



What evidence is there about the effects of health care reforms on gender equity, particularly in health?

November 2005



ABSTRACT

This is a Health Evidence Network (HEN) evidence report on the effects of health care reforms on gender equity, particularly in health. Emerging evidence shows that health care reforms can affect men and women differently, as a consequence of their different positions as users and producers of health care. This review assesses the impact of four key health care reforms – decentralization, financing, privatization and priority setting – on gender equity in health.

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Summary

The issue

In most countries the pressure for health care reform is aimed at improving the efficiency, equity and effectiveness of the health sector. Emerging evidence shows that health care reforms can affect men and women differently, as a consequence of their different positions as users and producers of health care. This review assesses the impact of four key health care reforms – decentralization, financing, privatization and priority setting – on gender equity in health.

Findings

Literature on health sector reform and gender equity is sparse and often focused on low-income countries. Moreover, gender-related papers are predominantly concerned with women's health issues and focus on adverse health effects. These limitations affect the generalizability of the findings.

Rapid decentralization of responsibilities without corresponding devolution of authority and requisite human, institutional and financial resources may lead to difficulties in providing affordable, accessible and equitable health services, as has been the case in many low-income countries. Decentralization may also inadvertently support more conservative reproductive health agenda, particularly in services for adolescents.

There is substantial evidence from both high-income and low-income countries that taxes and social insurance schemes provide the most equitable basis for health care financing. Other schemes, such as private insurance or direct out-of-pocket payment, are likely to increase inequities, particularly in access to care and health-seeking behaviour and this may affect women more, as they generally have fewer financial resources.

Privatization, accompanied by emphasis on reducing costs and maximizing efficiency, may have an important impact on gender equity in health care access and financial protection. In some countries patient/staff ratios have been raised, personnel have been shifted, duties have been reassigned to less skilled workers and the use of casual workers has increased. The negative consequences of these policies affect women more than men since women are over-represented among both patients and health care personnel.

A range of gender biases have been revealed in some priority setting methodologies, such as DALYs, which lead to the underestimation of women's burden of disease. These systematic gender biases are generated through various technical and conceptual limitations.

Policy considerations

Gender equity in health requires that men and women will be treated equally where they have common needs, and that their differences will be addressed in an equitable manner. This should be a consideration particularly in the planning and delivery of services at national, regional and local levels.

Decentralization of responsibilities in health care should be accompanied by a corresponding devolution of authority and adequate human, institutional and financial resources.

Well functioning and wide-ranging public health services provide equitable and affordable services to the less privileged, many of whom are women. Shifting from taxes to direct user fees to finance health services may increase the burden of payment among economically less privileged groups, reduces access, and may generate a serious poverty trap. When health insurance schemes are introduced, assurances are needed that vulnerable and marginalized groups, including poor men and women, will be adequately covered.

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Efficiency and equity need to be assured when privatizing health services. Incentives may encourage the commercial health care sector to invest in public health and preventive care. If private sector management practices are adopted, steps should be taken to ensure that the working conditions of health personnel do not deteriorate.

The priority-setting methodologies require good quality evidence and data free from systematic gender biases and investments in high quality, gender sensitive, medical and social research.

Type of evidence

The report is a synthesis of systematic reviews, narrative reviews and individual articles. As it focuses on the impact of health policies, the quality of the evidence has not been judged formally, but reference is made to the quantity of evidence and its generalizability.

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Introduction

In the last two decades, powerful international trends in health care reform have been observed around the world. In many countries, the objective of reform is to improve the efficiency, equity and effectiveness of the health sector, against a background of limited governmental resources and rapid demographic and technological changes (1,2). The challenges for most European health care systems also include accommodating rapidly increasing pharmaceutical costs and providing long-term and home care (3,4).

