



**Women, Health and Development Program**  
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**Gender and Equity in Health Sector Reform:  
A Review of the Literature**

Prepared by:

Christine Onyango, Consultant

For the Pan American Health Organization (PAHO/WHO)

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## **Introduction**

The purpose of this literature review is to review and synthesize published and unpublished literature examining the interaction between health sector reforms, gender and equity. The literature examined covers both developed and developing countries and includes the experience of a range of health systems as well as a variety of health sector reform strategies.

The literature in this review was obtained through searches of a number of databases covering various disciplines, including health services research, health economics, political science, and women's studies. Databases searched included Medline, Pubmed, Contemporary Women's Studies, Ecolit, ResEcon, Dissertation Abstracts, Silver Platter, and Latin American Studies. Additionally, Web sites of organizations known for their work on health sector reform were perused and relevant publications obtained.

## **Part I. Definitions and Conceptual Framework**

### **What is health sector reform?**

Health sector reform is broadly defined as a process whereby the organization, financing and management of health care delivery is changed to promote efficiency, equity, coverage of health service delivery. Health sector reform was championed by The World Bank's 1993 World Development Report (WDR), which provided a rationale for structural changes to the health sector based on failure of many health systems to improve health systems stemming from a lack of alignment between government actions and goals of economic development. The process of health sector reform was aimed also at changing in the role of government in provision and financing of health care, and implementing accompanying changes in national health policies.

Health sector reform has a long history however, which predates the 1993 World Development Report. Standing (1999) provides a chronology of health sector reform initiatives, additionally highlighting amongst others: the 1987 Bamako Initiative to provide a basic package of health care at the community level while promoting cost recovery and community management of health services; sweeping health reforms in developing countries in the wake of the 1993 WDR; health reforms in OECD countries in the 1980s and early 1990s; the move toward sector-wide approaches promoted by donors in the 1990s.

Distinction is made between first and second-generation health sector reforms. (Standing, 2000; Nanda, 2000) Standing (2000) describes first-generation reforms as those initially concerned with the supply-side, including financial resources mobilization and management for developing country health systems as well as improvement of management systems. Second-generation reforms focused on the demand side. Demand-side reforms take community needs into account and are more concerned with community participation and the impact of health sector reforms on equity. There is a wide perception that first-generation reforms did not produce desired results, and spawned the need for the second-generation approach. (Standing, 2000) Even donors concede that the competing goals of health sector reform pose a continuing challenge of balancing the supply-side aspects concerned with

increasing efficiency in health systems with demand-side concerns of participation and sustainability. (DFID, 1999)

Health sector reform is driven by different forces in different geographic contexts. As a result, we see different patterns of health sector reform strategies predominating by region and by country. Whereas decentralization and privatization are major features of Latin American health reforms aimed at expanding health coverage and promoting equity (Langer, 2000), African health sector reforms were heavily influenced by the 1987 Bamako Initiative and emphasized the introduction of new financing mechanisms such as user fees, revolving drug funds, and other community-run financing schemes as well as the cost-effective use of resources through the use of use of essential drugs lists. Reforms in South East Asia have focused on decentralization and improvement of financing mechanisms (Sharma, 2000), whereas reforms in the OECD countries have emphasized cost containment and the use of managed competition to increase efficiency. (Segall, 2000)

### **What is involved in the process of health sector reform?**

The 1993 World Development Report encouraged governments to improve the performance of health systems through a number of actions. These actions included creating an enabling environment by investing in female education, improving the status of women and implementing economic policies benefiting the poor were recommended. Actions specific to the health sector included shifting expenditures from tertiary to primary health services; providing a basic, cost-effective package of health services aimed at significantly reducing disease burden to the poorest segments of a population; significantly improving the manner in which health services were managed and delivered; and increasing efficiency in delivery of health services by increasing the private sector's role in supplying health services and providing insurance.

Health sector reform has also been driven by bilateral donors. Through its Partnerships for Health Reform project (1995-2000), the United States Agency for International Development (USAID) sought to test various strategies for health reform in a number of developing countries. PHR's major areas of activity in health reform mirrored the health sector reform activities outlined by the 1993 WDR. These activities included testing the effectiveness of: policy and legislative changes affecting the organization, financing and delivery of health services; various health financing mechanisms such as introduction of subsidies, prepayment plans, and private health insurance; measures to promote quality and health services and health providers; changes in the role of Ministries of Health – usually, decentralization of decision-making authority from central to regional or local levels; using government facilities for primary care rather than for secondary and tertiary facilities and; having government use cost-effectiveness data to define and deliver essential packages of healthcare targeted at the most vulnerable groups. (Abt Associates, 1999)

Through its work, PHR identified a number of stakeholders involved and affected by health sector reform. These include consumers, health providers, government donors, health insurance companies, private sector non-health providers such as pharmacies, pharmacists, pharmaceutical and medical supply companies. (Abt Associates, 1999)

## **What are the goals of HSR?**

Efficiency, equity, quality, access and sustainability of health services are all goals of health sector reform. (Knowles et al, 1997; PAHOa, 1999). However, it has since been recognized that these goals can counteract each other and that health sector reform measures should be carefully designed to strike balance among these goals. (DFID, 1999; Nanda, 2000) Since this literature review is focused on equity, much of remainder of this paper will concentrate on the impact of health sector reform on the goal of equity.

## **Equity as a goal in HSR**

Equity is one of several goals of health sector reform measures agreed upon by governments and international organizations. How, equity is defined, however remains somewhat elusive. Equity has primarily been defined as the reduction of inequalities in the health care context (Gwatkin, 2000). However, multilateral and bilateral aid organizations also include the provision of health services according to need and ability to pay as an added dimension of equity. WHO defines a state of equity as existing when "care is provided according to need" and "inequalities and unfair judgements between and within populations are removed or minimized. (p. 19)" The emphasis here is clearly on targeting those with poor health status, larger burden of disease and fewer resources: "favoring populations and countries with the greatest burden of poverty and health. (p. 19)" USAID defines equity in health as "the fair distribution of goods and services with respect to targeted groups" (USAID, 1995 p. 10)

Although there appears to be convergence on the definition of equity among international health organizations, the same consensus is not apparent in the health economics literature. Still, there are parallels in definition between health economists and the bilaterals and multilaterals. Carr-Hill (1994) points out the importance of distinguishing equity from equality, with the former referring to fairness, and the latter referring to having an equal share. He distinguishes between vertical and horizontal equality: "horizontal equity is concerned with equal treatment for equal need; vertical equity with extent to which individuals that are unequal in society should be treated preferentially."

There is disagreement in the literature as to whether the focus should be on equalizing health expenditures or on equalizing health status. (Culyer and Wagstaff, 1993) Doyal (2000) makes a compelling argument that the focus should be on equalizing inputs, since biological and genetic differences among individuals make equalization of health status an impossible goal. Pereira (1993) makes the argument for yet another approach to equity – one proposed by Amartya Sen, which defines equity as maximizing the ability of individuals to derive utility from health commodities and services, which in turn transforms into better health status.

Although achieving equity often seems an elusive goal, Carr-Hill (1994) argues that identifying inequity in health systems is relatively straightforward and that a number of factors can be identified as prerequisites for coherent policies for addressing health inequity. These factors include:

- Willingness of the current political regime to recognize inequalities
- Availability and use of data, which impacts the perception of whether or not inequalities exist
- Societal values re: whether health is an individual or collective responsibility

- Existing type of health system (e.g national health insurance systems based on progressive taxation cost less and are better at ensuring access)
- The ideologies of existing political parties and their positions in health care debate
- Relative position and power of disadvantaged groups.

### **Gender, equity, and health sector reform**

It naturally follows from the discussion above of equity's relationship to distribution of health resources and health outcomes, that examining how societies define the distribution of health resources and health outcomes is an important part of crafting equitable health sector reform strategies.

By definition, gender analysis is grounded in the distribution of resources and power between women and men. The socially-defined roles of women and men affect the way societies are organized, the way resources are distributed and redistributed and way in which the women and men and girls and boys interact. The concept of gender must be differentiated from the concept of sex, which refers to the biological differences between women and men arising primarily from their different reproductive functions.

Related to the concept of gender is the concept of productive vs. reproductive roles of women and men in society. The productive economy refers activities to the production of goods and services produced for consumption in the market. Productive work is frequently paid and is counted in a country's gross national product (GNP). Reproductive labor refers to the activities which are necessary to keep a society afloat, such as emotional nurturing and care of children, the aged and the sick. This work is mostly done by women and girls, is usually unpaid, and is normally carried out in the context of the community and the household and is not reflected in GNP. Advocacy by women's rights organizations and feminist economists result in modification of the System of National Accounts (SNA), the body created by the UN in the 1950's to measure global economic activity. The result is that the 1993 modification of the SNA requires that so called reproductive production should be included in GNPs. However, this has not occurred because national censuses and surveys have not been changed to adequately collect this information. (UNIFEM, 2000)

Increasing concern has been expressed by international organizations, bilateral donors and health activists in the last few years on the subject of the interaction between the impact of health sector reform and gender. (Gomez Gomez, 1999; Gideon, 1998) This is in part because a number of UN conferences held in the 1990s have put women's human rights at the center of health policy and have led to renewed commitment by international donors for funding programs improving women's status. Among these, the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women were key in galvanizing women's health and rights advocates worldwide to hold their governments responsible for taking a more proactive role in improving women's status. (WEDO, 1998)

In the meantime, evidence from around the globe demonstrating the inequality in health status between women and men, the large burden of disease of women experience due to their reproductive function, (Murray and Lopez, 1998) and the differential use of health services by sex, served to mobilize women's rights advocates with the ammunition needed to convince governments and donors to take action.

