

DISCUSSION PAPER

UNIVERSAL HEALTH COVERAGE, GENDER EQUALITY AND SOCIAL PROTECTION

A HEALTH SYSTEMS APPROACH



No. 38, December 2020

GITA SEN, VELOSHNEE GOVENDER AND SALMA EL-GAMAL
BACKGROUND PAPER PREPARED FOR THE 64TH SESSION OF THE COMMISSION ON
THE STATUS OF WOMEN 2019

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ACRONYMS AND ABBREVIATIONS

AAAQ	availability, accessibility, acceptability and quality
CBHI	community-based health insurance
CSO	civil society organization
DSF	demand-side financing
HRH	human resources for health
ILO	International Labour Organization
LMICs	low- and middle-income countries
MCH	maternal and child health
MDGs	Millennium Development Goals
NHIS	National Health Insurance Scheme (Ghana)
OOPs	out-of-pocket payments
RSBY	Rashtriya Swasthya Bhima Yojana (India)
SDGs	Sustainable Development Goals
SHI	social health insurance
SPF	social protection floor
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
UHC	universal health coverage
WHO	World Health Organization

SUMMARY

This paper focuses on the interconnections between policies to move toward universal health care (UHC), as a key element of social protection, and those to advance gender equality, women's empowerment and human rights. It is set against the backdrop of Agenda 2030 and the Sustainable Development Goals (SDGs). Rising concern over the exclusionary and impoverishing effects of out-of-pocket health expenditures, and the extent to which financial barriers tend to block access to health-care services, has been a major driver of the growing policy attention to UHC over the last two decades or so.

Recent years, especially since 2010, have seen advances on each of these fronts. Nevertheless, there has been considerable ongoing concern whether UHC is being designed to address women's specific needs, particularly their sexual and reproductive health and rights (SRHR). In this paper, we examine whether the experience with UHC has been gender-aware in its conceptualization and gender-responsive in its implementation. We argue that a human rights-based approach with an emphasis on the importance of solidarity is needed. We show that standard approaches to achieving UHC often exclude or marginalize gender concerns when framing problems, identifying and gathering data and evidence and designing programmes and policies.

We also argue that considering all elements of a health system and its functioning is necessary to advance towards UHC: governance, health service delivery, health information systems, human resources, financing and medical products and technologies. We show how gender is a key fulcrum on which all these elements are leveraged and is hence central to achieving UHC. Applying a gender lens to UHC by examining the health system entails recognizing and analysing how gender power relations affect all six of its building blocks. The paper considers the current state of evidence on the implications, through a gender lens and where feasible an intersectionality lens, of UHC reforms based on an analysis of country experiences.

This review of evidence found that

- Financing mechanisms often do not pay explicit attention to gender and other markers of exclusion and discrimination (race, caste, ethnicity, origin, religion, etc.) in either design, implementation or impact. Women, particularly those who are poor and marginalized, continue to experience financial barriers in accessing health services; and when they do access care, they bear out-of-pocket expenses particularly for services relating to their sexual and reproductive health-care needs.
- Inequities in access to services often persist along a range of intersecting dimensions including gender. Essential service packages are often gender-biased, excluding key services such as for violence, and may suffer from poor quality.
- The health workforce is deeply gendered in terms of its composition, its professional hierarchies, seniority, pay and conditions of work, with women typically being at the lower ends of the workforce hierarchy and in unpaid health-care work. Violence against health workers, particularly those operating at the front line, is a growing challenge and largely remains under-recognized and unaddressed.
- Expenditures on medicines are an important contributor to catastrophic health costs. However, evidence on the role of gender in determining access to medicines and health technologies and the financial burden of payment is currently very limited. Access to essential sexual and reproductive health medicines and technologies such as contraception and safe abortion services is often inadequate.
- Governance and accountability are central to UHC and Agenda 2030. For effective accountability, it is obligatory on States to ensure that women and groups that are marginalized are aware of their right to health, including SRHR, and are empowered to claim their rights.
- In low- and middle-income countries, weak health information systems challenge effective tracking

of critical gender and human rights concerns by UHC indicators on service coverage and financial protection. There is an urgent need to prioritize both investment in strengthening national health information systems and the reporting of

disaggregated data by sex and other markers of social exclusion.

The paper proposes a range of specific and detailed policy measures to address these limitations.

RÉSUMÉ

Ce document traite des interactions entre les politiques visant à instaurer une assurance médicale universelle, qui serait la composante principale de la protection sociale, et les politiques destinées à promouvoir l'égalité des sexes, l'autonomisation des femmes et les droits humains. Ce document s'inscrit dans le cadre de l'Agenda 2030 et des objectifs de développement durable (ODD). Au cours des deux dernières décennies, l'assurance médicale universelle a suscité une préoccupation croissante en raison des effets appauvrissants et « exclusionnistes » des dépenses sanitaires non remboursables et des obstacles financiers qui bloquent l'accès aux services de soins de santé.

On a assisté au cours des dernières années, notamment depuis 2010, à des avancées sur chacun de ces fronts. Mais malgré ces progrès, il convient de se demander si l'assurance médicale universelle, en tant que composante importante de la protection sociale, est en mesure de répondre aux besoins spécifiques des femmes, concernant notamment leur santé et leurs droits sexuels et reproductifs. Dans ce document, nous tentons de savoir si l'expérience concernant l'assurance médicale universelle a été sensible au genre dans sa conceptualisation ainsi que dans sa mise en œuvre. Nous arguons qu'une approche fondée sur les droits humains qui met l'accent sur l'importance de la solidarité est nécessaire. Nous montrons que les approches standard visant à instaurer une assurance médicale universelle excluent ou marginalisent souvent les préoccupations liées au genre lorsque l'on tente de cerner les problèmes, d'identifier et de rassembler des données et des preuves, et d'élaborer des programmes et des politiques.

Nous insistons également sur le fait qu'il est nécessaire de prendre en compte tous les éléments d'un système sanitaire et son fonctionnement pour promouvoir l'assurance médicale universelle. Les composantes essentielles de ce système sanitaire incluent la gouvernance, la fourniture de services sanitaires, des systèmes d'information sanitaires, des ressources humaines, un financement et des produits médicaux et des technologies. Nous montrons comment le genre est un point d'appui essentiel pour tous les éléments du système sanitaire et est donc indispensable pour parvenir à instaurer une assurance médicale universelle. Une analyse de l'assurance médicale universelle fondée sur le genre en examinant le système sanitaire implique de reconnaître et d'analyser la manière dont les relations de pouvoir genrées affectent les six éléments essentiels du système sanitaire. Ce document examine les conséquences actuelles des réformes du système d'assurance médicale universelle en analysant les expériences nationales du point de vue de la problématique hommes-femmes et, lorsque cela est possible, de l'intersectionnalité.

Cet examen a conclu que :

- Le financement des mécanismes ne se soucie souvent pas assez du genre et des autres marqueurs d'exclusion et de discrimination (à savoir la race, la caste, l'ethnicité, les origines, la religion, etc.) qu'il s'agisse de l'élaboration, de la mise en œuvre ou de l'impact. Les obstacles financiers continuent d'entraver l'accès des femmes, notamment celles qui sont indigentes et marginalisées, aux services sanitaires et lorsqu'elles ont accès aux soins, elles doivent s'acquitter des dépenses non remboursables, s'agissant notamment de leurs besoins en matière de santé sexuelle et reproductive.