The main health care reform interventions – which are often market-oriented and pursued by international financial institutions – include a range of measures, such as decentralization, privatization, improving health sector management systems, priority-setting and broadening financial options (5). Although health care reform is a global phenomenon driven by common financial and political actors, adopted reforms vary by country and region (6). For example, the Netherlands, Sweden, the United Kingdom and other European countries implemented new financial and health care delivery arrangements in the 1990s, while central and eastern European countries instituted fundamental reforms of Soviet-style health care systems. In Hungary, for example, reforms involved introduction of a centralized social insurance system and decentralization of ownership to the municipal level. The Czech Republic introduced privatization of state-owned services, state-linked and private health insurance funds, and new payments mechanisms (1). While health sector reforms in the Americas have mainly focused on decentralization and reform of social security systems, reforms in sub-Saharan Africa have involved financial mechanisms and human resource management (6).

Regardless of the national and regional contexts in which health care reforms are implemented, the changes have fundamental consequences for many people's day-to-day lives and well-being (7).

Affected groups include:

- those in need of medical and nursing care (both those who receive help from the formal care systems and those who do not)
- workers in the formal care system
- unpaid caregivers in the informal care system.

The gender balance among affected groups varies from country to country and across occupations. For example, there are often gender differences between use of primary and tertiary care, with higher levels of primary care use by women and higher levels of tertiary care by men. Moreover, neither men nor women are homogeneous groups; health care reforms may affect them differently depending on their age, class, race and ethnicity (8).

Gender analysis of health sector reform programmes suggests that many of the reforms may affect women differently than men, due to their respective status as users and producers of health care. However, the consequences of health care reforms for gender equity in general and particularly in health care are seldom discussed or taken into consideration in planning (9,10).

Some most commonly used health care reform measures are decentralization, financing, privatization and priority setting using disability-adjusted life-year (DALY) methodology. The impact of these reforms on gender equity, from the perspective of health care producers and consumers in the formal and informal sectors is the focus of this synthesis.

Sources for this review

A systematic search of literature published in English was conducted. It identified systematic reviews, narrative reviews and individual articles published in scientific journals, available in the Cochrane Library, Medline and PubMed. The search was performed in stepwise manner, starting with the search term "health care reform" and refined by adding terms such as "gender equality/equity", "women",

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“men”, “health impact”, “privatization”, and “decentralization”. The search was also extended to include relevant books, electronic databases and websites of international and regional institutions and organizations.

As the synthesis focuses on the impact of health policies, the quality of the evidence has not been judged formally, but reference is made to the quantity of evidence and its generalizability, with discussion of issues supplied by the author.

Findings

Only a small number of core articles focus on the four key health care reforms and their impact on gender equity. The reviews and bibliographies suggest that the majority of studies are concerned with health sector reform and gender in developing countries (11-13) and the focus is predominantly on the adverse effects on women.

Decentralization

Decentralization of health care is a pervasive global trend that seeks to enhance client responsiveness, administrative efficiency, and improve service access. The term "decentralization" is often used very loosely in the literature, despite the existence of several well-established approaches to its definition by Rondinelli (14) and Collins (15), among others. The European Observatory on Health Care Systems and Policies (16) defines decentralization as “changing relations within and between a variety of organizational structures/bodies, resulting in the transfer of the authority to plan, make decisions or manage public functions from the national level to any organization or agency at the sub-national level”. Frequently cited types of decentralization are delegation, deconcentration and devolution.¹ Few studies have evaluated the impact of these different types of decentralization, let alone their impact on gender equity in health.

One danger with rapid decentralization of responsibilities without corresponding devolution of authority and the requisite human, institutional and financial resources is difficulty in providing affordable, accessible and equitable health services (17). This may affect women's health more, as they need more health care, particularly during child-bearing ages.

One gender issue that may be relevant to decentralisation is gender representation and gender awareness at the different decision-making levels. Women in most countries are heavily under-represented in decision-making bodies at all levels and hence have little influence on health care planning and resource allocation. As a result, in much health care planning there is often insufficient attention to the differential needs of men and women (18,19). In many developing countries, health services for women often focus on only reproductive functions and matters unrelated to their reproductive role tend to receive less attention. It is not clear what mechanisms are available at district or community levels to redress the balance when allocation decisions result in gender inequities (6,20). Evidence from Canada shows that regionalization of health care can make it more difficult for women's organizations to address policies at the provincial level (21). Regional health boards are often caught between provincial funding limits and community needs. In this context, women voices often go unheard. Bringing services and decisions closer to communities can also benefit service delivery and accountability, through fiscal devolution to local government.