The Beijing Platform for Action (strategic objective C, paragraph 91) expresses concern regarded the differential impact of economic and health care policies on women:

*In many countries, especially developing countries, in particular the least developed countries, a decrease in public health spending and, in some cases, structural adjustment, contribute to the deterioration of public health systems. In addition, privatization of health-care systems without appropriate guarantees of universal access to affordable health care further reduces health-care availability. This situation not only directly affects the health of girls and women, but also places disproportionate responsibilities on women, whose multiple roles, including their roles within the family and the community, are often not acknowledged; hence they do not receive the necessary social, psychological and economic support.*

International organizations, governments and civil societies have all contributed to shaping thinking on the relationship of gender to health status. WHO's Health for All in the 21<sup>st</sup> Century (2000) proposes that a gender perspective must be subsumed into health strategies and policies, and that this is to be achieved through research and analyses to uncover gender issues, activities to promote gender awareness, and projects that pay attention to the different needs of males and females throughout their lifespan, while supporting the human rights of girl's and women, and improving women's participation in decision-making.

The Pan American Health Organization (PAHO) has made it a priority to examine the impact of health sector reform on gender equity and has sponsored a number of fora on the subject which have produced several papers examining both the theoretical underpinning and the practical implications for gender equity in health sector reform. Langer et al (2000) have examined health sector reform from the standpoint of reproductive health, and have produced typologies to classify Latin American countries with respect to health sector reform and reproductive health.

### **A Conceptual Framework for Analyzing Gender and Equity in Health Sector Reform**

Literature examining the interrelationships between gender and health sector reform is relatively recent. Standing (1997; 1999; 2000) has contributed a great deal to the creation of a conceptual framework for examining gender in the context of health sector reform. She poses a number of important questions with respect to various health sector reform activities and the corresponding potential gender impact. These questions will be used to frame the remainder of this paper.

Earlier literature linking the impact of economic policies with women's health status laid the groundwork for looking at gender within health sector reform. This earlier work created of a framework for formulating gender-aware macroeconomic policies, of which health policies were a part. While it was clear that economic reforms could have direct positive impacts on women's lives such as decreasing labor market inequalities and increasing the number of women employed in the private sector, it was also discovered that these policies could be detrimental if women's workload in the paid and unpaid economies were to increase. In short, ignoring gender impact of economic policies could prevent governments from achieving economic development goals. (Elson et al, 1997)

Elson et al (1997) and Hanson (1999) clarify the manner in which gender-based distortions and institutional barriers could impede economic reforms related to health care. Specifically, opportunity costs of women caring for sick (waiting time, travel time) are not included as costs in costing and cost effectiveness studies. Cost containment strategies such as earlier discharge require an increase in women's and girl's roles in home care and the costs of

caring are not counted anywhere. They concluded that what appeared to be cost reductions in the paid economy was in fact a transfer of costs to the unpaid economy. Ripple effects lead to women having to take time off of work in productive economy which lead to a decrease in income just add to stress and exhaustion of already busy and burdened women.

## **Part II. Review of literature**

The remainder of this paper will first examine literature related to the assumptions behind the links between gender and the use of health services. An attempt will be made to follow the definition of “gender” given earlier in this paper, and to also review the literature’s contents with respect to specific health sector reform activities and the differential impact on women and men.

### **Assumptions behind Links between Gender and Use of Health Services**

Logically speaking, gender impact of health sector reform strategies is linked to gendered dimensions of health systems. Goméz Goméz (1997) has identified several underlying assumptions that would result in gendered impact of health sector reform policies. They are as follows:

- Women use more health services than men
- Women are expected to take care of the sick and disabled when policies decreasing access to health care are implemented
- Women are overrepresented among the poor
- Women are underrepresented in formal sector jobs that provide employer-based health insurance.
- Women are underrepresented among power structures that make health and economic policies

The literature is mixed on confirming the assumption that women use more health services than men. Studies have found that have an overall women use more of certain health services such as preventive and dagnostic services (Bertakis et al, 2000) and mental health services (Newell and Saltzman, 1997), whereas men use more of emergency room services. (Anson et al, 1991) Other studies have found that there is no difference in the use of health services between women and men. (Murphy and Hepworth, 1996; Wadell and Floate, 1986) However, most of these studies have been carried out in developed countries, and similar utilization data is not as available from developing countries.

By the nature of their particular biology, women use reproductive health services far more than men. (Doyal, 2000) Women will also frequent facilities more often because they are usually the custodians for children's health. (Scott Collins et al, 1998) Evidence from Canada and China found that though women use more health services in their reproductive years, men surpass them in health services utilization in the later years. (Mustard et al, 1998; Green and Pope, 1999) However, health services studies from North America and Australia have also found no sex differences in health services utilization (Murphy and Hepworth, 1996; Anson et al, 1991)

Both anecdotal and empirical evidence confirms that women are the principal caregivers for sick and disabled family members. Changing demographic patterns (such as increased life expectancy) in some countries combined with unchanging gender roles mean that family caregivers are increasingly middle-aged women who are simultaneously expected to care for both

their adult children and spouse and elderly parents or in laws while maintaining employment in the paid labor force. (Binney and Estes, 1988) Women provide over 70% of family care-giving in the United States and 63% in the United Kingdom. (Tarman, 1994)

This socially-constructed care-giving role for women contributes to their poverty level, as well as to their ill health in old age. (Binney and Estes, 1988) A large survey of women's health in the United States found the poor women involved in care of sick or aged relatives can work more than 20 hours a week at caregiving, while holding down other paid work. Most women surveyed had no paid help with caregiving – only 24% had paid help in caring for sick and elderly relatives. (Scott Collins et al, 1998)

A study by Soldo and Myllyluoma (cited in Hogan, 1990) found that 1 in 5 homes providing care to an older unmarried relative is headed by a woman who must also work outside of the home because of economic necessity. The majority of caregivers were married women with children who worked outside the home and provided financial support to parents and parents in law. Some women quit their jobs to care for their mothers and others cut down on work hours. Almost one third (28%) of caregivers end up leaving their jobs. Stone (in Tarman, 1994) found that 12% of daughters vs. 5% of sons left jobs to care for family members.

Caregiving tasks are also gendered: women are more likely to be responsible for household tasks, hygiene, emotional work, whereas men involved in caregiving are more likely to take care of transportation, home repairs and financial management. (Tarman, 1994) Most women suffer physical and psychological burden from taking on this role of caregiver. (Binney and Estes, 1988) Even when women are paid to carry out caregiving work the working conditions are often suboptimal. Workers tend to no pay, few or no benefits, and are often not. (Tarman, 1994)

The only published study on caregiving in developing countries found in carrying out this literature review was one on women in Brazil. Messias et al (1996)'s qualitative study of 75 women found that women are expected to be responsible for domestic work even when they work outside the home. They are often overwhelmed and this domestic burden has a detrimental effect on their health.

The United Nations's 1997 Report on the World Social Situation analyzed a number of studies on women and poverty, and concluded that although the results from analysis of data examining women's overrepresentation among the poor was mixed, there was sufficient evidence to suggest that women comprised a disproportionate percentage of the rural poor in developing countries, which was rising at a faster rate than the number of women, suggesting that there has been a relative rise of poor households headed by women. They concluded that even where women are not overrepresented among the poor, the dual roles of worker both inside and outside the home reduced women's ability to escape poverty. Moreover, discrimination in formal sector employment as well as in education reduced women's economic potential. Combined with the lack of social safety nets in many countries, these factors put women at a higher risk of poverty.

It is also true that women are less likely to have employer-based insurance than men. Most employer-based insurance is based on employment in the formal sector, and given that women are more likely to be employed in the informal sector than are men (UNSD, 2000), they are less likely to enjoy the benefits of formal sector employment that include health and disability insurance as well as social security.

In general, women are underrepresented in power structures that political power structures, although no systematic study has been done of women's representation in power

structures where health policies are determined. On average, women are only 12% of representatives in national parliaments worldwide and 15% of cabinet members. Scant information is available on the representation of women in local governments around the world, and estimates range from around 4 % in Africa and Latin America to 20% in Europe. (UNDP, 2000)

### **Gender Impact of Specific activities in Health Sector Reform**

Having examined the underlying assumptions about the gender impact of health reform, we can now summarize the relevant literature on the gender impact of specific health reform strategies. As mentioned before, Standing (1997) provides a useful conceptual framework for analyzing the impact of health sector reform in developing countries. She identifies several activities in health sector reform that could have a significant impact on health care reforms. These categories include: improvement of performance of the civil services, decentralization, privatization and measures to improve functioning of MOH, introduction of new financing mechanisms and introduction of managed competition. The remainder of this paper will analyze the literature with regard to the gender impact on these categories of activity.

### **Gender Impact of Reforms to Improve Performance of Civil Services**

In many countries, health services have historically been provided directly by the civil sector, through the Ministry of Health, and health workers are therefore employed directly and supervised by this government agency. As part of health sector reform, the 1993 World Development (WDR) recommended reductions in the size of the public sector to reduce costs and lay the groundwork for opening up provision of health services by the private sector in order to promote efficiency. A key goal of improving the performance of civil service employees in health care has been to contain health sector costs by making better use of existing health resources.