- Les inégalités dans l'accès aux services persistent souvent parallèlement à un certain nombre de dimensions entrecroisées, notamment le genre. Les services essentiels sont souvent sexistes, à l'exception des services fondamentaux destinés à combattre la violence, et peuvent être de mauvaise qualité.
 - Le personnel soignant est très genré en termes de composition, de hiérarchies professionnelles, de séniorité, de salaires et de conditions de travail, les femmes étant souvent positionnées tout en bas de l'échelle, maintenues dans des emplois sanitaires sans rémunération. La violence contre les soignants, notamment ceux qui sont en première ligne, représente un défi croissant et n'est dans l'ensemble pas assez reconnue et combattue.
 - Les dépenses médicales contribuent largement à la situation catastrophique concernant les dépenses sanitaires. Néanmoins, les éléments probants concernant le rôle joué par le genre pour définir l'accès aux médicaments et aux technologies sanitaires et le fardeau financier du paiement sont actuellement très limités. L'accès aux médicaments et technologies essentiels concernant la santé sexuelle et reproductive tels que la contraception et les avortements sécurisés est souvent inadéquat.
 - Une gouvernance et une responsabilisation sont indispensables au régime d'assurance médical universel et à l'Agenda 2030. Pour assurer une responsabilisation efficace, il faut que les États s'emploient à faire en sorte que les femmes et les groupes marginalisés ont conscience de leur droit à la santé, y compris leurs droits en matière de santé sexuelle et reproductive, et se sentent autorisés à les revendiquer.
 - Dans les pays à revenu intermédiaire de la tranche supérieure, les systèmes d'informations sanitaires peu performants représentent un défi pour assurer le suivi des préoccupations cruciales concernant le genre et les droits humains par le biais des indicateurs du régime d'assurance médicale universelle concernant la couverture de ces services et la protection financière. Il est urgent de donner la priorité au renforcement des systèmes d'informations sanitaires, d'investir dans ces outils, et de donner la priorité à l'établissement de rapports sur les données ventilées par sexe et d'autres marqueurs d'exclusion sociale.
- Ce document propose un certain nombre de mesures politiques spécifiques et détaillées visant à aborder ces obstacles.

RESUMEN

Este trabajo se centra en las interconexiones entre las políticas orientadas a la cobertura sanitaria universal (CSU) como uno de los elementos clave de la protección social, y aquellas destinadas a promover la igualdad de género, el empoderamiento de las mujeres y los derechos humanos. El documento se enmarca en la Agenda 2030 y los Objetivos de Desarrollo Sostenible. La creciente preocupación por los efectos de pauperización y exclusión de los gastos directos en salud en que incurre la población, y el grado en que las barreras financieras tienden a obstruir el acceso a los servicios médicos, han sido uno de los principales factores que originaron la creciente atención política en torno a la CSU durante aproximadamente las últimas dos décadas.

En años recientes, sobre todo desde 2010, se han registrado avances en cada uno de estos frentes. Sin embargo, pese a dicho progreso, ha crecido considerablemente la preocupación acerca de si en el diseño de la CSU—como componente importante de la protección social— se contemplan las necesidades específicas de las mujeres, y la salud y los derechos sexuales y reproductivos en particular. En este trabajo, examinamos si la experiencia con la CSU demuestra una perspectiva de género en su conceptualización e implementación. Sostenemos que es necesario aplicar un enfoque basado en los derechos humanos con énfasis en la importancia de la solidaridad. Mostramos que en los enfoques convencionales para el logro de la CSU a menudo se excluyen o marginan las preocupaciones de género al momento de enmarcar los

problemas, identificar y recopilar datos y evidencias, y de diseñar programas y políticas.

Asimismo, sostenemos que para avanzar hacia una cobertura sanitaria universal se hace necesario considerar todos los elementos de un sistema de salud y su funcionamiento. Los pilares del sistema de salud incluyen la gestión institucional, la prestación de los servicios sanitarios, los sistemas de información sanitaria, los recursos humanos, el financiamiento, y los productos y las tecnologías asociados a la medicina. Exponemos de qué manera la perspectiva de género es uno de los puntos de equilibrio fundamentales en los que se apoyan todos los sistemas de salud y resulta, por lo tanto, vital para el logro de la CSU. La aplicación de una perspectiva de género a la CSU al analizar el sistema sanitario implica reconocer y examinar de qué manera las relaciones de poder entre hombres y mujeres afectan los seis pilares del sistema de salud. En este trabajo se estudia el estado actual de las evidencias sobre las implicaciones a través de una mirada de género y, en la medida de lo posible, una mirada interseccional sobre las reformas de la CSU en función de un análisis de las experiencias en distintos países.

Mediante el examen de la evidencia se detectó lo siguiente:

- Los mecanismos de financiamiento a menudo no prestan explícita atención a las cuestiones de género y otros marcadores de exclusión y discriminación (por ejemplo, dimensiones como la raza, la casta, el origen étnico, la procedencia, la religión, etc.) en el diseño, la implementación o el impacto. Las mujeres, en especial aquellas más pobres y marginadas, siguen tropezando con obstáculos financieros al momento de acceder a los servicios sanitarios y, cuando sí lo logran, deben sufragar de su propio bolsillo los gastos, particularmente para los servicios relacionados con sus necesidades de salud sexual y reproductiva.
- Las desigualdades en el acceso a los servicios en general se mantienen en una amplia variedad de dimensiones interconectadas, incluida la dimensión de género. Los paquetes de servicios esenciales comúnmente presentan sesgos de género, por lo que quedan excluidos servicios vitales como los

destinados a atender casos de violencia, muchos de los cuales son de escasa calidad.

- Entre el personal sanitario se registran profundos sesgos de género en cuanto a su composición, jerarquías profesionales, tiempo en el servicio, salarios y condiciones de trabajo. Las mujeres se desempeñan habitualmente en los últimos eslabones de la jerarquía laboral y en trabajos de cuidados de la salud no remunerados. La violencia contra el personal sanitario, sobre todo contra quienes se desempeñan en la primera línea del sistema, constituye un problema creciente que, en gran parte, sigue sin recibir reconocimiento ni atención.
- Los gastos en medicamentos son un componente importante del catastrófico gasto en salud. Sin embargo, la evidencia sobre el peso de los aspectos de género que determinan el acceso a los medicamentos y las tecnologías médicas y la carga financiera de los pagos es actualmente muy limitada. El acceso a los medicamentos y las tecnologías esenciales para el cuidado de la salud sexual y reproductiva, como los anticonceptivos y servicios de aborto seguro, en general es inadecuado.
- La gestión institucional y la rendición de cuentas son fundamentales para la CSU y la Agenda 2030. Para una rendición de cuentas efectiva, es obligatorio que los Estados garanticen que las mujeres y los grupos marginados conozcan su derecho a la salud, incluida la salud sexual y reproductiva, y que gocen de empoderamiento para reclamar sus derechos.
- En los países de ingreso mediano y de ingreso bajo, la escasa solidez de los sistemas de información sanitaria supone un desafío a la hora de supervisar con eficacia las preocupaciones críticas relacionadas con las dimensiones de género y los derechos humanos en los indicadores de la CSU sobre la cobertura de los servicios y la protección financiera. Existe una necesidad urgente de dar prioridad al fortalecimiento de los sistemas nacionales de información sanitaria y de invertir en estos, así como a la elaboración de informes con datos desagregados por sexo y otros marcadores de exclusión social.