¹ *Delegation*: Giving an authority the right to plan and implement decisions relating to particular activities without direct supervision by a higher authority. *Deconcentration*: Passing some administrative authority from central government offices to the local offices of central government ministries. *Devolution*: passing responsibility and a degree of independence to regional or local government, with or without financial responsibility.(16)

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One study assessed the extent to which changes necessary for the delivery of reproductive health services were compatible with decentralization (22,23), suggesting that in most countries decentralization fails to take into account either the broad range of changes or the institutional capacity needed at the local level. Moreover, decentralization can inadvertently support more conservative agendas in reproductive health, particularly in services for adolescents.

Financing

From a gender equity point of view health care financing is of interest since it determines the availability of health care as well as who has access to care and the degree of protection from increased health care costs due to acute or chronic disorders. High-income and low-income countries usually use a mixture of the following sources for health care financing: general tax revenues, social insurance contributions, private insurance premiums, direct out-of-pocket payments and community financing. In low income countries foreign aid can also provide health care financing.

The experiences gained in high-income and low-income countries provide the following lessons from an equity point of view:

- Taxes and social insurance schemes provide the most equitable basis for health financing.
- In OECD countries, shifting from tax to direct user fees increases the burden of payment on economically less privileged groups, reduces access, and may generate a serious poverty trap. In low-income countries, user fees have reduced access to health services by the poor.
- Private, for-profit health insurance schemes, direct user fees for public services, and direct fees to private for-profit schemes produce substantial – usually increasing – inequities of financing, access, and financial security (24).

The policy lessons above are particularly important from a gender equity perspective given that women's financial resources to pay for services and social entitlements, in general, are fewer than those of men. Furthermore, the evidence from the United States (25) show that women have fewer financial resources to pay for private insurance premiums.

Despite recognition that cutbacks in health services, education and other social programmes in response to structural adjustment policies in many developing countries may have adverse impacts on health, little has been done to protect the most vulnerable sectors of the population (8). Direct effects may include decreased access to health services and delays in health-seeking behaviour, leading to worse outcomes (26). This may affect women disproportionately, as they require more preventive reproductive health care services (27,28).

In many countries, the majority of formal lower-tier health workers and informal household carers are women. As a result, cuts in health and social sectors can lead to higher levels of unemployment among female health workers, as well as increased work burdens in informal home care. This was the case in Sweden, for example, during the late 1980s, when financial constraints affected the health care system in general and care for the elderly in particular (7).

In developing countries, low health care spending may result in declining quality and accountability of public sector services and a consequent rising costs and an exodus to services outside the public sector. For example, it was assumed that user fees would enable increased budgetary allocations for improving service quality (29), but this was not borne out by the evidence: the imposition of user fees has neither provided the anticipated advantage nor enhanced equity of access (30).

High health care costs place financial barriers on universal access by the poor and other vulnerable groups unless they are deliberately protected from them; and the costs fall more directly on the sick, children and the elderly. Furthermore, studies have shown that health care fees reinforce gender inequity, as has been a case e.g. in Thailand (31). The consequences of people's inability to pay for services are untreated morbidity, reduced access to care, long-term impoverishment and irrational use

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of drugs, such as the use of contraindicated drugs for women in pregnancy (32). In many countries however, it is illicit charges that impose the greatest burdens on the poor.

There is also substantial evidence from transitional economies and from those where health systems have undergone considerable change, that a well functioning and wide-ranging system of public health services is the best guarantee of equitable and affordable services for the less privileged (33). When such services are gender sensitive – adjusted according to women's and men's special health needs – equity is doubly served (34).