Standing (2000) identifies four main ways in which gender issues arise with regard to human resource planning in health sector reform. Not including health workers in discussions in training and career paths may result in work arrangements which conflict with women's gender roles, and which therefore, by design, preclude them from hiring, training and promotion opportunities.

Secondly, not taking into account the predominance of women in certain occupations in the health sector can be devastating when job cuts are made and large numbers of women are fired. Thirdly, preferential hiring of men limits women's ability to benefit from any job opportunities created by health reform. Finally, bias against entire categories of female workers (reflected in legislation which limits authority of nurses, for example) limits their ability to move into the private sector and reap similar benefits of private practice enjoyed by predominantly male categories of health workers.

In developing countries, the health workforce is sometimes the largest formal sector employer of women, who tend to be concentrated in lower level and lower-paying positions, and hence may be seen as more "expendable" as workers. (Standing, no date provided) Findings from Nicaragua's health sector reforms reflect this phenomenon. In this country, women represent 70% of all technical and professional staff, and the majority of all health professions except for medicine, where they constitute 40% of doctors. Women health workers experience 3.5 times more unemployment than men. Interestingly, technicians (of whom 73% are women) are the category of health worker most affected by job cuts carried out by the Ministry of Health. They

have the highest levels of unemployment, the lowest salaries, and have had the most difficult time of all the health professions with going into private practice. (Nigenda and Machado, 2000)

The clearest evidence related Standing's assertions concerning the disproportionate downsizing of persons health care occupations dominated by women comes from research on nurses in developed countries. Health reform of the UK's National Health System, has been characterized by the creation of increased competition among health providers and hospitals. Staff reductions resulting from reforms have been concentrated among support service staff who are predominantly female -- part-time and ancillary workers. (personal communication and Buchan, 1999)

Downsizing or reallocation of public sector health personnel has resulted in shifting persons to other functions or even to other geographic areas. In her analysis of health sector reforms in Zambia, Nanda (2000) describes the impact on reproductive health of actions taken to downsize or reallocate health personnel. Zambia created local health boards which become responsible for hiring and supervising personnel in their district. Health personnel had to resign and reapply to the local boards for reinstatement. Unskilled persons lost their jobs.

All these changes created resistance and moral problems, especially since they were not accompanied by better training and increased salaries for health workers. Hanson's (1999) evaluation of health reforms in 8 African countries found that: "workload of health workers increases significantly with the reforms, often without any increase in their basic salary level" Nanda (2000) reported of the nurses in one district in Zambia that "they could do a lot, but that they needed information and training. We want information about clients' rights and written policy guidelines, stated one nurse. Only one of these eight women had been to several training workshops while the others had not benefited from attending training or passive learning through other trained staff. The women who had not attended any training workshops felt much marginalized on this account."

Evidence from Europe shows that quality of care can be compromised with health personnel reforms. A survey of UK nurses revealed that layoffs have created more work for them, and has affected their ability to provide good patient care. Cotton (1997) reported results of a survey of more than 1000 gynecological nurses of the United Kingdom's National Health Services examining the impact of cost containment strategies on patient access to health services and to quality of care. Such measures include reduction in the number of hospital beds and the reconfiguration of nursing duties. Two-thirds reported that services had been restricted because of bed closure, 54% reported restrictions in hospital admissions for elective procedures and 27% reported restrictions in emergency admission. "Restriction" of services was defined as anything from ward closure to treatment rationing. Although the majority reported that standards of care had remained the same, 26% reported that patients were being discharged inappropriately early. Respondents also reported that some gynecology patients were being transferred to general wards where specialist care required was not as readily available.

A survey of nurses in Ontario, Canada found less dramatic impact, and in fact, found there was little change in factors such as job satisfaction, workload, and physical work conditions following the restructuring resulting from health reforms; however other factors such as supervision were negatively affected. (Armstrong-Stassen et al, 1996)

Healy and Mckee (1997) used literature reviews, field visits and surveys of trade unions, to study the impact of health sector reform on those in the health professions in Central and Eastern Europe (CEE). Though most doctors in this region were women, most female doctors

were general practitioners and most specialists were men. Since higher-level jobs were mostly occupied by men, many women doctors made 25% of the average salaries of men. They found that closing down of publicly-owned health facilities drove many female health professionals to enter the private sector, where they were less likely to have benefits such as sick and maternity leave.

Standing (2000) asserts that changes to improve human resources in the health sector such as increased emphasis on staff capacity building and retention can be gendered. Training programs can reinforce women's traditional roles in society while simultaneously preventing them from advancing socio-economically. She gives the example of women not being considered for training opportunities or job transfers to overseas or rural locations because of assumptions their ability to take up these opportunities due to family obligations. Furthermore, women may not be able to respond to the incentives created to improve performance of health workers in reformed systems or to encourage health providers to enter the private sector to the different societal roles and hence, restrictions, assigned to women and men. For example, women doctors in Sudan valued physical safety over higher pay when considering work in rural locations (Salim in Standing 2000).

The dearth of health providers can increase the amount of informal care of the sick, disabled and young assigned to women and girls in the context of the home and the community. In most societies, women and girls are expected to take care of the sick, the disabled, and the aged. However, no empirical studies have been carried out to evaluate the impact of health reforms on the care burden on women.

The Women's Environment and Development Organization survey of NGOs and governments from 50 countries to evaluate the progress on implementing the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women commitments also examined the impact of certain health sector reforms on women. Their surveys found that job insecurity for women health providers in countries such as Zambia and Mali, increased once they were removed from civil service and become employees of District Health Services. Though figures are not provided specifically for the health sector, Tanzania's Civil Service Commission reports that 40% of all civil servants who were downsized were women.

A case study of Zimbabwe's previously highly effective contraceptive logistics system illustrates this point further. Before health sector reform, Provincial Nursing Officers were in charge of family planning logistics at the provincial level and supervised workers in the districts. Health sector reform measures replaced these experienced Provincial Nursing Officers with district health officers who had many other competing priorities and were not able to properly carry out their supervision of family planning workers, let alone the logistics systems. The result was less frequent supervision of family planning workers in clinics, and consequent decreased quality of services, including increases in stock-outs of family planning commodities. (Rogers, 2000)

As health providers are pushed out of the public into the private sector, they resort to all kinds of activities to survive economically. Again the traditional concentration of women in nursing rather than medicine in many countries means that women may not be able to continue supporting themselves in nursing jobs and may drop out of nursing or resort to illegal activity to supplement their incomes. Though some categories of nurses in developed countries can establish their own practices and prescribe medications, many developing country laws do not

allow for nurses to practice independently, thereby limiting their ability to benefit from privatization. (Standing, 2000)

### **Gender impact of Decentralization**

Decentralization is a health sector reform strategy described in the 1993 World Development Report which involves transferring authority from central authority to sub-national levels, and whose goals are to increase performance accountability and to promote democracy and equity. Depending of the model of decentralization implemented, decentralization has the potential to increase powersharing, address the needs of the poorest and powerless and decrease regional inequities. (Gershberg et al, 1998). Bossert (1998) describes four models of decentralization: *deconcentration*, where some authority is shifted to local offices of the same body, but central control is retained; *delegation*, where authority is shifted to a semi-autonomous body; *devolution*, where authority is transferred from a central administrative body such as a Ministry of Health to another within the public administration such as a provincial government; *privatization* transfers operational function and/or ownership to a private party, usually through contracting.

Standing (1997) poses two key questions in analyzing the gender impact of decentralization -- whether local management structures are gender sensitive and whether or not women are represented on them. The idea here is that where women or gender-sensitive men are not represented on local decentralized structures such as health committees, their priorities will not be reflected in local health priorities and financial and human resources will not be allocated accordingly.

Programs greatly affecting women's health in some African and Asian countries such as population and family planning program have benefited from decentralization policies which have increased autonomy to respond to local health priorities and have resulted in wider coverage of the population. However, where decentralization has occurred too quickly and without training local-level staff to take over functions previous carried out by the central government (such as in the Philippines, Zambia and Papua New Guinea), a breakdown in local health systems has resulted. (Aitken, 1998)

One case study sheds light on the impact of decentralization on health services related to women's reproductive functions. Mwesigye (1999) reported on the impact of decentralization in a district in Uganda on maternal health services. In Ugandan model of decentralization was midway between de-concentration and devolution. Management and financial control of resources for health was devolved to local authorities, but central government funding came with strings attached and strong external controls, as did funding from external donors. In reality, district health authorities had very little autonomy -- donors defined priorities and conditions, set targets and evaluated outcomes. Additionally, NGOs receiving funding exercised discretion in funding certain activities and not others.