En este trabajo se propone una gama de políticas específicas y pormenorizadas para abordar todas estas dificultades.

“... At present, no government in the world is systematically applying a gender lens to its UHC system...” (Rodin 2013: 711).

*“... Anyone who believes that design choices in social protection programmes...are purely pragmatic technical issues...is missing the point...Which choices are made, and for what reasons, reflects the kind of society that policymakers and technocrats with power to direct social policy wish to promote... Social protection is self-evidently about a vision of society...”
(Devereux and Sabates-Wheeler 2007: 2).*

1.

INTRODUCTION

This paper focuses on the interconnections between policies to move toward universal health care (UHC) as a key element of social protection and those to advance gender equality, women’s empowerment and human rights. It is set against the backdrop of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs).

Recent years, especially since 2010, have seen advances on each of these fronts, despite difficult economic circumstances, rising inequality, constrained political space and continuing and new forms of political backlash and resistance.¹ Slow recovery from the global financial crisis of 2008 and continuing financial instability, combined with the worsening of global warming, have raised concerns about risk and vulnerability for large numbers of people, including women, in both high- and low-/middle-income countries (LMICs). Social mobilization and advocacy on these issues has opened policy space for global agreements, such as ILO Recommendation No. 202 in 2012 and target 1.3 of the SDGs, which recognize the mitigating potential of national social protection floors (SPFs) as tools against poverty and vulnerability.

At the same time, there has been considerable ongoing concern whether UHC, as an important component of social protection, is being designed to address women’s specific needs²—and their sexual and reproductive health and rights (SRHR) in particular.³ In this paper, we examine whether the experience with UHC has been gender-aware in its conceptualization and gender-responsive in its implementation. We argue that a human rights-based approach with an emphasis on the importance of solidarity is needed. We show that standard approaches to achieving UHC often exclude or marginalize gender concerns when framing problems, identifying and gathering data and evidence and, consequently, in designing programmes and policies. We also argue that considering all elements (not just one or two such as financing)

of a health system and its functioning is necessary to advance towards UHC. We show how gender is a key fulcrum on which all health system elements are leveraged and is hence central to achieving UHC.

The paper considers the current state of evidence on the implications of UHC reforms through a gender lens, and where feasible an intersectionality lens, based on an analysis of country experiences. This entails addressing the following questions:

- Under what circumstances does UHC lead to improving or worsening gender inequalities in terms of access, population coverage and services delivered?
- Are there examples of UHC reforms that have paid explicit attention to gender and inequalities in terms of design?
- Does looking more broadly at all six building blocks of a health system (see below) deepen our understanding of the above?
- Are there specific examples of targeting within universalism in the context of UHC to ensure that groups that face specific barriers, especially on the basis of gender, are effectively covered?

1 Sen 2018a; Tessier et al. 2013; World Bank and USAID 2018a.

2 Rodin 2013; Witter et al. 2017.

3 Kowalski 2014; Sen and Govender 2015.

1.1

UHC as a key component of social protection

Rising concern over the exclusionary and impoverishing effects of out-of-pocket payments (OOPs), and the extent to which financial barriers tend to block access to health services, has been a major driver of the growing policy attention to UHC over the last two decades or so. The early years of UHC advocacy saw debates about whether the ‘C’ stands for coverage or care. The People’s Health Movement (PHM), founded in 2000, called for a broad approach going beyond financial coverage and highlighted the importance of comprehensive primary care, attention to social determinants of health and a predominant role for the public sector in the provision of health care. They also raised important questions about the limitations of private insurance, the need to focus on who provides health services and under what institutional arrangements, the excessive power of the private sector with its perverse incentives and the need for regulation.

Against this backdrop, recognition of UHC as central to social protection has been relatively recent. It was consolidated with the passing of the Social Protection Floors Recommendation (No. 202) in 2012 by the International Labour Conference.⁴ This recommendation guides International Labour Organization (ILO) member States on how to build comprehensive social security systems, starting with national social protection floors (SPFs). UHC is defined as one of four minimum elements for an SPF: “...access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality...”⁵ This is in line with Articles 22 and 25 of the Universal Declaration of Human Rights, which affirm the human right to social security and to a standard of living adequate for health and well-being, including access to food, clothing, housing, medical care and necessary social services.⁶ The

4 ILO 2012.

5 Ibid.

6 UN General Assembly 1948.

Recommendation also calls for applying the principle of “non-discrimination, gender equality and responsiveness to special needs”.⁷

1.2

UHC, human rights and solidarity: The need for a broader frame

Despite the above, much of the debate around social protection, including UHC, has focused on the relative merits of programme instruments such as targeting and conditionalities, where human rights concerns do not have pride of place. They tend instead to be excluded and are evaluated (if at all) on a par with efficiency, effectiveness and other criteria. It is important, therefore, to be clear about the place of human rights in the larger approaches that frame the instruments chosen.⁸ This is indispensable for a gender analysis, as we argue below.

Different multilateral agencies have used varying definitions of social protection. While the United Nations Development Fund (UNDP) defines it as a right⁹—as do the ILO, UNAIDS, and UN Women—others, such as the World Bank and the Asian Development Bank, emphasize resilience, equity, opportunity and efficient labour markets.¹⁰ Variations in whether and how rights are recognized are not trivial as they underpin programme design, implementation and monitoring. This has implications for UHC programme direction, quality and effectiveness as well as directly and indirectly for gender equality and women’s human rights, as our cases show below. While it is generally

7 ILO 2012.

8 Devereux and Sabates-Wheeler 2007; Sen and Rajasekhar 2012.

9 A useful UNDP Primer argues that social protection “... ensures access to basic social services to all, especially for groups that are traditionally vulnerable or excluded; stimulates productive inclusion through the development of capabilities, skills, rights and opportunities for the poor and excluded; builds resilience and protects people against the risks of livelihood shocks throughout their lifecycle; and helps remove structural barriers, including barriers within the household, that prevent people from achieving well-being...” (UNDP 2016: 15-16, emphasis added).

10 Ibid.: 14-15, Table 2.

agreed that effective social protection is necessary to manage risk and vulnerability, there is often disagreement about the causes of that vulnerability and who is responsible for tackling it.