Privatization

The European Observatory on Health Care Systems and Policies (16) defines privatization as “the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations and for-profit and not-for-profit private organizations”. For example, privatization of health clinics and hospitals has become more widespread in high-income, middle-income and low-income countries. However, the degree of government regulation is variable: while in OECD countries privatization is usually government-regulated, in many middle-income and low-income countries it has been unregulated as a consequence of state's failure in managing health care markets and patient exodus from poorly managed public services (35). In low income countries there has also been a considerable delegation of services to NGOs and churches.

Key elements in market-oriented health care reforms are the privatization of provision and financing for services through user fees or private insurance. Moreover, commercial interests have striven to open up public services to foreign investors and markets (36). It was believed that a mixture of private sector efficiency and public sector equity would result in an ideal health service and that privatization would increase the public's appreciation of health services and prevent overuse (37). Privatization of care and non-medical services in health care facilities in Canada has demonstrated that for-profit services are often of poorer quality, more costly, and subsidized by lowering the wages of workers (the majority of whom are women) (38).

Privatization is often followed by adoption of some private sector management practices in health care administration. Due to the increased emphasis on reducing costs and maximizing efficiency, health care administrators in many countries have increased patient/staff ratios, shifted personnel, reassigned duties to less-skilled workers and increased the use of casual workers. The negative consequences of these policies hit women harder than men since women are over-represented among both patients and personnel. In Canada during the 1990s, health care workers repeatedly raised concerns about understaffing, heavier workloads, and increased levels of stress and injury in the workplace (38). Similar privatization and organizational changes in Sweden resulted in a substantial decrease of health care employees. In Stockholm county, the number of health care workers decreased from 67 000 in 1990 to 41 000 in 2004 (39). The number of nurses decreased by 50% and the number of hospital orderlies by 80%, at a time when the demand for services was increasing due to aging of the population. A representative survey among health care providers revealed a substantial increase in stress levels, increased workload, and increased overtime for both men and women of all categories of health care providers, especially among physicians. These strains lead to symptoms of burnout and a substantial increase in short and long-term sick leave among women in particular (40,41).

Priority-setting

Global Burden of Disease (GBD) methodologies were strongly advocated in the 1990s as tools for planning and priority-setting in the health sector. The GBD methodology and the use of DALYs have been widely applied in many countries undertaking health sector reform to set priorities for resource allocation. However, these methodologies raise important questions from a gender equity perspective (28,42). A number are related to the availability of disaggregated data about gender differences in susceptibility, natural history and consequences of illness. Then there are issues concerning the

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measurement and valuation of health. For example, some conditions, such as sexually transmitted infections (STIs), injuries caused by violence against women or other conditions that are associated with fear or stigma, are systematically under-reported and thus underestimated. Moreover, other health conditions are also under-reported because women are more likely to be asymptomatic. For example, 50% to 80% of STIs in women have either no symptoms or symptoms that are not easily recognized. These conditions often remain invisible to health service statistics and population-based information.

The DALY approach is constructed on the basis of four components:

- life expectancy at each age, reflecting a low-mortality setting
- a gender gap in life expectancy, assumed to be related to biological differences
- the value of a year of life at each age
- the value of life at different ages.

As discussed by Hanson (28), all four components are based on value judgments and carry serious gender implications that may introduce systematic biases in the estimation of the disease burden for women (43). Moreover, the measure of disease burden excludes the process of care as well as its quality dimensions. The current disease burden methodologies also neglect the informal care burdens born disproportionately by women and ignore social and cultural factors that determine the seriousness of the disability. Due to its well-documented limitations, most countries have stopped using the DALY methodology as a planning tool in recent years.

Priority-setting methodologies in general can be useful for allocating resources, but their usefulness in priority-setting needs to be evaluated in the light of possible inherent biases (including gender biases) generated through various technical and conceptual limitations.

Gaps in the evidence

Although there are a number of publications about health sector reform in general, only a few reviews and bibliographies focus on impact on gender equity, and most of them are concerned with developing countries (11-13) and women's issues, assessing adverse impacts. The limited number of in-depth articles on particular regions and reform interventions also reflects a major gap in the literature. Studies of central and eastern European health sector reforms from a gender equity perspective are particularly scarce.

