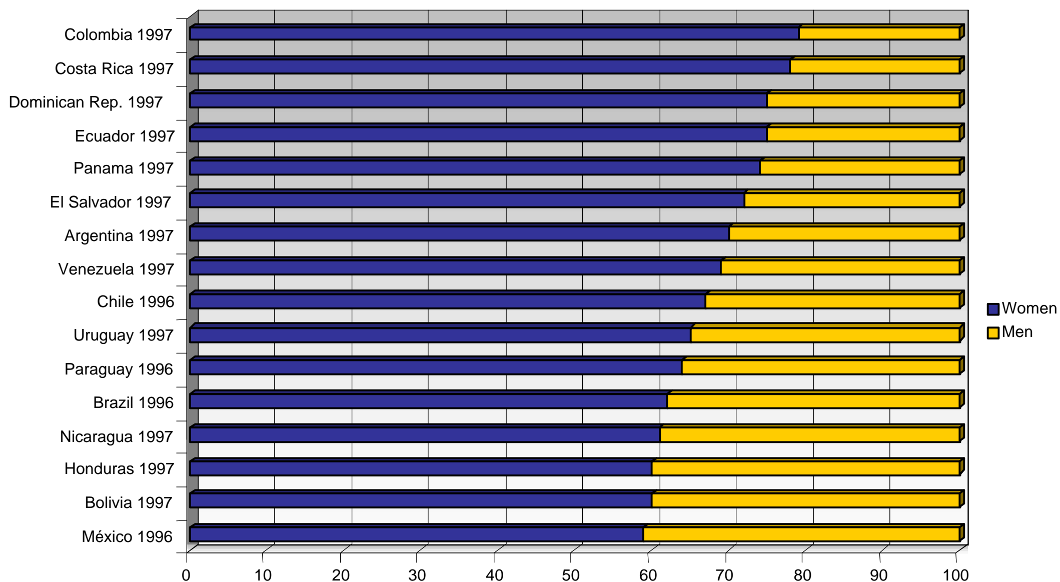
Source: CEPAL - Panorama Social de América Latina 1998

Figure 4: Unemployment Rate in Urban Areas by Sex



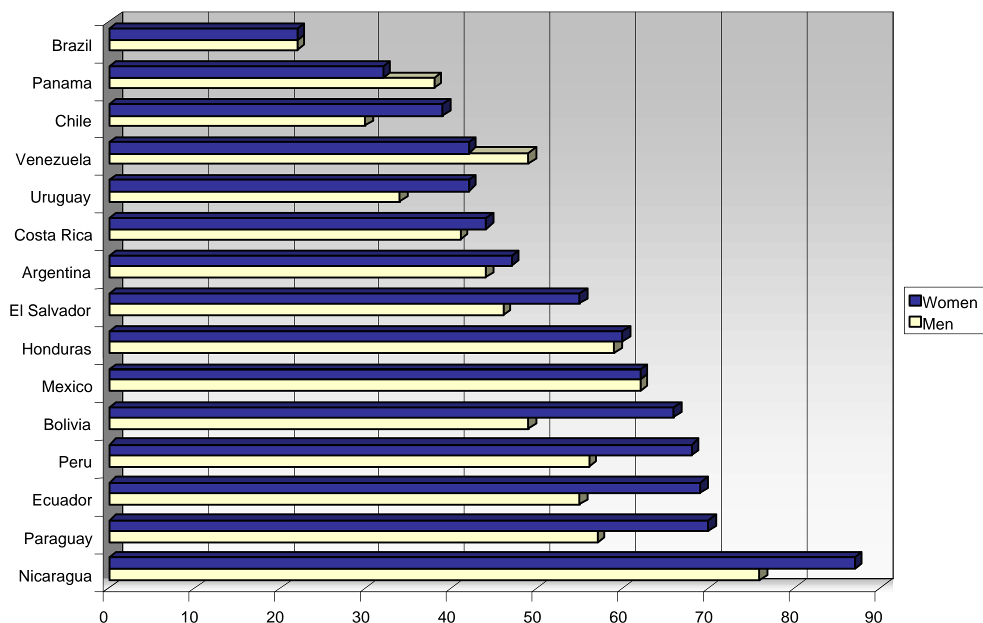
Source: CEPAL - Panorama Social de América Latina 1998