The politics of UHC and social protection more generally is also a function of the other, less understood, side of the rights coin, namely, the extent to which the idea of solidarity underpins policies and programmes.¹¹ Solidarity is the recognition by the ‘haves’ of the intrinsic importance of the basic needs of the ‘have-nots’, an issue that has special importance in the current era of soaring national and global inequality. It means that the better-off are willing to support the public provisioning of those needs because the poor cannot afford them at market prices and not having them means hardship and deprivation. The rationale for solidarity is based on collective acceptance that the “basic needs of the poor are as worthy of fulfilment as those of the better off”.¹²

A rights-based approach combined with social commitment to solidarity as a rationale for public action provides the strongest and most sustainable basis for public provisioning for UHC (and indeed all social protection) and provide an ethical and durable framework for programme choices and decisions. Recognizing the importance of solidarity can lead policymakers to prioritize attention to creating it through the government’s power to persuade and direct and through intelligent programme design intended to create ‘win-win’ processes rather than competition between social groups. In particular, the approach of solidarity may allow UHC policies to break through the existing fierce debate about the relative merits of targeting versus universalism.¹³

11 Sen 2007.

12 Ibid.: 183. This “...does not necessarily mean they are identical, but that they are viewed as intrinsically having the same worthiness. Similarity may be measured on a number of different metrics, including common citizenship or common humanity. The fault-lines for solidarity are often precisely the commonly experienced bases of social difference – nationality, ethnicity, race, caste, gender and economic class. The more unequal a society and the more fragmented along such lines, the less likely it is to recognise solidarity as a value or to build it into institutions or behaviour...” (Ibid.: 180).

13 Sen 2018a.

From the perspective of gender equality, a human rights-based approach is essential to move beyond the limitations of a narrowly technicist view of UHC, as we argue in the next section. Solidarity is important because health problems and their manifestations often entail physical (and other) differences between women and men (and between different groups). This can make it all too easy for policymakers who are usually male and from dominant social and economic groups to distance themselves from the ‘other’ while sliding into top-down, welfarist approaches. Such approaches can be blind to the common humanity underpinning basic health needs and to the central role that all people should play in fulfilling their intrinsic right to health. An approach based on solidarity would pool risk and resources so that groups that are lower on the socio-economic ladder—such as women, racial minorities or lower income groups, for example—are not left to cover risks on their own.

An essential question, therefore, is whether and how far the push towards UHC has gone beyond such blindness.

1.3

UHC: Advances, challenges and areas for improvement

1.3.1 Advances

The field of global health had mixed and controversial experience during the 1980s and 1990s with identifying what ought to be included in a package of essential health services. That controversy pitted supporters of the Alma-Ata approach based on comprehensive primary health care against promoters of selective care based on cost-effectiveness and as part of health sector reform packages supported by the World Bank.¹⁴

These bitter debates notwithstanding, progress towards and achievement of UHC is now widely

14 Magnussen et al. 2004; Unger and Killingsworth 1986. The Alma-Ata Declaration of 1978 identified primary health care as the key to the attainment of the goal of Health for All.

recognized as central to improving health and equity, “lift[ing] people out of poverty and driv[ing] economic growth.”¹⁵ Access for all residents to ‘essential health care’ that meets the human rights criteria of availability, accessibility, acceptability and quality (AAQ) is one of the four essential guarantees of ILO Recommendation No. 202 and was also picked up in the SDGs. Specifically, SDG 3 (“ensure healthy lives and promote well-being for all at all ages”) includes UHC as target 3.8, “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”¹⁶ In addition, financial risk protection in health can play a crucial role in achieving SDG 1 (“end poverty in all its forms everywhere”) by reducing the known contribution of catastrophic, out-of-pocket health expenditures in pushing people into poverty.

The World Bank Group, the World Health Organization (WHO) and other organizations have clarified that UHC will be achieved through improvements in health care that

- Prioritize the poorest, with specific attention to addressing inequalities and focusing on the vulnerable;
- Increase reliance on public funding, recognizing that public financing is essential for UHC to cover people who cannot contribute financially;
- Reduce, if not eliminate, out-of-pocket spending; and
- Develop the health system by going beyond health financing to strengthen essential components of the health system.¹⁷

The acceptance of UHC in recent global policies¹⁸ has opened space for what Gwatkin and Ergo have called “progressive universalism”.¹⁹ It can be argued that UHC is constructed on the basis of the 2030 Agenda’s equity pillar²⁰ and should be operationalized in the following ways. First, universalism means that no one should be left behind, and that health services should be allocated according to people’s needs. Second, on the principle of vertical equity, those with higher needs (e.g., pregnant women) should receive more services than others. Third, the notion of financial protection implies that people’s financial contributions towards funding health services should be according to their ability to pay. UHC, therefore, requires that healthy and wealthy members of society should cross-subsidize services for those more sick, vulnerable or poor, underpinned by the notion of social solidarity discussed earlier.

But will these expectations be met, and how? Broad notions of equity and universalism are built into both ILO Recommendation 202 and the SDGs, but how will they translate into the specifics of expanding coverage of people, financing and services, as represented in the well-known UHC cube (see Figure 1)?²¹ The devil may well be in the details. On the road to UHC, countries are required to pay attention to three interconnected elements corresponding to the three dimensions of coverage used in the World Health Report 2010.²² These are: (1) provide financial protection by reducing the reliance on out-of-pocket payments towards mandatory pre-payment mechanisms; (2) gradually expand services starting with essential services that are of good-quality according to need; and (3) ensure that everyone in the population is covered.²³

15 World Bank Group et al. 2014.

16 UN General Assembly 2015.

17 World Bank Group et al. 2014.

18 UN General Assembly 2012.

19 Gwatkin and Ergo 2011.

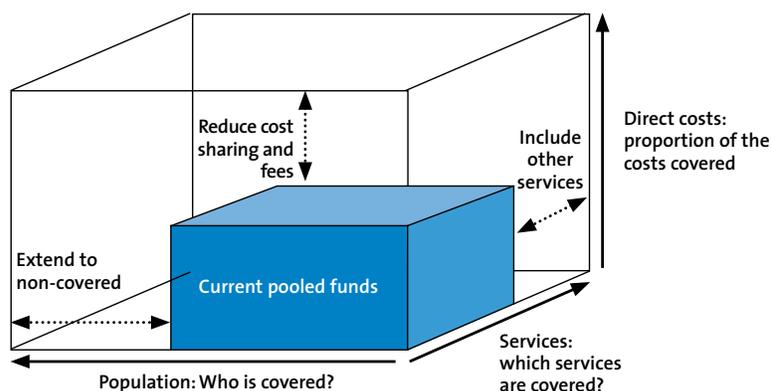
20 UN General Assembly 2015.

21 WHO 2010a.

22 Ibid.

23 Ibid.; WHO 2014.

**FIGURE 1:
The UHC cube**



These three dimensions to consider when moving towards universal coverage

Source: WHO 2010a: xv.

1.3.2 Challenges and areas for improvement

Over-simplification

The UHC cube was introduced as a heuristic device in the World Health Report²⁴ but has two limitations as an analytical tool. The first is that, by itself, it cannot help in making a choice among the pathways by which UHC may be achieved and especially how to ensure equity on the path.²⁵ Policy implementers may be tempted, for instance, to first pick the low hanging fruit in terms of ease of coverage at the expense of services or groups, including poor and marginalized women and girls who may be more difficult to reach or cover. This would be an example of the ‘inverse equity hypothesis’ under which expansion of coverage first reaches the better-off, thereby worsening inequality.²⁶ The limitation is that the cube in itself cannot distinguish between more and less equitable pathways.