Discussion

Overview

Key reform measures, such as decentralization, financing, privatization of services and priority-setting methodologies may differentially affect women and men due to the positions they occupy in society, the different roles they perform, and the variety of social and cultural expectations and constraints placed on them. There is evidence to show that deteriorating health services and infrastructure, and unaffordable services may affect women disproportionately both as consumers and producers of health care. This is because of women's greater need for health care due to their reproductive functions, their greater social, cultural and financial vulnerability, and their greater enrolment as both formal and informal health care producers. Furthermore, if decision making is decentralized, women may be under-represented on planning groups, so care must be taken to ensure that the differential needs of men and women are adequately represented.

Generalizability of findings

Four health care reform measures have been studied in this synthesis. Other measures, such as development of health information systems and improvement of human resource management, may also be important from a gender perspective, but are not assessed here.

Most literature on health sector reform and gender equity in health is concerned with low-income countries. Moreover, gender related papers are predominantly concerned with women's health issues and focus on adverse health effects. These limitations affect the generalizability of findings.

Policy considerations

Gender equity in health requires that men and women will be treated equally where they have common needs, and that their differences will be addressed in an equitable manner. Provincial, regional and local health planning committees should seek to create processes that allow the needs of men and women to be represented equally.

The following are some of the general policy considerations identified by the author. It is beyond the scope of this synthesis to determine their cost or how and by whom they should be undertaken; these are questions that must be addressed in specific national settings.

- A well functioning and wide-ranging system of public health services is the best guarantee of equitable and affordable services for the less privileged, many of whom are women.
- Decentralization should include a devolution of authority and adequate human, institutional and financial resources and the participation of women and men on equal terms in decision-making bodies at all levels.
- Health insurance schemes should ensure that vulnerable and marginalized groups, including poor men and women are adequately covered. These schemes must cover reproductive health needs and parental leave and must not discriminate against women or men who leave the workforce to care for their children.
- A shift from tax to direct user fees to finance health services may increase the burden of payment among economically less privileged groups, reduce access and generate a serious poverty trap.
- Both efficiency and equity concerns need to be assured when privatizing health services. Incentives are needed to encourage the commercial health care sector to invest in public health and preventive care. Adapting private sector management practices in health care administration should not worsen the working conditions of health personnel.
- Priority-setting should be based on evidence that is free from systematic gender biases and investment is required in high quality, gender-sensitive medical and social research.

Conclusions

Gender analysis of health sector reform programmes suggests that many of the reforms may affect women differently than men, due to their respective positions as users and producers of health care. However, the consequences of health care reforms for gender equity – particularly in health care – are seldom taken into consideration when designing fundamental changes to health care systems (9,10). This review assesses the impact of four key health care reforms (decentralization, financing, privatization and priority setting) on gender equity and gender equity in health.

Decentralization

Rapid decentralization of responsibilities without corresponding devolution of authority and requisite human, institutional and financial resources may lead to difficulties in providing affordable, accessible and equitable health services, as has been the case in many low income countries. Services should be

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planned taking account of the differential needs of men and women. Decentralization may inadvertently support more conservative reproductive health agenda, particularly for adolescents.

Financing

There is substantial evidence from both high-income and low-income countries that taxes and social insurance schemes provide the most equitable basis for health financing.

Other schemes, such as private insurance or direct out-of-pocket payment, are likely to increase inequities, particularly in access to care and health-seeking behaviour and this may affect women more, as they generally have fewer financial resources.

Privatization

Privatization has an important impact on gender equity in access to health care and financial protection for those who are ill. Privatization may lead to increased emphasis on reducing costs and maximizing efficiency. In many OECD countries where privatization has been introduced, patient/staff ratios have been raised, personnel have been shifted, duties have been reassigned to less-skilled workers and the use of casual workers has increased. The negative consequences of these policies affect women more than men since women are over-represented among both patients and personnel.

Priority-setting

A range of gender biases have been revealed in some priority-setting methodologies, such as DALYs, which seriously underestimate women's burden of disease.

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What evidence is there about the effects of health care reforms on gender equity, particularly in health?

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