# Gender Equity and Health Sector Reforms

Sweeping health care reforms have shifted the structure of health care throughout the world in the past twenty years.

Largely, health care has become more market oriented. In much of the developing world this has been dictated by international financial institutions and put in place through structural adjustment policies. In the developed world nations have responded to the wants of the international financial institutions such as the World Trade Organisation and the World Bank by increasing the tendency toward decentralisation and privatisation or a refocus in financing. In New Zealand we have seen a shift in policy toward more market friendly reforms across government. In health care this has been reflected in the restructuring of regional health boards into the 21 District Health Boards, and an attempt to meet more of the community and public health needs through the development of Primary Health Organisations. As far as WHA is aware these shifts in health care structure have not analysed from a gender perspective. The World Health Organisation has however done an evidence report on the effects of health care reforms on gender equity. The 2005 report found that health sector reform programmes affect women and men differently due to their respective positions as users and producers of health care. However most reform programmes do not take gender equity into account when designing changes to the health care system and may lead to increasing inequalities.
The evidence report, based on a systematic review of the literature, looked at four key health care reforms (decentralisation, financing, privatisation and priority setting). The review looked at the literature examining reforms in both developed and developing countries, although it noted that most articles looking explicitly at gender and health care reform were in developing countries.

This is a summary of the report findings:

**Decentralisation**
A growing trend toward decentralisation is characterised by the transfer of authority for decision making and management from the national level to agencies and organisations on the sub-national level. A problem with decentralisation is the devolution of responsibilities without a corresponding devolution of resources and authority. This lack of resources frequently leads to difficulties in providing adequate services. This may affect women's health more as any decrease in available service or service quality is disproportionately felt by women as they need more health care, particularly during childbearing years.

The decentralisation of decision making may be a challenge for providing adequate gender representation and gender awareness at different policy making levels. Evidence from Canada shows that the regionalisation of health care can make it more difficult for women's organisations to address policies at varying levels. Some studies show that decentralisation may inadvertently support more conservative agendas in reproductive health.

**Financing**
There is substantive 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 inequalities, particularly in access to care and health-seeking behaviour. This generally affects women more, as they tend to have fewer financial resources and less access to them. Additionally, women form the majority of lower-tier health workers and are the primary informal carers in the household. As a result cuts in health and social sectors can lead to higher levels of unemployment among women health workers, as well as increased burdens in informal home care.

Evidence has shown that a well functioning and wide ranging system of public health, especially when gender-sensitive, is the best guarantee of equitable and affordable services for the less privileged.

**Privatisation**
Privatisation is the transfer of ownership and function from government (public) organisations

to private ones. The hallmark of health care privatisation has been the increased reliance on user fees or private insurance.

Privatisation has an important impact on gender equity in access to health care and financial protection for those who are ill.

Privatisation may lead to increased emphasis on reducing costs and maximizing efficiency. The negative consequences of these policies affect women more than men since women are over-represented among both patients and personnel.

**Priority-setting**
Throughout the 1990s health care planning and priority setting were increasingly influenced by Global Burden of Disease (GBD) methodologies. These methodologies rely on gender disaggregated data to determine the needs and successes of different health care policies. One of the most common methodologies is the use of DALYs (disability adjusted life years).

A range of gender biases have been revealed in some priority-setting methodologies, which seriously underestimate women's burden of disease and in turn affects resource allocation and priority setting.

The report concludes there is a clear need for gender equity considerations to be taken into account when planning health care reforms. Unfortunately, there is little evidence of this occurring in the past. Policy considerations need to look at gender equity needs in planning and services at national, regional and local levels. It concludes that a well functioning and wide-ranging system of public health services is the best guarantee of equitable and affordable services for those less privileged, many of whom are women.

**References**
Ostlin, Piroska (2005) What evidence is there about the effects of health care reforms on gender equity, particularly in health? World Health Organisation Europe
Available at: http://www.euro.who.int/HEN/Syntheses/genderEquity/20051027_1