The second challenge is that the three dimensions—people, services and financing—are not independent as the cube could be taken to imply. For instance, expanding coverage to adolescent girls will require

a change in the kinds of services provided (e.g., comprehensive sexuality education) and more focused financing. Technologies such as intra-uterine devices may be covered in the essential benefit package and provided through the public sector but may entail co-payments, which can become a financial barrier for poor women and adolescents. Inclusion of services within an essential package does not automatically imply financial protection or services free at the point of care. Similarly, premiums within a community-based health insurance scheme (CBHI), which are unaffordable for women in the informal economy, may effectively block access and ultimately uptake of services.

The UHC cube is not well suited to capture such interdependencies among people, services and financing mechanisms. There are also other limitations, including from a gender perspective, to the way UHC is traditionally approached.

The challenge of access – towards progressive realization

Coverage is primarily about removing financial barriers to UHC through suitable health financing mechanisms, which reduce out-of-pocket expenses and aim to eventually do away with these. Access, on the other hand, depends on various social determinants and

24 WHO 2010a.

25 Sen and Govender 2015.

26 Victora et al. 2018.

on health system factors such as sufficient service delivery points, drugs and equipment as well as the availability of primary, secondary and tertiary services and trained providers.

The challenge of reaching UHC within highly restricted fiscal spaces (especially in low-income countries) and in the presence of high inequalities (especially in middle-income countries) implies difficult choices and politically sensitive trade-offs with respect to resource allocation. Expanded access is usually dependent on expanded financing. But, as stated in the World Health Report, “Pooled funds will never be able to cover 100 per cent of the population for 100 per cent of the costs and 100 per cent of needed services. Countries will still have to make hard choices about how best to use these funds.”²⁷

Progressive realization is the guiding principle for countries on their own path to UHC and achievement of the SDG health targets. It refers to the governmental obligations to begin immediately and to progressively move towards the full realization of UHC, recognizing that countries are at different starting points and are constrained by available resources.²⁸

The WHO Consultative Group on Equity and UHC spelled out a three-pronged strategy to ensure progressive realization, fairness and equity on the path to UHC, beginning by categorizing services into classes based on priority to the worse off, cost effectiveness and financial risk protection.²⁹ The group argued this would mean expanding coverage for high-priority services to everyone; eliminating out-of-pocket payments and increasing mandatory progressive prepayment with risk pooling; and ensuring that disadvantaged groups are not left behind. The Consultative Group went on to identify a set of unacceptable choices from the viewpoint of equity and fairness. A similar approach has been taken in a recent one-pager based on the Background Report prepared for the 3rd Annual UHC Financing Forum organized jointly by the World Bank and USAID.³⁰

27 WHO 2010a: 2.

28 WHO 2014.

29 Ibid.

30 World Bank and USAID 2018b.

Both sets of recommendations require close monitoring of the inequality consequences of different methods of financing health services. Useful as it is, the approach of identifying unacceptable choices is somewhat minimalist. Advancing gender equality and equity typically requires more than abjuring negative actions; positive measures are also required so that women’s and girls’ human rights are not only protected but also promoted and fulfilled.

The approaches put forward by the WHO Consultative Group on Equity and UHC and the World Bank are spelled out in more detail in Annex 1. What is striking about them is that they do not pay attention to the ways in which social factors such as gender inequality may translate into financing inequality. For instance, as pointed out by Sen and Iyer,³¹ girls and women within households may suffer from gender-biased household rationing of limited household financial resources. This can result in less spending on their health needs and worse access to health services than men and boys have.

In addition, while these efforts mark important advances towards choices that support greater equity in UHC, their attention has been on financing with relatively little focus on the other two dimensions (i.e., service and population coverage). From a gender perspective, all three dimensions and their interdependencies are important and warrant attention. As Kowalski says, “The design and delivery of health programmes, the quality of health services, the strength of the institutions that govern them, health policies and social determinants of health, all play a role in determining whether people can access good quality health services, including sexual and reproductive health care.”³² Similar arguments have been made by others.³³ In other words, even if health financing is adequate at the household level, gendered barriers to access and utilization can be a major source of inequality and inequity.

31 Sen and Iyer 2019.

32 Kowalski 2014: 662.

33 See, for example, Fried et al. 2013.

Access and utilization are the outcome of both the supply side (e.g., availability of health services in rural areas or respectful and confidential care for adolescents seeking abortion services) and the demand side. On the demand side, sex, age, geographic location and disability, and their interaction with socio-economic stratifications and consequent inequalities (e.g., income, gender, age, race, sexual orientation, caste), are important. They are often the concealed determinants of women's and men's differential access to and claims on resources at multiple levels (i.e., household, community, state). Through their complex and multiple paths of interaction with the supply side, demand-side factors shape both immediate perceptions and ultimate experiences of the health system.

Addressing such interactions requires going beyond narrow considerations of income and affordability as often currently conceived under UHC. It requires a broader, more intersectional approach, looking within and across households at the distribution of and access to resources. As argued by Sen and Iyer, this means tackling questions such as the following: "When health resources are scarce, what criteria are used to determine who gets access to them within the household? Even when policies are designed to augment household resources through public insurance or other schemes, are they sensitive to power relations and distributional challenges within households and across different sets of households, and do they attempt to mitigate them?"³⁴ For groups at the bottom of the socio-economic order, only focusing on economic barriers to access is not sufficient. Other forms of subordination and disadvantage such as ethnicity, gender, disability, widowhood, or caste can be barriers that call for sustained and focused policy attention.

An important issue that often comes up in the context of addressing the health needs and barriers faced by groups such as women or adolescent girls is whether this implies a form of targeting. If so, does it conflict with the basic premise of UHC, namely, universality? We believe this may be a misdirected debate. By arguing for attention to the specific needs and disadvantages

of particularly deprived and subordinated groups, we are insisting on the importance of recognizing social factors and power relations that go deeper than household poverty alone. Without this attention, such groups tend to be excluded and marginalized and their needs and circumstances ignored or distorted. It is only by addressing the rights and need of these groups that UHC can be truly universal and inclusive of all and not only focused on the single dimension of economic inequality across households.

Partial approach to health system components

In addition to its weakness in relation to access, the traditional approach to UHC suffers from another inadequacy. WHO has long defined the building blocks or components of a health system to include not only financing and services but also the health workforce, access to medicines /diagnostics /supplies, data and health information systems and the critical function of health governance. It bears emphasizing that insufficient attention to these other components can make UHC unachievable since they are essential ingredients of a well-functioning health system.

Policymakers know, of course, that all of these components matter. Yet, too often, discussions on UHC and on the health system occur in separate silos to the detriment of both. A central argument of this paper is that policies to achieve UHC need to address all of the health system building blocks as defined by WHO, not only financing and service provision. Such an approach is not without precedent. In India, the High-Level Expert Group on UHC set up by the Planning Commission in 2010 took such a broad approach. It addressed health system components by focusing on financing and financial protection, health service norms (including essential packages), human resources for health, access to medicines and medical devices, management and institutional reforms (including information systems and regulation) and community participation.³⁵

Such a broader approach to UHC allows for attention to be paid to issues that may otherwise be ignored,

34 Sen and Iyer 2019: 4.

35 Planning Commission 2010.

such as gender inequalities and hierarchies in health workforces and in the provision of unpaid care in families and communities, the role of women and girls in community participation and accountability processes, and whether gender, age and other data are collected and used effectively in health management information systems. Such issues are not only important in themselves but can have significant impacts on the availability of, access to and quality of health services, on whether financing mechanisms function equitably and on ongoing monitoring and accountability.