Figure 5: Women's Income as a Proportion of Men's in Urban Areas



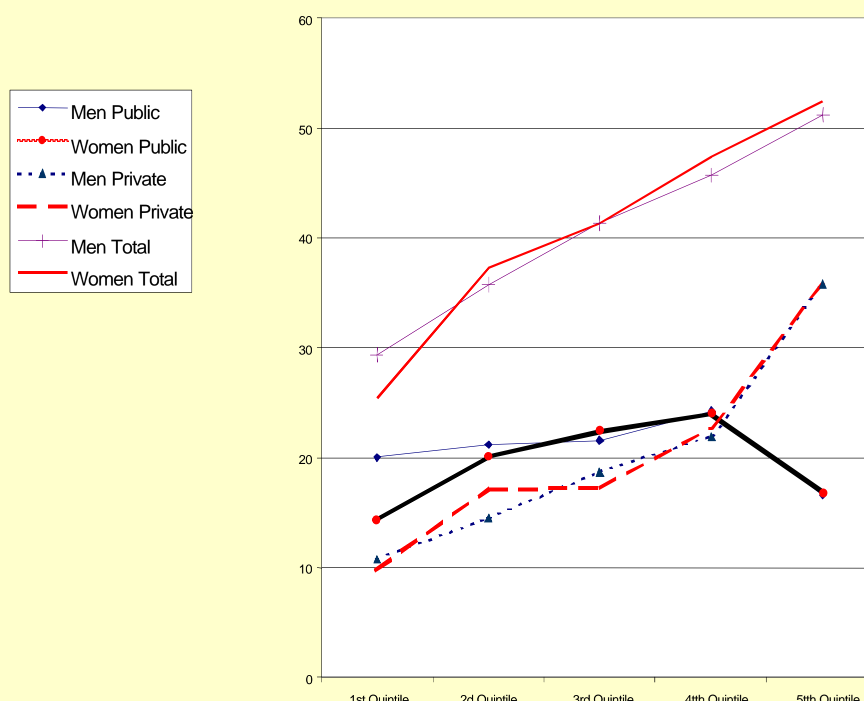
Source: CEPAL - Panorama Social de América Latina 1998

Figure 6: Male and Female Labor Force Participation in the Informal Sector, (for 25 to 45 years olds) 1995



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

Figure 7: Percent of individuals who sought health care by sex and family consumption quintiles and type of service



Fuente: Encuestas
LSMS – BOL, COL, ECU, NIC, VEN (1994-1996)

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

- When conditions favor broad access by the population to health care, women tend to use the health services more frequently than men. However, when economic conditions limit such access, the relationship between gender and use of services is less clear. For example, recent household surveys of five countries in the Region indicated that, when ill, the poor utilize the services less frequently than the rich, and that among the poor, particularly in private health care systems, women use services less than men (Figure 7).[38]

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[38] Casas, J. A. *Economic, Social and Health Inequalities in Latin America and the Caribbean*. Paper presented at the Fourth Annual Meeting of Ficosser, National Institute of Health of Mexico Cuernavaca, Mexico, 1998.

➢ *c) Economic Responsibility for Care*

The cultural responsibility of women for the health care of their family members is not restricted solely to the in-kind contribution characteristic of their work in the home. More and more frequently it also represents payments to cover medical care, particularly for their children and, increasingly, their elderly parents. In this respect it must be recalled that this responsibility is not shared in a sizable number of cases, since, for example, the proportion of households headed by women already exceeds 30% and even 40% in a Latin America and the Caribbean. The vast majority of laws that oblige fathers to contribute to the upkeep of their children are largely ineffective. Several studies have shown that contributions from absent fathers are minimal or non-existent. Mechanisms to enforce them are very limited and time-consuming for mothers[39] .

d) Considerations

Some important considerations with regard to financing and private sector participation in health care from the gender equity perspective would thus be:

- Has the government established regulatory frameworks to set standards for service delivery by the private sector? Are these regulations aimed at improving equity or counteracting existing or potential inequities in services provision? Do they explicitly address the health needs of women and gender inequities with regard to access?

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

- To what extent do the various financing systems provide access to preventive care and contribute to the achievement of public health objectives? These kinds of interventions are of special importance for women for two reasons: first, because of their particular needs with respect to family planning, prenatal care, and the detection of cervical cancer. Secondly, because, as emphasized throughout this document, women absorb the additional burden of the care required for environmentally induced diseases, such as infectious diarrheal diseases in children.

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

Attention should be called here to the priority need for information sufficiently disaggregated to identify the most affected groups and to measure and monitor the impact of diverse types of health care financing.

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

4.1 Challenges

Incorporating the gender perspective into health and social security reform policies requires a response to three major challenges:[40]

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

Generation and Dissemination of Information

At present, the discussion of gender equity and reform is supported only by fragmentary empirical evidence and general conceptual "principles". The lack of a solid information base as a foundation for policy formulation is a particularly urgent problem when discussing the impact of the reforms. This deficiency is not limited to the gender dimension, but extends to the entire sphere of social inequalities. However, in the case of gender it is exacerbated by the scarcity of routine information in the health sector with a breakdown by sex. It is important to emphasize, nevertheless, that although the health sector does not systematically obtain or publish data with a breakdown by sex—except

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

with regard to mortality—relevant information from household surveys is available in a sizable number of countries in the Region. This information, which is currently underutilized, would facilitate the measurement and monitoring of the inequalities in health, access to care, and health financing.