In this case, since power-sharing regarding decisions on budgetary allocations did not change to allow for women to voice their health priorities or their priorities within reproductive health. Decentralization therefore resulted in no increase in the district budgetary allocations to maternal and child health, no visible improvements in the quality of health services provided, and therefore no appreciable increase in the utilization of maternal and child health. One district was only allocated 1.2% of local revenue to MCH, which comprised 15% of the health budget. (Mwesigye, 1999)

There is evidence from Brazil that decentralization initiatives which confer full autonomy to districts combined with strong participation of local feminist organizations can produce positive results in terms of increases in allocation of financial, physical and human resources to women's health programs. Pressure from women's organizations early in the process to decentralize health services in the state of São Paulo, Brazil led to the creation of a Women's Health Care Office (WHCO) charged with management of women's health care services offered in all municipal facilities. The WHCO was integrated into the municipal governing body and its Board included seasoned feminist female health professionals. WHCO was successful in implementing a women's total health program throughout Sao Paulo by creating District Health authorities – local health systems to introduce and promote a gender perspective in implementation of health programs—to which WHCO provided permanent technical support. (Araújo, 1998)

By working in an inter-sectoral manner with police stations, shelters, and a variety of NGOs, WHCO pioneered women's health programs at all municipal health centers. For example: the first legal abortion service; assistance to women and adolescents in situations of sexual abuse or violence at home; access to information and family planning services. Additionally, WHCO formed maternal mortality prevention and survey committees with community participation and implemented new practices at childbirth at municipal hospitals and birthing centers. In this scenario, the implementation of governmental programs for women was more vigorous in a context where there were strong and demanding women's organizations. (Araújo, 1998)

Decentralization can have both direct and indirect effects on health services that are primarily used by women. John Snow Inc.'s Family Planning Logistics Management project (FPLM) has documented both direct and indirect effects on availability of contraceptive commodities in developing countries. FPLM found that project countries undergoing health sector reform started out with strong vertical delivery systems for contraceptives. Reform measures such as the integration of logistics and decentralization of decision-making significantly affected the functioning of such vertical systems. In four FPLM countries where success that had been achieved in improving central storage facilities of contraceptives, this success could not be replicated at the district level, in part because of a lack trained staff at the local level or inadequate training and supervision.

A case study of Zimbabwe's experience illustrates the harm that can be done to access to contraceptive services when a well-functioning program is decentralized. In the early 1990's Zimbabwe had the best contraceptive logistics system in the world. The strong Zimbabwe National Family Planning Council (ZNFPC) working in concert with strong rural districts and a robust community distribution network all contributed to the fact that Zimbabwe had the highest contraceptive prevalence rate in Africa. Health sector reform in the 1990s brought in decentralization and a change in the role of the ZNFPC, which went from being in charge of the entire FP program including the logistics program to handing this function over the District Health Authorities. Along with the decentralization, there were attempt integrate what was previous a vertical program into other health services and this integration included integration of information systems of drugs with family planning commodities. Different crises distracted attention from FP and contraceptive management information systems as well of the logistics system to include other drugs and commodities. (Rogers, 2000)

Analysis of longitudinal data examined prior to and following Chinese health reform (which featured introduction of user fees and decentralization among others) found that women used more health services than men. The analysis treated gender as an independent variable and showed that a younger ages, women used health care more than men (this was not explained by reproductive health). While women's utilization stabilized, men's utilization increased as they

aged. Having insurance status did not increase use of service (no difference in use of services between those who did and did not have insurance). Focus group confirmed the author's hypothesis that people with insurance are no more likely to use health services because employers (for employer-based insurance) dissuade employees from using insurance by making them pay first for medical services and may take years to reimburse employees for services. (Henderson et al, 1998)

Langer et al (2000) assert that decentralization is capable of supporting the holistic approach to reproductive health care ushered in by the 1994 International Conference on Population and Development, since both ICPD and decentralization goals emphasize accountability and client-centeredness. They conclude, however, that since decentralization requires high technical and management capability at all levels of the health system, and the success of countries in building this capacity has been mixed. Success depends on how decentralization is done – what model, how fast and what shape the health system is in when decentralization is started. When countries have no population or reproductive health policy at the outset of decentralization, this policy vacuum creates a problem in that it makes it more likely that reproductive health will be ignored as health sector reform is being implemented, especially if reproductive health is not expressed as a priority on the local level.

### **Gender Impact of Privatization**

Since privatization of sources of financing are covered in another section, this section will focus on for private provision of clinical services and privatization of public health facilities and hospitals. Privatization in this context refers to the transfer of ownership and conferral of authority from the public sector to the private sector. As mentioned earlier in this section, circles, privatization is viewed as the most extreme version of decentralization. However, privatization can also include the creation of private markets for services that were previously provided by the public sector.

The 1993 World Development Report (WDR) spoke to the need for governments to reduce their role in the provision of clinical health services. Legal and policy changes were recommended so that this function could be handed to for-profit and non-profit organizations and individuals. The government's role would be to define a minimum package of health services and, where necessary, subsidize NGOs to provide this package to the poor. Government could pursue its targets in terms of coverage of the population with the essential health package by requiring that private insurance cover the essential package. Regulations would be changed as necessary so that both traditionally and formally trained health providers would be capable of and motivated to set up shop to deliver clinical services either as individuals or as groups. The government would a major role of regulating this private sector through licensing of health providers, accreditation or health facilities, clinical audits and inspection of health facilities.

There is evidence from developed countries that privatization can negatively affecting the livelihood of women health workers disproportionately. One outgrowth of the privatization strategy is the creation of "managed competition" among providers and health institutions such as hospitals. Managed competition in the United Kingdom has been characterized by the creation of "internal markets" or competition among public providers. (Bach, 1995) On the one hand, the United Kingdom government reports that increased efficiency in patient care, which is evidenced by dramatically lower waiting lists. However, trade unions and professional associations report that decreases in waiting lists have occurred at the expense of female health workers who are expected to work much longer hours and have less job security. (Personal communication)

Further evaluation of UK reforms has not been possible because of the UK government's refusal to commission research on the effects of its health care reform strategies. (Ham, 1995)

Health workers can also experience a decrease in benefits as the government transfers the responsibility for providing health and disability benefits to private employers or to the self-employed. The Egyptian government embarked on privatization of health services which introduced fees in certain hospitals and providing doctors with government loans to set up private practices. However, the Egyptian government has also stepped back from providing services has also removed some of the protective regulations through actions such as reducing the number and duration of maternity leaves for health workers and putting caps on the number and type of reproductive health services provided at clinics. (WEDO, 1998)

Giffin (1994) reports on the impact of the privatization of fertility control in Brazil. The separation of fertility control from general health care created a system where socioeconomic status determined the types of contraception which were available to women. Women who were better-off economically could afford to go to private physicians for contraception and abortion services (even though abortion is illegal), but poor women had to resort to drug shops for certain contraceptives where there was a large variability in the quality of information they received from the drug seller.

To summarize, privatization may cause women to be pushed in using certain family planning methods while drastically limiting their choices -- Giffin (1994) points to the drastic reductions in fertility among the poor in places like North Eastern Brazil, where, she argues -- sterilization -- though not necessarily women's first choices, may be the most highly promoted method of family planning since a large percentage of them are provided free of charge in the private and public sectors (usually following Cesarean deliveries).

Prior to the publication of the 1993 WDR, a trend of privatization in the health care sector had already started in certain countries, particularly in Latin America. Semi-privatized social security systems have existed in Latin America since the mid 20<sup>th</sup> Century. Usually divided into separate funds managed by parastatals within a given country, these systems provided health care and retirement benefits primarily to workers employed in the urban formal sector representing an average of 25% of workers in the region. Contributions to these funds were usually made by employers, employees and the central government. Mismanagement and corruption in many of these social security funds, however, created a crisis in the 1980's, where funds were threatened with insolvency. Structural adjustment policies of the World Bank and the IMF forced governments to cut pensions and other retirement benefits. (Paul and Paul, 1995)

Social security systems also had distinct health systems which in some cases had much more funding than the Ministries of Health. These systems were inefficient, with high administrative costs, poor management, and a bias toward hospital-based tertiary care. Poor quality and patient dissatisfaction with quality and convenience of social security systems led to wide spread duplication in insurance coverage, with about 30% of employers in some countries providing private insurance or onsite health care to employees already covered by the social security system. (Paul and Paul, 1995)

Reforms in the social security systems in Latin America have addressed some gender inequities, including expansion of coverage to more workers (including male spouse of female workers where only female spouses of male workers were covered before). (Fiedler, 1996) However, privatization of some social security systems have led to greater inequities, with

privatized health insurance companies refusing to pay for certain conditions specific to women, or charging exorbitant premiums for women of reproductive age, for example.

New contractual arrangements are increasingly common as relegating certain provision of services to the private sector becomes a popular solution to address the inefficiencies in the public sector. The private sector in the developed and developing countries are increasingly turning to contracting of clinical and non-clinical services to reduce costs. There is evidence that though contracts may save money, contracting may result in lower quality if unit costs are too low. Moreover, if countries are not experienced with contracting, the process can be costly and wages paid to workers can be too low. (Mills, 1998)

So far, no studies have explicitly looked at how gender equity is affected by these contractual arrangements. However, there is evidence that when contracts are given to NGOs that are not gender-sensitive, even programs that are specifically targeted at women's need may not be delivered optimally. Gideon (1998) reports on the Latin American experience of increasing the role of NGOs in the provision of social goods and services, including health care. In her assessment, not all NGOs were capable of delivery gender sensitive services, and NGOs that focused on women's strategic needs (decreasing inequity and changing women's traditional roles) are marginalized.

With the increase in privatization in low income countries on the one hand, and the consolidation of health institutions in order the better compete in the developed countries on the other hand, contracting out for health services and non-health activities is a more commonly seen feature in many health systems around the world. The best example of gender impact resulting from actions taken to compete for contracts comes from the experience of hospital mergers in the United States. The trend in a great increase of mergers and acquisitions of US hospitals has resulted from the necessity to compete for managed care contracts. Health facilities have had to cut costs to eliminate empty beds. Additionally, there has been an increasing trend of involvement in such affiliations since 1993, since anti-trust provisions governing mergers have been relaxed. (Weisman et al, 1999)

An alarming phenomenon has emerged, however, when non-sectarian hospitals merge with non-sectarian hospitals. Because Catholic Church rules forbid Catholic hospitals from providing certain reproductive services, including contraceptive services, abortions and some infertility treatments, there is an increasing trend of some of these services being eliminated when Catholic hospitals merge with non-Catholic hospitals. In some cases, hospitals even refuse to provide referrals to other facilities for patients. (Donovan, 2000) Donovan gives the example of a merger that resulted in elimination of abortion services from a hospital. Another merger resulted in an out of court settlement whereby the new organization agreed to provide referral and follow-up of family planning and contraceptive services.