Some might argue that to overcome the limitations discussed above, the approach to UHC not only needs to include all health system building blocks but should go further to address even broader social determinants of health. Socio-structural factors

including cultural, socio-economic, geo-political and legal environments are critical contextual factors that will influence not only the trajectory but also the time taken to strengthen health systems on the path to UHC. A further broadening along these lines would be in consonance with the SDGs themselves.

This paper does not, for reasons of length and focus, address the broader social determinants of health, especially those contained in SDGs 1, 2 and 8 and their relevant targets (see Annex 2). However, it takes a needed step in this direction in the context of SDGs 3 and 5 (on health and gender equality) by applying a systematic gendered approach to the key building blocks of the health system. We turn to this discussion next.

2.

AN ANALYTICAL APPROACH FOR CONSIDERING GENDER, UHC AND HEALTH SYSTEMS

Strong health systems are essential for advancing towards UHC and ultimately improved health outcomes.³⁶ We apply WHO's analytical framework for health systems³⁷ to assess the gendered implications for UHC.

As previously noted, the building blocks of the health system include governance, health service delivery, health information systems, human resources, financing and medical products and technologies.³⁸ Financing, the formal and informal health workforce and medical products and technologies are key input components of service delivery. Leadership and governance and health information systems are cross-cutting components that provide the basis for overall policy and for the regulation of the other building blocks. How well the building blocks work, individually and in combination, affects the ultimate goals of health outcomes along with equity, responsiveness, handling of financial risk and efficiency.

Applying a gender lens to UHC by examining the health system entails recognizing and analysing how gender power relations affect all six of the health system building blocks. Table 1 provides an illustrative list of gendered questions to be considered in appraising the evidence. It should be noted that these questions are starting points and, as countries gather momentum in policy and programme implementation, additional questions may be raised requiring further investigation.

³⁶ Kieny et al. 2017.

³⁷ WHO 2007.

³⁸ Ibid.

TABLE 1:

Applying a gender lens to UHC through a health systems approach

Financing	What is the extent of financial protection of essential services for addressing the health of adolescents and women? Are they affected by out-of-pocket payments?
	How is coverage for informal workers (e.g., in subsistence farming or self-employment) financed?
	Are health insurance premiums affordable for women in the informal economy?
	Are services financed to ensure that women are not penalized for inability to pay at the point of service delivery?
	Do co-payments exist for services and how does this impact on intra-household claims on resources?
Health services	Do service packages include a comprehensive range of sexual and reproductive health services needed by women, men and adolescents (older and younger), including services for violence against women across the life-course? Are beneficiaries aware of their service entitlements?
	Do they pay attention (e.g., ensuring privacy and confidentiality) to providing services viewed as 'sensitive' or stigmatizing?
	Is service provision designed to ensure access for adolescents and women, especially for sexual and reproductive health (SRH) services such as contraception, safe abortion and post-abortion care?
	How does service provision ensure that women's disproportionate responsibility for childcare, infant feeding and caring for the ill and infirm does not delay or prevent their access to and utilization of health care?
Health workforce	Do the financially covered services have adequate staffing (mix, competencies, geographical or other distribution) to meet the needs of the population covered, especially women and adolescents?
	Are health workers trained adequately to ensure ethics and equity in the services they provide? Do health workers abide by the principles of equality and non-discrimination in their response to specific groups of clients based on perceived ability to pay, gender, race or other such criteria?
	Are they trained at all levels to provide respectful care and to prevent disrespect and abuse? Is such training integrated into the core curricula for health staff?
	Are there gender and other socially based hierarchies among health workers? Are policies, programmes and training designed and implemented to reduce such hierarchies and their impacts on pay, conditions of work, interpersonal relationships and job satisfaction?
	Are policies designed to ameliorate the unpaid health care that women typically provide in the home, or do they take advantage of this labour and exacerbate its inequities?
Information systems	Are there data disaggregated by sex, age and other social criteria on population coverage under different health programmes and financing including insurance schemes?
	Are there data on barriers (e.g., geographic access, affordability, stigma) to women and adolescents in accessing services (e.g., violence against women, safe abortion)?
	Where such data are collected, are they analysed effectively and acted upon?
Access to medicines	How does expenditure on diagnostics and medicines differ for women and men and by socio-economic status?
	How do women and men within households and communities prioritize individuals' access to medical technologies, e.g., are boys or girls more likely be prioritized?
	How do drug stockouts impact on treatment adherence of women and men for chronic care? Is it gender differentiated?
Leadership/ governance	Who designs health financing including insurance policies? Are women or people from marginalized and vulnerable populations included in decision-making processes?
	To what extent are there policies in place guiding health services to be more gender-responsive? Do they have review procedures to ensure follow up?
	What are current regulations and policies for 'sensitive' services such as female genital mutilation (FGM) prevention, treatment of fistulae, safe abortion care and comprehensive sexuality education, which affect access, and how does this impact on women and girls from marginalized groups?

3.

STATE OF THE EVIDENCE: GENDER, UHC AND HEALTH SYSTEMS

In this section, the available evidence for each of the six health system building blocks is examined. Where appropriate, more detailed illustrations of country experiences are presented in boxes, drawing from a synthesis of five country cases: Brazil, Ghana, Mexico, Rwanda and Thailand. The countries were selected based on diversity in terms of their geographic location, stage of economic development and approaches to financing of UHC. Where gaps exist, additional country experiences will be cited.

Some countries are making considerable progress towards UHC (e.g., Ghana and Rwanda). Others, such as Mexico and Thailand, are considered to have achieved UHC. The content of reforms, financing and benefit packages also vary. With respect to financing, for instance, community-based health insurance (CBHI) in Ghana and Rwanda covering the informal and rural economies operates alongside social health insurance (SHI), which typically focuses on the urban formal economy. In contrast, middle-income countries such as Brazil, Mexico and Thailand fund UHC primarily through taxation. A summary overview is presented in Table 2.

It is important to bear in mind that although the evidence for each of the health system building blocks is presented separately, they are inter-connected. While unique in terms of scope, content and function, they are closely linked both conceptually and at the point of policy and programme implementation. Therefore, while an attempt will be to present the evidence linearly within the key UHC and health systems dimensions, there are instances when topics will be deliberated in the logical order of the argument in which they arise.

3.1 Health financing

In this section, we focus on the gender implications of two key elements of health financing: mandatory pre-payment mechanisms and demand-side financing (DSF). We focus on mandatory pre-payment mechanisms given their prominence in recent years in low- and middle-income countries (LMICs) as a mechanism for extending financial coverage and protection to the informal sector. DSF (through cash transfers and/or vouchers) has also gained currency over the past two decades as a component of broader social protection programmes. We pay special attention to DSF in this paper because it is a form of targeting within universalism, primarily targeted towards women, and has been promoted as an approach for addressing issues of affordability and improving access, particularly in relation to reducing maternal mortality.