The first need with respect to the generation of information is the development of gender-sensitive indicators and gender inequity indicators,[41] together with evaluation and monitoring instruments. Some of these indicators will be applicable regionally, whereas others will be context-specific. Parallel with such development, it is essential to promote and support research to document the differential impact of reforms on various social groups and on the women and men in these groups.

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

Political Advocacy and Institutionalization of Changes

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

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

The plan of work that PAHO proposes to implement is designed to address these challenges and promote gender equity in health and social security reforms, taking advantage of their institutional incorporation in two types of scenarios: First, the national scenarios, where support will be provided to strengthen local capacity for the analysis, evaluation, and monitoring of health and social security reform policies; and second, the

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[41] Anand and Sen, *op. cit.,* 1995.

international scenario, where the sharing of experiences and joint efforts will be facilitated, promoting the production, adaptation, and application of the knowledge generated in the countries. Collaboration between countries in this effort is particularly important, because of the opportunity that it offers to evaluate the various policy alternatives, learn from each other's successes and failures, and foster changes that are regional in scope.

4.2 Strategies

This project seeks to promote dialogue and coordinate activities among the technical teams and representatives of relevant sectors of government and civil society in a concerted effort to foster gender equity in health and social security reform policies and processes. The joint efforts of these actors will revolve around diagnostic studies, identification of priorities, formulation of corrective policies, and implementation of the means to monitor compliance with such policies.

In the initial stage, the activities would take place at the regional level and in a limited number of countries (possibly three), selected on the basis of the following criteria: a) sustained development of health and social security reform processes that facilitate impact assessment; b) national authorities' interest in integrating the gender equity perspective in the contents and processes of reform; and c) the presence of an organized women's movement interested in participating in public policy-making.

Activities at the regional level would consist basically of the following:

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

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

- Workshops on gender and health for politicians, planners, and nongovernmental organizations;

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

Summary and conclusions

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

The conceptual tripod of equity, gender, and participation constituted the basis for the analysis, which underscored the interrelation of these three concepts. Regarding *equity*, it was pointed out that not all differences constitute inequity and that this term is reserved to designate those differences considered avoidable, unnecessary and unjust. In relation to gender, it was emphasized that the focus of the gender approach is one of the sexes but the *relations of inequality* between women and men. It was called attention to the fact that the guiding vision of this approach is that of an equitable society in the *distribution of the resources* and benefits of development and in the *participation* of its members in the decisions that shape that development. It was further emphasized that the meaning assigned to participation is not instrumental, but referred to the citizens' right to influence and demand accountability regarding the political processes that affect their well-being. It was also accented, that a gender approach is not reductionist: It does not restrict its aim to the general inequalities of power between women and men, but to the systematic articulation of these inequalities, with those of class, race, age, and geographical residence.

Four types of reform policies frequently implemented in Latin America and the Caribbean were examined from the perspective of their implications for gender equity. These policies were: a) decentralization and promotion of social participation; b) reorganization of services, including redefinition of models of care and determination of basic service packages; c) restructuring of the systems of development and administration

of human resources; and d) restructuring of the systems of financing, including the participation of the private sector.

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

1. The conceptual bias that permeates the economic policies causing women's work to be severely undervalued: the economic contribution of their "reproductive" work is ignored and their "productive" work is underpaid.

2. The importance of recognizing the interaction existing between the spheres of formal and informal provision of health care, and the unequal impact of this interaction on men and women.

3. The need for understanding the different positions of women and men as producers and consumers of health goods, and the inequities ensuing from this difference..

4. The sex-differentiated effects of the policies of allocation of resources, public spending, and financing of care, on the physical and economic well-being of society, and the distribution of its care burden.

5. The implications for society's health, of gender inequalities in access to and control of resources and decision-making.

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

For the purpose of confronting these obstacles and seeking the incorporation of the perspective of gender equity into the processes of RSS, a cross-sectoral strategy with stakeholder participation was proposed. Its main elements were the following:

1. Improvement of the availability and quality of routine information on health and its determinants, and breakdown of this information by sex, age, and socioeconomic criteria.

2. Analysis of existing inequalities between men and women regarding the production and consumption of health. Emphasis is placed on differences in needs, risks,

contributions, access to, and power over health resources: groups most affected will be identified and measurement and monitoring of the impact of the different types of reforms on these groups will be assessed.

3. Targeted dissemination of the knowledge thus acquired, with a view to inform policy formulation at decision-making and planning levels, "empower" stakeholders in civil society, and shape public opinion.

4. Fostering active participation of the *less heard* groups in society--particularly women--so that they can have **voice** in the generation, planning and monitoring of solutions.

5. Promotion and support of cross-sectoral institutional mechanisms that address the multiple determinants of health and inequity, and actively involve gender equity advocates from civil society.

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