A 1995 survey by Catholics for a Free Choice of institutions involved in 57 mergers found that from 1990 to 1995 10 of these mergers resulted in complete elimination of Church-prohibited services. 12 allowed continuation of RH services with the exception of abortion. The solution included establishing autonomous facility nearby that would provide RH or establishing endowments to make sure that women received services elsewhere.

Weisman et al (1999) reported that 18% of all formal mergers or acquisitions reported the American Hospital Association between 1990 and 1996 involved a Catholic organization. 80% of affiliations involved were between Catholic and non-Catholic organizations, and the most common affiliation was mergers and acquisitions. Weisman et al (1999) were able to document

through case studies that elimination of reproductive health services was raised as a concern in every set of negotiations analyzed. Availability of hospital-based surgical abortion was terminated or significantly scaled down in all cases. Provision of emergency contraceptive pills for rape victims was also reduced. However, obstetric services were most likely to be expanded.

### **Gender Impact of Measures to Improve Functioning of National Ministries of Health**

Health sector reform usually involves a redefinition of the role of the public sector in financing and providing health care. The 1993 WDR Report recommended that the public sector retreat from directly providing health services and that it instead leave this function to the private sector. The public sector's role would instead be to define priorities for the health sector and translate this down to decentralized health systems. Additionally, defining and introducing cost-effective basic packages of interventions for entire populations, improving human and financial resource management, and improving health sector performance would be the responsibility of the public sector.

Defining national priorities for health care in developing countries has traditionally been done in a top-down manner by Ministries of Health, often with input from international donors, but with virtually no input from ordinary citizens. Events such as the UN Conference in the mid-1990s which redefined priorities in women's reproductive health and set these in the context of women's human rights (UN, 1995; UN 1996) changed this by setting in motion processes which forced democratization of priority-setting processing in the health sector in both developing and developed countries. The increased sophistication and improved coordination of NGOs both within and among countries resulting from these conferences has made it increasingly likely that governments incorporate the viewpoints of women's activists into policy formulation to address health priorities. (WEDO, 1998) Furthermore, NGOs and technical agencies have developed tools such as policy mapping and stakeholder analysis that can be used to facilitate civil society participation in health policy formulation. (Abt Associates, 1999)

Langer et al (2000) warn that in light of the fact that goals agreed upon at conferences such as the 1994 International Conference on Population and Development are not being successfully met in places such as Latin America and Caribbean, and that there is danger that reproductive health will be neglected in health sector reforms. They point out that even though convergent interests exist to some extent between health reformers and reproductive health activists, (such as democratization, community participation, improving health and promoting human development), health sector reform risks undoing the success of vertical family planning programs, since these must now be combined with other health services.

There are some success stories in participatory priority-setting in the context of health reforms. The Nepal Safe Mother Network (NSMN), ensured that NGOs played an important role in carrying out advocacy and providing information on the gravity of maternal mortality and making sure that this issue became a priority in health sector reform. The Network brought people together at the district level to define safe motherhood and to discuss implications of maternal mortality. By raising stakeholder awareness of this issue while forging relationships with policymakers, NSMN was able to ensure commitment of resources to reduce maternal mortality. Whereas the Nepalese government was initially concerned about the number of private NGOs involved in reproductive health activities, it grew to encourage the active participation of NGOs in improving maternal care services at the community level through its Safe Motherhood Policy. (Putney, 2000)

The 1993 WDR introduced a new methodology for determining the cost-effectiveness for health interventions by ranking them according to disability-adjusted life years (DALY) gained per dollar spent. Interventions with the lowest cost per DALY gained were classified as more cost effective. Although DALYs were an important development since they were the first measure which incorporated both disease and disability, they have recently been criticized as being inadequate to capture the full disability and ill health experienced as a result of reproductive health conditions. (Abou Zahr and Vaughn, 2000; Paalman et al, 1998; Anand and Hanson, 1997).

Standing (1997) questions whether it is possible to have affordable packages of health care while ensuring equity. Key questions she raises include: "By what process are the priorities defined? What considerations are involved in determining cost effectiveness? What will be the response, if any, amid an overall improvement in health systems function and health status improvement, equity worsens for particular groups of rural women?" p. 9

Even though essential packages are in theory defined by national authorities, Ministries of Health must negotiate with local health authorities in increasingly decentralized health systems in order to ensure that basic packages are correctly adopted in local areas. Langer et al (2000) report that comprehensive packages of services have proven difficult to deliver in the Latin American and Caribbean context because of conflict between national and local health priorities.

Usually, delivering an essential package of health services requires integration of services and management support systems. Already, Family Planning Logistics Management Project (FPLM)'s experience in Mali had found that the integration delivery of contraceptives with essential drugs could disrupt delivery of family planning services (Chandani et al, 2000)

Where an essential package of health care can be successfully delivered, the equity improvements in terms of serving women who have historically been marginalized can be striking. Evidence from the US shows that including key reproductive health services in essential packages and targeting these to women in need of these services can result in desirable increases in utilization of these services. The Oregon Health Plan implemented provided medically underserved population with capitated services. The Plan formulated a basic package of health services using input from various stakeholders and from evidence-based literature. A study the change in use of mammography after the barrier of price was removed (with the Plan being available to poor women) found that mammography rates more than doubled within one year as did use of other preventive services among a population with high risk factors for utilization. (Schillinger et al, 2000)

A lot of energy has gone into the formulation health sector reform indicators. However, only recently have indicators been proposed to that would measure the gender impact of health sector reform. However, there is little in the literature in the impact on measures to improve and monitor performance on gender equity in health services. Quality in health services serving women has oft been defined by donors and national governments, not by the women using the services. (Gijsbers van Wijk et al, 1996)

More recently, health services literature has begun to pay attention to quality, and has found there to be sex differences in the definition of quality. One North American study found that women were more likely to value informational content, continuity of care, and multi-disciplinarity, whereas men valued the personal interest shown to them by physicians. (Weisman et al, 1999)

## **Gender Impact of new financing mechanisms**

The 1993 WDR suggested that the only way that governments will improve health services and afford to make essential packages of health care available to their countries is to cut spending on tertiary, clinical services that are not part of an essential package and reallocate spending to cost effective interventions that will reduce disease burden for the majority of people. Cutting public spending on non-essential clinical services meant that private individuals would have to shoulder more of the cost of health. New financing mechanisms had to be created to make this happen. The financing mechanisms most commonly introduced in health sector reforms have included user fees, various forms of private and public health insurance, and community financing.

Standing (1999) suggested that the differential gender impact of new financing mechanisms would stem from women's inferior position in society. Generally, women have much less disposable income than men. It would therefore follow that women would feel larger economic burdens if financing mechanisms that increase out-of-pocket costs are promoted. Furthermore, given that women are usually the custodians of child and family health in most societies, health services fees or premiums set at a level that are not affordable to women would result not only in worse health outcomes for women, but also for children.

### **User Fees**

Introduction of user fees for clinical services provided at public sector facilities is a strategy for recovering costs championed by the 1987 Bamako Initiative and implemented in many African countries in the 1980s and 1990s. There is a good body of literature on the impact of user fees on utilization of health services. Further studies have looked at how quality of services interacts with user fees introduction or increase (Diop, 1995).

Some examination has been made of the impact of user fees on the utilization of health services by women. A Philippine study found that user fees had a negative effect on utilization among poor women. The study results suggest that for ob-gyn services, if prices are increased with an accompanying change in services, women do not stop using that particular health service – they merely switch to another type of provider (e.g. from using public sector services to private providers) which are more affordable. (Hotchkiss, 1998)

Langer et al (2000) report that user fees in Latin American and the Caribbean are usually not a great part of income collected by family planning services. Levying user fees can be an effective strategy for mobilization financial resources if the funds collected are retained at the facility level and used to improve quality of services and infrastructure. However, user fees can also serve to marginalize the poor if means testing is not used to determined client ability to pay and if no exemption mechanisms exists to allow some clients to receive free or sliding-scale services. Lewis (1993) report on the introduction user fees in public hospitals in Jamaica, the Dominican Republic and Honduras with various levels of autonomy and accountability among the three health systems. They report that the highest fees assessed were for labor and delivery. Although exemption mechanisms were in place so that those not able to afford to pay to still access health care, it was unclear as to whether or how women's access to health services was being affected. The impact on women's health status was not assessed in this study.

## **Community financing**

Community financing schemes which operate using community participation techniques are another strategy for financing healthcare which has been adapted widely in African, Asian and Latin American countries. The appeal of community financing lies in the notion of local control of resources generated by the community, and the possibility that financial and non-financial resources generated by the scheme can be used to upgrade health services, supplement health worker salaries, and ensure a funding stream to replenish drugs and medical services – all which will compel community members to use health services.