3.1.1. Mandatory prepayment schemes

Publicly financing health systems through either tax revenue or pre-paid, mandatory health insurance (i.e., SHI, CBHI) or a combination of both have been recommended as the most equitable route towards

TABLE 2:
Overview of country case studies (UHC reforms, financing and benefit packages)

Country	Brazil	Ghana	Mexico	Rwanda	Thailand
(GDP/capita)	(\$11,339)	(\$1,604)	(\$9,741)	(\$619)	(\$5,473)
Reform	1988: Unified Health System (SUS). Publicly-funded services run at the municipal level.	2004: National Health Insurance Scheme. National network of CBHIs combined with national social security (formal sector) insurance scheme.	2003: Seguro Popular. Publicly funded 'insurance' system for poor and informal sector to reduce disparities with social security in formal sector.	2003: Mutuelle de Santé. Heavily subsidized CBHI system integrated into a national network combining local accountability with national pooling and cross-subsidization.	2001: Universal Coverage Scheme. Newest and largest scheme covering everyone not included in two schemes for formal sector workers.
Financing and benefits covered	General federal government revenues pooled at municipal level. Comprehensive benefits divided into three tiers: basic, specialized and high complexity.	General tax revenue combined with payroll tax of social security beneficiaries (formal sector) and limited premium contributions from beneficiaries (except most vulnerable). National pool with fee-for-service payment to fund a benefits package that covers 95 per cent of reported health problems.	Government budget transfers. Original idea of enrollee premium tied to income largely dropped. Package covers 95 per cent of causes for hospital admission.	Budget transfers (from tax revenues and donor aid) combined with sliding scale member contributions. National benefits plan with some scope for variation by each <i>Mutuelle</i> branch; must at least cover all services/drugs at health centres.	Solely general government revenues. Strong incentives for efficiency through various forms of active purchasing, global budgets and provider payment. Comprehensive benefits; includes both curative and preventive care; recently added HIV treatment.

Source: WHO 2014: 2.

UHC.³⁹ As described earlier, publicly funded and pre-paid mandatory schemes have the potential to (1) build solidarity through cross-subsidization (i.e., rich to poor and healthy to sick), (2) improve access and utilization by the most marginal, including women, and (3) reduce the financial burden on women and households. These improvements are necessary to reach the twin goals of universal coverage of effective health services and financial protection from the costs of accessing these services.

However, the extent to which countries can rely on public funds for their health systems is a function of the size of their formal economy and resulting tax base as well as subject to other competing claims on public resources. Upper middle-income countries such as Brazil, Mexico⁴⁰ and Thailand⁴¹ rely largely on a combination of tax revenue, which covers the financial contributions of those who are economically vulnerable (i.e., poor, children, elderly, informal sector), and compulsory SHI, which covers those who are formally employed and salaried. In contrast, low-middle- and low-income countries (e.g., Ghana and Rwanda), with

39 WHO 2010a.

40 Andión Ibáñez et al. 2015.

41 Tangcharoensathien et al. 2015.

relatively limited potential for generating tax revenue given the size of their formal economy, depend on a combination of compulsory SHI (covering formal sector and often civil servants), CBHIs, overseas development assistance and out-of-pocket payments (OOPs).

CBHIs: An equitable alternative to user-fees?

In low-middle- and low-income countries, the primary challenge is extending financial coverage to the informal sector. While middle-income countries have been able to progressively provide financial coverage to the informal sector through tax revenue, this avenue remains limited in lower-income settings. In Ghana and Rwanda, CBHIs emerged as an alternative to user fees and have taken centre stage. CBHIs are often driven by donors as a promising approach for extending population coverage, increasing revenue generation and improving financial protection under the UHC umbrella. Although there is considerable variation in the design, scope, premiums and entitlements under CBHI schemes, they have two defining features: They are typically voluntary; and they are usually based on principles of solidarity among individuals with the same location, occupation, ethnicity, religion and/or gender.⁴²

In both Ghana and Rwanda, CBHIs were integrated into national funding and pooling schemes but remained autonomous in terms of being community- and district-managed. Evident from both these countries are the trade-offs between the levels of membership premiums on the one hand and the financial protection and benefits offered on the other.⁴³ As Chuma et al. argue, when the membership premiums are kept at a low level to ensure affordability and allow a larger enrolment of the poorer population, the actual revenue that is generated and the financial capacity of the insurance pool remains low.⁴⁴ This means the level of financial protection and range of services offered in the benefit package are relatively small, ultimately limiting the attractiveness of the scheme.

From the literature, it is evident that much of the focus remains on addressing exclusion based on economic status. In Thailand, population coverage increased from about a third of the population in 1991 to over 95 per cent in 2003 through a pro-poor intervention that entailed the Government subsidizing the inclusion of the near-poor population into the Universal Coverage Scheme⁴⁵ Alongside governments, donors have also played a role in ensuing coverage of the poor. This has been the experience in Rwanda where *Mutuelles de Santé*, a mandatory CBHI scheme that provides coverage to the rural population and informal sector through donor funds, subsidizes premiums for those who cannot afford them⁴⁶ Without donor funding, the scheme's sustainability and ability to build cross-subsidies across a large number of risk pools would have been a challenge (See Box 1).

While subsidies such as these can expand population coverage, it is not only the poor who are left out of CBHIs. Viewed through the lens of gender and intersectionality, CBHIs often exclude the vulnerable and marginalized based on other markers of exclusion (gender, location, language, race, religion, etc.), the very groups that the schemes are seeking to reach.⁴⁷ This is illustrated by the experiences with CBHIs schemes targeting the informal sector under the NHIS in Ghana and targeting poor households under the Rashtriya Swasthya Bhima Yojana (RSBY) in India (see Box 2). In both these cases, women and other marginalized groups (Dalits, tribal communities, non-Hindus in India; poor women in the informal economy in Ghana) were not explicitly targeted for subsidies, and as a result were excluded due to unaffordability of premiums in Ghana, to gender power relations within households in India and to inadequate administrative and managerial capacity in both countries.

42 UN Women 2015: 342.

43 Mathauer et al. 2017.

44 Chuma et al. 2013

45 Yu and Nonkhuntod 2017.

46 Chuma et al. 2013.

47 Averill and Marriot 2013.

BOX 1:**Subsidizing *Mutuelles de Santé* for universal coverage in Rwanda**

CBHI schemes have been part of an overall strategy of the Government to rebuild the country's health system after the 1994 genocide. *Mutuelles de Santé* were piloted in three districts in 1999 and later extended to other districts. The *Mutuelles* enrol entire households and provide a minimum service package at the primary care level as well as a complementary services package at district level. Users contribute through co-payments, but the poorest quarter of the population is exempt thanks to international donor funding. The service package includes family planning, antenatal and postnatal care, childbirth, HIV testing and treatment as well as prescribed drugs. By 2011/2012, the coverage of the *Mutuelles* had reached 91 per cent of the population. Together with pre-existing private and social insurance schemes, this has brought Rwanda close to universal coverage within a decade. The importance of the subsidy in expanding population coverage is clear, although calling this UHC is questionable. Important as the covered services are, they do not include many primary care and higher level services that should arguably be covered by a well-functioning health system.

Source: UN Women 2015: 342.