However, in parts of the world where women taking leadership roles is frowned upon, community financing schemes may not allow for meaningful participation of women, which may in turn affect important features of the scheme such as which services or expenses related to medical care are covered. WEDO (1998) reported that though many community health committees had been formed in Mali since the Cairo conference, few women participated actively on these – only 12.9% of committee members were women in 1996, and almost majority had minor roles and/or few key responsibilities.

Empirical studies have found that the creation of community financing schemes can result in the increased use of services that greatly reduce the burden of disease and mortality among women. Criel et al (1999) concluded that though national health insurance programs have not promoted equity in Africa, locally-developed and managed schemes seem to achieve better results. They report on the voluntary Bwamanda hospital insurance scheme requiring an annual premium payment by per enrolled family to be used to cover hospital services only. Started in the mid-1980s in the Democratic Republic of the Congo, this scheme found that there were more Caesarean sections among the insured than among the uninsured – the authors concluded that this reflected a great unmet need for Caesarean sections among the uninsured, since the Caesarean section rate among the insured was comparable Caesarean section rates in other rural African district. They conclude that “the findings strongly suggest that the observed deficit in Caesarean sections has led to a number of obstetrical disasters in the noninsured population.”(p. 907)

Health services research conducted using quasi-experimental designs can help elucidate the potential impact of variations in forms of community financing on health services utilization, which in turn has gender implications in terms of health outcomes. Diop et al (1995) reported on an experiment in Niger which introduced cost recovery mechanisms in three health districts in Niger with similar health sub-systems. Quality and management improvements were introduced in two of the districts, and the third district served as a control. The two experimental districts had alternative methods of financing introduced – fee-for-service in one district and social financing + small fee-per-illness episode in the second district.

This experiment found that in the control district, utilization worsened. In the fee-for-service district, there was no significant change in utilization and utilization of the 25% poorest segment of the population remained low. In the social financing + fee-per-illness episode district, utilization improved significantly, and utilization among the poorest inhabitants doubled. Women reporting any type of illness were one of the target groups surveyed in the study, and this group’s utilization increased significantly in the social financing + fee-per-illness episode district, from 15.5% to 20.3 %, whereas it decreased slightly but not significantly in the fee-per-episode district (from 14.4% to 13.4%) and decreased significantly in the control district (from 10.5% to 6.2%)

Involvement in some kind of community financing scheme has implications for health services utilization for reproductive health. Noterman et al's (1995) experiment involving the introduction of a prepayment scheme in Masisi district where subscription units as well as fee levels were varied found that women enrolled in the prepayment plan were almost 5 times as likely to give birth in the hospital as non-subscribers. However, when the unit of subscription was changed to the family rather than the individual, there was less preferential selection and there was little difference between the women and men in terms of utilization.

### **Social and private insurance schemes**

Social health insurance refers to insurance schemes whereby a premium consists of a combined contribution of an individual subscriber and the government. The individual in turn is entitled to certain health insurance benefits. This type of insurance is based around the principle of solidarity which means that everyone in the society contributes financially for the benefit of the health of the whole society. Social insurance schemes can be either voluntary or mandatory. Private insurance, on the other hand, is usually voluntary, and involves an individual contributing a premium determined by the insurance company which entitles the enrollee to benefits which are often tailored to the persons depending on the premium level paid.

In many contexts, access to private health insurance is differential between women and men because it is tied to employment. Meyer and Pavalko (1996)'s analysis of insurance status among older women found that having insurance was very much tied to women's marital status, and that older women were much more likely to have insurance as wives than as workers. Unmarried women were three times as likely to be uninsured to be on public assistance, and Black women were two to three times as likely to be uninsured or to be on Medicaid.

Scott Collins et al (1998) found that fewer and fewer women in the United States were being covered by health insurance between the mid and late 1990's. Seventy-six percent of women under 65 (and therefore not eligible for Medicare, the health insurance program for the elderly) who had insurance had managed care. Of those with insurance, women with managed care women were more likely to receive at least some health care compared with women with fee for service insurance.

Access to public insurance can be gendered where it is tied to women's reproductive health status. For example, in the United States' Medicaid program for the low-income, women usually become eligible when they are pregnant, and often lose their eligibility after giving birth. Therefore, women of reproductive age in the United States are more likely to have insurance coverage than men because they are more likely to be eligible for Medicaid coverage (for low-income persons). One study found that 82% of women aged 15 to 44 versus 77% in the same age bracket are insured. (WREI, 1994)

Even when women are insured under programs such as Medicaid because of their reproductive status, they may not receive adequate coverage. Medicaid is the largest single source of public funding for family planning services in the US and funds 46% of all public spending of contraceptive services in addition to paying for 40% of all US births. As more and more state Medicaid programs contract with managed care organizations, however, new problems are arising regarding coverage for reproductive health care. Some states Medicaid programs leave out coverage for certain contraceptive services from managed care contracts. Moreover, women may not know that they are eligible for certain reproductive health coverage, even though it is not mentioned in the managed care contract. Furthermore, only 39% of reproductive

health providers have managed care contracts, and traditional providers of reproductive health to low income women frequently are not included among those in managed care contracts. (Salganicoff and Delbanco, 1998)

Although fewer women in the United States have health insurance than men, they are likely to have higher out of pocket health costs for men, and are more likely to use reproductive and preventive services during their reproductive years. Analysis from the 1987 National Medical Expenditure Survey showed that 28% of women paid more than \$500 out of pocket, compared to 16% of men. 7.4 million compared to 3.4 million men had out-of-pocket expenditures for health care services that exceeded more than 10% of their income. In 1993, expenditures for reproductive health services for women aged 15-44 was 40.7 billion or one-third of all health expenditures for women in this age group. If the spending for reproductive health services is removed, the expenditure gap between men and women goes from \$2123 to \$1,429. Adding to the problem is the fact that many health plans do not adequately cover preventive and reproductive services. (WREI, 1994)

Developing countries are increasingly being encouraged to develop some type of insurance model – particularly private insurance—as a part of health sector reform. Several schemes are aimed at women’s reproductive functions, such as those implemented in Bolivia and Indonesia. The Bolivian government introduced a national government insurance program known as Seguro Nacional de Maternidad (SNM) in the late 1990s. The program was targeted to mothers and children with the aim of decreasing maternal and infant mortality. A 1998 evaluation of this program showed an increase in utilization of all services, where many patients previously had not sought formal health services. Furthermore, utilization was highest among the poor and strong among adolescents, and most patients reported satisfaction with quality. On the other hand, , some health providers experienced an increase in workloads, which they felt resulted in a decrease in quality in social security health units. (Dmytracezenko et al, 1998)

There were numerous problems with this insurance scheme, which indicate that despite the goals of extending access to maternal and neonatal services, poor reimbursement and management practices result counteract positive effects of program, and may decrease the quality of services. The greater utilization of services has led to greater health worker dissatisfaction. Health workers have too many clients and worker pay is not linked to volume of services provided. Reimbursements are not enough to cover actual costs incurred by health facilities and reimbursement rates are not adjusted to type of facility. Tertiary facilities are overused since they are free to SNM eligibles. SNM does not cover labor costs, so sometimes services to SNM clients are rationed (as occurs with Medicaid patients in US); Reimbursements to SNM from the government are often delayed, and as a result; patients are being asked to pay fees even though services are supposed to be free. (Dmytracezenko et al, 1998)

On the positive side, the growth of private insurance markets in developing countries can actually result in more choices and higher quality in health services for women. Langer et al (2000) report that the introduction of private health insurance in Colombia has resulted in increased demand of family planning services, which in turn has created competition among providers in both public and private sectors that has ultimately resulted in an increase in quality and innovation design, management and financing of health services.

Murray et al (1997) reports that since privatization of health insurance in Chile in the 1980’s, the number of private health insurance companies in Chile tripled. The percentage of the population covered by private health insurance went from 1.4% in the early 1980s to almost 25%

in the early 1990s. The majority of the population (64.8%) still covered by the national health fund known as FONASA. However, unregulated private health insurance can result in discriminatory risk rating against women, and inadequate benefits coverage.

ISAPRES are private health insurance entities which have proliferated in Chile which have historically discriminated against women by refusing to insure some women at all, and by charging premia twice as high as those for men in the same age bracket, based on the premise that women of reproductive age will incur more medical expenses than their male cohort. (Pollier, 1999) Though this premise is borne out in evidence from health services research, it is also true that Chilean women earn on average only two thirds the salary of Chilean men, and that they are therefore less likely to be able to afford these premia. (Matamala, 1997)

Moreover, ISAPRES do not cover preventive care or health promotion, and expects its enrollees to instead seek these services in the public health sector. The author raises the question of who should bear the responsibility for childbearing expenses, when in fact both men and women are responsible for procreation. In response ISAPRES's practices, SERNAM, a Chilean women's organization has pressed for legislation to compel ISAPRES to provide comprehensive coverage and adjust its premia to more affordable levels. However, since legislators are greatly influenced by the insurance industry, this legislation was not passed. (Pollier, 1999; PAHOb, 1999)

ISAPRES receives various public subsidies which create inequality between the public system and the private systems of health care. A 1985 law provided the ISAPRES with subsidies to cover pre and post- natal care and medical care for children under 1, and this has increased women's access to health services. An additional 2% payroll tax was levied on the population enrolled in ISAPRES, in order to raise money for cross-subsidization purposes so that more workers could afford to buy private insurance. NGOs are instrumental in providing reproductive health services, but are increasingly charging higher fees due to pressure from donors to be sustainable. Cross-subsidization is a common strategy and works to a certain extent, but poor people are still being left out. The solution proposed by SERNAM is the creation of a public fund for maternal health whose financial are generated through social insurance contributions. Additionally, SERNAM proposes family coverage which includes units beyond "husband and wife." (Pollier, 1999)

Murray et al (1997) found significantly higher rates of Cesarean section among women covered by private insurance than those covered by the national health fund (59% vs. 28%). It is not clear whether this pattern is induced by patient or by provider preferences. A similar pattern has been found in Thailand, where patients of providers in private practice are almost six times more likely to have Cesarean sections than patients whose babies are delivered in public hospitals. Although this study did not analyze data according to method of payment, researchers concluded that financial incentives (in the form of higher under the table payments for Cesarean sections) prompted physicians to choose this method of delivery for private patients. (Hanvoravongchai et al, 2000)

### **Managed care**

Managed care is an insurance model which has been in existence for several decades, but which only became popularized in the last 15 years. The 1993 WDR encourages the promotion of managed care as way of organizing and financing health services in private markets. Managed care is a loose term to describe a number of ways in which health services can be organized. In the past, it referred to the integration of financing and delivery of health services,

such that comprehensive services could be provided to an enrolled population in a way that would greatly control costs of providing medical care.

Initially, managed care organizations (MCO) were typically non-profit, prepaid group practice health maintenance organizations which would directly provide health care to an enrolled population in exchange for a monthly flat fee known as capitation. The MCOs would coordinate provision of services not provided by the MCO to the enrollee. Other forms of managed care have evolved, which include networks of physicians which contract with various insurers to provide services at discounted rates while assuming varying degrees of risk (Churchill, 1999).

In managed care, the benefit package is negotiated between the purchaser and the insurer and includes components such as services included, how care will be accessed (open or closed networks, gatekeepers, etc), and whether or not co-payments or coinsurance will be assessed. Provider payment is another aspect of managed care. More and more commonly, capitation is the model used whereby the physician is provided with a sum of money per member per month (PMPM) and assumes full risk for managing that patient's health using the PMPM amount. If the patient turns out to be sicker and therefore more expensive than the PMPM allows for, then the physician has to eat the difference and loses money. Other methods of reimbursement include fee for service, discounted FFS, salaries and partial capitation. (McGlynn, 1998)

Managed care organizations contain costs mainly by having primary care physicians act as "gatekeepers" to control the referral of patients to more expensive specialists. Through utilization reviews, MCOs scrutinize the use of hospitalizations and encourage shorter lengths of stay. They discourage the unnecessary use of diagnostic procedures, and encourage the use of cost-effective treatments and medications. MCOs are known for providing financial incentives to physicians to keep down the cost of treatment per patient, and use methods such as provider profiling to keep each other informed of physician performance in terms of cost containment compared to their colleagues. (Churchill, 1999)

For a long time, managed care was an American phenomenon. Managed care plans have dramatically grown in market share in the United States, where between 1993 and 1998, there was an 87% increase in the enrolled in managed care plans. (AAHPa, 2000) The majority of Americans insured through employment are in managed care plans. (Catholics for a Free Choice, 2000) Increasingly, US public sector programs providing insurance coverage to the poor and elderly are contracting with managed care organizations in an effort to contain costs. (AAHPb, 2000) At least 50% of publicly-funded family planning agencies in the US were serving patients in managed care plans by the late 1990s, and one quarter of these plans were had contracts with managed care organizations to provide contraceptive services. (Frost, 1998)

Increasingly, managed care has materialized as a feature of European reforms. Although there is some support among physicians' unions for adopting managed care concepts into health systems, the strongly centralized nature of European systems and societal values of solidarity and the right to health has given rise to stronger political resistance. (Elze, 1998)

In the United States, the most popular models are the voluntary contract and voluntary integrated models. Many European countries, however, have abandoned the voluntary models for the following reasons: "high administrative costs, difficulties in ensuring universal coverage and equitable access to health care for different groups in the population, cream-skimming, and incentives for users and providers to over-utilize and inappropriately use services.....from a

European perspective, government intervention is necessary to guarantee basic social goals such as equity and access to health care.” (Ham, 1995 p. 145)

The increase of numbers of the upper-middle class, proliferation of regional and global trade agreements and the formation of consortia by multinationals in developing countries to buy lower cost health insurance for their employees have all contributed to the growth in managed care in the developing world. (Stocker et al, 1999)

Most recently, managed care has begun to appear in higher income developing countries of Latin America. Organized security systems which include health and retirement benefits financed by social insurance make some Latin American countries attractive to multinational companies. As US markets have become saturated with managed care companies and profit margins have consequently slimmed, US managed care organizations have sought expand to overseas markets. Strong profit margins have been reported by multinational corporations who have set up shop in countries such as Brazil and Argentina. (Stocker et al, 1999)

Corruption and inefficiency in social security systems has led to the privatization of government health care programs and social security systems in several Latin American countries. In Chile, social security funds have been diverted to privatize managed care institutions, which have in turn been bought by multinational corporations. In the Chilean privatized social security system, 24% of enrollees cannot afford co-payments and therefore must seek care in some other part of the private sector. Means testing to receive free care in Brazil and Argentina take a long time and 30-40% of applicants for free care are routinely rejected. (Stocker et al, 1999)

There are many concerns about the impact of this phenomenon for the quality of health care of Latin Americans. The emphasis of many of these managed care organizations seems to be on profit margins, and not on preventive care. These managed care companies spend a high percentage of their budgets on administrative costs and a lesser amount on clinical costs. (Stocker et al, 1999)

Although managed care has been touted as being superior to traditional indemnity insurance in terms of containing costs and promoting quality of care, it has been heavily criticized by patients, providers and policy makers alike. Patients complain of lack of choice in selecting providers, problems with timely access to care, a lack of mechanisms for redressing complaints about provider quality of care. Physicians resist managed care tools such as the use of standard treatment guidelines to promote evidence-based treatments, viewing these as threatening physician autonomy and discretion. Depending on the model of managed care and the level of risk assumed by providers, health providers may have ethical dilemmas with the conflict of interest inherent in offering financial incentives to essentially limit patient care. The fact that managed care remains largely unregulated in some countries contributes to patient and provider dissatisfaction unregulated. (Churchill, 1999)

### **Gender equity and managed care**

In countries where managed care is the dominant form of private health insurance, the majority of women depend of managed care for both reproductive and general health services. The majority of existing literature on the impact of managed care on women’s health and access to health care comes from the United States, so the following section will provide mostly examples from the United States.

Seventy-six percent of American women of reproductive age with private, employer-based health insurance coverage are in managed care. (Scott Collins et al, 1998) Overall, managed care can be advantageous to women because managed care plans are more likely to cover preventive services than are indemnity plans. For example managed care is more likely to cover routine gynecological care (99% of plans) compared to traditional indemnity insurance (49%). Coverage for birth control is found in 93% of managed care plans vs. 51% of indemnity plans. (AGI, 1994) Data from the United States, for example, shows that reproductive health services covered by indemnity plans are primarily surgical procedures and curative care whereas preventive and non-surgical care are better covered by managed care plans. (Gold et al, 1998)

Although considerable research has been carried out in the United States on the impact of managed care on women's access to health services, much of this research compares women in managed care to women with other types of insurance or with uninsured women. There are few studies that carry out gender analyses -- that is-- comparing access to services and health outcomes of women to that of men. However, the literature that does exist on how women's access to services and outcomes is affected by type of insurance provides foundation from which to build an analysis on the impact of managed care on gender equity in access to health services.

Women have been found to be more likely to use particular types of health services depending on the type of insurance they have. McGlynn (1998) found that 64% of women with insurance received a Pap smear compared to 48% of women without insurance. 64% of insured women in the same survey obtained a mammography compared to 31% of uninsured women. Furthermore, women who have a usual source of care (such as an HMO) are more likely to receive important screening tests. The same study found that the type of physician a women uses as her primary health provider also influences the type of services she receives. Women who see both an obstetrician gynecologist and a general practitioner are most likely to access a full ranged of health services with includes preventive screening such as the Pap smear, compared to women who see only one type of specialty. (McGlynn, 1998)

There is evidence to suggest that women in the United States enrolled in the Medicaid program for the low-income's plans that are now under managed care contracts have better access to reproductive health care. Frost (1998) presents the results of a survey of family planning providers, and compares publicly and privately-insured patients seeking care at public family planning agencies that were enrolled in managed care plans. Among the findings, are that privately insured patients experienced significantly more instances of having to obtain permission to receive preventive care such as gynecological exams, or for contraceptive services such as hormonal contraceptive implants.

However, these findings are contradicted by evidence from Gold et al (1998), who surveyed managed care enrollees in American states with substantial managed care markets. The investigators examined coverage of contraceptive services by managed care plans, and procedures involved for patients to obtain those services. They found that although most managed care plans (79%) covered at least some contraceptive services, 15% did not cover the most commonly used five contraceptives, and 6% did not cover any contraceptives at all. 50% of enrollees reported that plans did not inform them over whether or not contraceptives were covered. Only 25% of managed care plans brought community-based family planning into their networks. One third of women in managed care plans had difficulties in obtaining contraceptive services, and 13% of enrollees had to wait at least 4 weeks to get appointments for contraceptive care.

Further research on the performance of managed care in public assistance programs for poor women in the United States revealed that poor or no information regarding covered reproductive health services were made available to enrollees. Deception by plan marketers regarding covered services, lack of patient confidentiality and refusal to provide appropriate services such as contraceptive methods and referrals were other common problems encountered by plan enrollees. (Gordon, 1998)

Frost (1998) does speak of the reluctance of managed care organizations to contract with community-based family planning providers in the United States as a potential obstacle to providing quality reproductive health care as managed care plans gobble up a larger share of health insurance markets. The immediate nature of the need of clients of family planning services calls for convenient and efficient services. Requirements such as prior authorization for certain services potentially affect convenience, quality of patient care and ultimately, service utilization. Breaches in confidentiality because of reporting requirements to release clinical information can also seriously affect patient care and safety, as well as the willingness of patients to use these services.

One study brought out some of the particular problems women with differential access to resources but with the same type of insurance face in accessing health services because of additional hidden costs of accessing health care. Such factors have been mentioned earlier in this paper as potential factors that when examined in the context of gender analysis could bring out differential opportunity cost of obtaining health care between women and men. This study of women in US Medicaid managed care compared Mexican-American women with white women who were enrolled by the sixth month of pregnancy. Mexican-American women remained more than twice as likely to seek care in the last trimester of pregnancy and had fewer prenatal than white women. They were significantly more likely to have problems with child care and transportation than white women. Qualitative research confirmed that these two factors were major reasons for not accessing health services. (Stewart, 1995)

Although managed care plans are known for their superior provision of preventive services, a subset of managed care plans are becoming increasingly notorious for restricting key health services – notably, reproductive health services—to women. There are at least 50 Catholic managed care health plans in the United States, and 2.5 million of the nearly 170 million persons in the United States enrolled in managed care plans are in Catholic plans. Many of these plans have restrictions on the types of contraceptives and other reproductive health services and surgical procedures they cover for religious reasons. Further, Catholic hospitals do not provide reproductive health services such as abortion, sterilization and infertility treatment, and increasingly many will not facilitate their patients receiving these services elsewhere. (Miller and Chelala, 2000)

U.S.-based Catholics for a Free Choice commissioned a survey to determine the extent to which women in the US felt that Catholic hospitals refusing to provide certain reproductive health services should at least refer patients to other appropriate and accessible health facilities. The majority of women (88%) felt that referrals should be provided, and 90% felt that pharmacies that refused to fill birth control prescriptions should be required to provide similar referrals. 74% of US women disapproved of mergers culminating in elimination of reproductive health services. (Belden Russonello and Stewart, 2000)

It is clear from this section that even women covered by medical insurance may not receive adequate services because insurance companies or managed care organizations may refuse to cover services on financial or religious grounds. Furthermore, the administrative procedures

characteristic of managed care organizations may serve to delay care, resulting in lower service utilization and potentially poorer health outcomes. Clearly, better regulation of insurance companies and managed care organizations is required, particularly as these models are increasingly promoted for and exported to developing countries.

Rogge (1998) summarizes recommendations by patient advocacy groups and medical associations regarding restrictions that health plans should be subject to safeguard women's access to health services, health, and privacy. Prohibitions are recommended on: cream skimming, arbitrary restrictions in covered medical services, limiting patient information regarding treatment options, profit-sharing by providers in ways that create incentives to compromise patient care. Among things plan should be required to do are: timely and geographically accessible primary care, coverage for family planning and mental health, coverage for preventive health, coverage for health maintenance programs, contract with community-based traditional providers, and create continuous quality improvement programs which reports on quality indicators relevant to women's health.

### **Part III. Discussion and recommendations for further research**

#### **Building consensus on a definition of equity and clarifying the definition of "gender"**

There is consensus that research on the impact of health sector reform on gender equity is an area that deserves further attention. It is clear from the literature to date that all the major areas of health sector reforms have implications for gender equity. Although much conceptual groundwork has been laid on this topic and scattered research findings exist, there is a strong need for the development of a deliberate and coordinated body of research on the impact of health sector reform on gender equity.

In undertaking research on this question, consensus needs first to be reached between the health economists and international aid organizations on how equity will be measured. Will we aim for similar outcomes in health status (very hard to measure, and does not really make sense due to biological difference between women and women), or equality of health inputs? Do we want to do programs that target only women? Will research focus on health issues beyond reproductive health?

Some of the literature reviewed confuses "gender", with "sex", and therefore reports on studies done only on women as studies on gender impact, when in fact, there is no data on men, and little analysis about how underlying social roles contribute to study results. Elson and Evers (1998) make an important point regarding the limitations of this approach to date in addressing gender inequity in health:

"The 'targeting women' approach represents an effort to address gender inequalities in access to health services and health status; however, it has both conceptual and practical limitations. It allows gender to become 'women' and is likely to marginalize gender inequality concerns within the health sector framework because women-specific programs are always a tiny minority in the budgeting and implementation process. It also fails to address the whole health picture, over men's and women's lifetime, is not capable of addressing gender bias in health service design and delivery, and does not address the key issue of households, and especially woman within them, as providers of health care. "

Hanson (1999) raises important issues about the need to address underlying gendered aspects of societies which may lie outside of the health system, but which nevertheless contribute to women's differential use of health services compared to men, and to women's differential morbidity and mortality compared to men. This points to the need for a multidisciplinary approach to measuring the gender impact of health inequity – one involving not only economists and public health specialists, but also collaboration with women's studies specialists, sociologists and anthropologists.

### **Creating a comprehensive body of research on gender impact of health reforms strategies**

Most of the literature from which conclusions could be drawn about the gender impacts of health sector reforms concern decentralization and privatization of financing and services. Though there is interesting preliminary work on the gender impact of public sector downsizing, much of the existing evidence is anecdotal and not generalizable. Much information exist of the impact of managed care in developed countries but even this is limited to analyses of women having different types of insurance , rather than comparing women and men with similar insurance status. As private health insurance expands in developing countries, empirical research is needed to measure the differential impact of this and other trends on women and men.

### ***Measurement***

Measuring gender impact resulting from health reforms should be tied into overall measurement of impact for health sector reforms. Realistic indicators are required for gender impact. Some multilaterals have already laid the groundwork on how to bridge the research gap on gender equity and health sector reform. PAHO's Health Sector Initiative recognizes that though equity indicators exist on coverage, distribution of resources, access and resource utilization, the only indicators that allow a look at gender are the ones related to women's reproductive functions (such as % of pregnancies attended by trained personnel and the % of women using contraception). (PAHOc, 1998)

Useful measures of gender impact gleaned from some of the studies in this review often did not initially aim to measure gender impact, but did so "by accident." These include: changes in demand for health care (measured through household surveys pre and post as in Diop et al), changes in utilization of health services (health services records and/or health service utilization prospective study). Many studies would yield useful data for gender analysis if they treated gender as an independent variable instead of controlling for it. CIDA (1996)—cited in Elson and Evers, 1998 – presents a set of gender aware indicators that can be adapted to the health sector. Standing (1999) points out that the problem is not always a lack of data sources. In fact, gender disaggregated data is usually available only at facility level and is not used or the data is difficult to retrieve. The right questions are not asked before research is undertaken, and discussion regarding the impact on gender usually happens as an afterthought.

### ***Future areas of research***

What is really needed is empirical data on the impact of health sector reform to catalyze the process on creating solutions to remedy negative gender impact of health sector reform already in progress, and to prevent or mitigation the potential impact of reforms in countries where health sector reforms are in their infancy. Some case studies already exist, but systematic case studies should be carried out – perhaps on a regional basis -- to examine the impact of the same reform, (as in the FPLM case studies) within a region.

Based on the outcomes of the case studies, empirical applied research could be carried out in individual communities (gathering data pre and post the health services intervention), or simultaneously evaluating variations of a health services interventions in neighboring communities. In countries where health sector reform is already underway, it will be more difficult to do pre-post type research.

Some researchers have identified important gaps in research that need to be addressed. Elson et al (1997) recommend time use studies to measure the impact of reforms on women's unpaid time, and suggest local research institutes as important resources to help to identify where to do these studies, as well as to assist in carrying them out.

Langer et al (2000) recommend more extensive quality research examining and central and local authorities interact to decide how to allocate funds, make priorities, and develop standards in reproductive health. Experiences should be shared among countries in the LAC region regarding. NGOs should be involved in this process, including in training and retraining local managers in gender sensitivity, accountability, and quality improvement. Participatory processes that include key stakeholders should be used, and it is suggested that sector-wide approaches (SWAPS) should be carefully monitored to determine where donors might be undermining country efforts to reduce differential impacts of health sector reforms.

To summarize, important areas for research to systematically uncover the gender impact of health care reforms would include:

- Examining the differential access to insurance and type of coverage within insurance types
- Quantification of women's caregiving burden, and qualitative research to evaluate how health sector reform affects women's roles as caregivers in their communities
- Examining the impact of health reform on human resources – especially in the nursing profession, where the workforce is predominantly female. Systematic surveys of health providers to determine impact of public sector downsizing and new managerial practices on women and men. Standing makes recommendations on the type of data that need to be collected and the key questions that should be asked to uncover the gender dimensions of human resources in a given health system.
- Outcomes research related to insurance coverage
- Examining the impact of privatization -- what exactly is happening at the institutional level (case studies) and what is the impact on utilization and health outcomes (using a quasi - experimental format with controls)
- Participatory research on decentralization –measuring the impact on resource allocation at the local level; impact on service delivery; documenting social and organizational processes which promote community influence in prioritizing community health concerns (and therefore influencing commitment of financial resources) comparing outcomes of decentralization by examining the experiences of adjacent communities

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