BOX 2:**Excluding the poor and marginalized women: The NHIS in Ghana and RSBY in India****Ghana and NHIS**

The National Health Insurance Scheme (NHIS) was created as a 'pro-poor' health system, alleviating the need to pay out of pocket at the point of service delivery and specifically through District Wide Mutual Health Insurance (DWMHI) schemes. DWMHI membership is voluntary and schemes are managed at the district level. Within limits set by the NHIS, DWMHI are able to set their own premiums. However, challenges with variability in premiums and criteria for establishing the socio-economic status of potential members have been identified. Affordability of premiums remains an issue for those in the poorest quintiles, most of whom are in the informal sector. The informal sector employs two fifths of employed Ghanaians aged 15 years and older, and sex-disaggregated data reveal that it employs a larger percentage of currently employed females (47.8 per cent) than males (35.5 per cent) (Ghana Statistical Service 2014).

A study of women in the informal economy revealed that "...while the informal workers who participated in the study have welcomed the idea of the NHIS, there are significant barriers to them accessing it. The major factor for poorer workers was the cost of the premiums, which often sit well above the mandated minimum in urban areas. For better off workers, the major barrier was the chaotic administration of the district schemes, which meant that a significant amount of time had to be spent trying to register with the NHIS. It was also discovered that there has been very little direct involvement of informal workers particularly women in either the design or the ongoing management of the scheme, with the result that it does not take into account the particular needs of informal workers... it was concluded that...NHIS reflects the wider inequalities of Ghanaian society and is itself reproducing them... The implication is that if the NHIS is to ever truly promote the ideal of universal access to healthcare, systemic changes in social and economic policy are necessary" (Alfers 2013: 1).

India and RSBY

Rashtriya Swasthya Bhima Yojana (RSBY) is a nationwide Indian scheme catering to the needs of poor and informal sector workers in parts of some states, providing coverage for households below the poverty line (BPL). Up to five members may be insured in a household, entitled to receive cashless, in-patient services in empanelled public and private hospitals, with a ceiling on expenses at the household level per year. Through the lens of intersectional equity, there are several challenges associated with the scheme. Enrolment rates are lower in remote areas inhabited

by Dalits and tribal communities and among socio-economically backward castes. Further, certain categories of poor families eligible for inclusion in the scheme are systematically kept out: those without BPL cards; those that have lost the 'household head' whose name appears on the government's list; and migrants who cannot present themselves during enrolment drives. In some instances, RSBY cards were more likely to be found in the possession of better-off Hindu households than among poor Dalit and non-Hindu households.

"Women in these uninsured households - products of multiple intersecting sources of disadvantage - are also the ones most likely to suffer from deep poverty, an amalgam of economic, caste and gender disadvantages. Even among insured households, more male members tend to get enrolled than their female counterparts. At a national level as estimated on 31 March 2012, the ratio of male to female enrollees was 3:2 with significant state-level variations (Cerceanu 2012). Gender relations may determine the selection of the three dependents to be included in the five-member list for each eligible household (other than the head of household and his/her spouse). Women have very little influence on this selection (Cerceanu 2012), which is usually biased against daughters in families that have more than five members (Sun 2011). In joint families, the brothers and sons of the household head may make it to the list at the expense of unwanted girls, daughters-in-law and widows" (Sen and Iyer: 12-15).

Have there been attempts to foster solidarity going beyond economic status? In Rwanda, within *Mutuelle de Santé*, churches and community members took deliberate steps to build solidarity and inclusion in helping to pay enrolment fees for the poor, widows and orphans.⁴⁸ Such initiatives to build solidarity by specifically targeting groups that are marginalized are not, however, widely cited in the literature. While fostering solidarity and inclusion at a community level is critical, it needs to be supported by national legislation and policies anchored in a human rights-based approach that articulate a commitment to equity and non-discrimination.

The other side of the UHC insurance coin is financial protection. A growing body of evidence is unequivocal: Even when there is financial coverage through either publicly funded health systems or pre-payment schemes, beneficiaries may still have to bear the direct costs (e.g., payment for drugs, supplies, transport) and indirect costs (e.g., loss of income) of seeking care. This is especially the experience with CBHIs, which often cover a very limited package of health services and sometimes require co-payments.⁴⁹

As Ravindran observed, women shoulder a higher burden of OOPs for health-care services than men who have similar levels of insurance coverage, largely due to non-coverage or limits on coverage for sexual

and reproductive health (SRH) services.⁵⁰ Therefore, as noted earlier, financial coverage does not automatically translate into access and utilization, particularly when services are not free at the point of provision. In such contexts, OOPs typically limit women's access to health care due to their lack of control over financial resources. According to WHO "[w]omen incur more out-of-pocket payments than men... [P]aying for delivery care and other reproductive health services places a higher financial burden on women...[and] out-of-pocket expenditure may prevent more women than men from utilizing essential services."⁵¹

The burden of OOPs on women is also borne out in the country case studies. It is evident from both Ghana and India (Box 3), that even under pre-paid health insurance schemes, women—particularly those who are poor or less-literate—are offered inadequate financial protection. In India, the lack of a comprehensive benefit package responding to the priority health needs of women not only challenges access but also has implications for health outcomes.⁵²

Recent evidence from across several countries, including Ghana and India, also indicates how the rights of women are violated when they are detained in health facilities for non-payment of fees (see Box 4).⁵³

50 Ravindran 2012.

51 WHO 2010b: 23.

52 RamPrakash 2018.

53 Yates et al. 2017.

48 Schneider and Diop 2004.

49 Chuma et al. 2013.

BOX 3:**Financial protection missing the mark for women under the NHIS in Ghana and the CMCHIS in Tamil Nadu, India****Ghana**

In Ghana, under the NHIS, exemptions were introduced for certain groups of individuals to improve their access to health services. These include pregnant women, children under 18 years of age, elderly people over 70 years, the indigent (poor and vulnerable) and persons with mental health disorders. In addition, pregnant women, indigents and persons with mental health disorders are not required to make any payment for processing fees before being registered under the NHIS. The free maternal health policy sought to enhance the utilization of antenatal care (ANC), skilled attendance at childbirth and postnatal care. The policy entitled a pregnant woman registered with the NHIS to free health services to cover pregnancy, labour and birth and up to three months postpartum. However, it was found that women and their families still bore considerable expenses including payment for drugs and ultrasound scan services. Sixty-five per cent of the women used savings, while 22 per cent sold assets to meet the out-of-pocket costs. Some women were unable to afford payments due to poverty and had to forgo treatment (Dalinjong et al. 2018).

Migrant girls and women who work in Accra as head porters reported challenges in obtaining insurance and accessing health care. Although eligible (poor, pregnant) for NHIS exemptions, they experience challenges in accessing formal health services, even when needing care. Financial barriers prevented them from registering with the NHIS, renewing their expired health insurance policies or taking time away from work. Both insured and uninsured migrants did not seek formal health services due to the unpredictable nature of OOPs. Catastrophic and impoverishing medical expenses also resulted in them searching for work to repay loans and hospital bills. They also reported being unable to access care either because they did not have a valid health insurance card in Accra or they lost their cards or left them behind when migrating (Lattof 2018).

Tamil Nadu, India

Tamil Nadu, a southern state in India with an estimated 80 million population, has been implementing the publicly financed Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) since 2009 for households with an annual income less than US\$972. The scheme covers all members of the enrolled households for a range of surgical and medical procedures, mostly tertiary in nature, provided through empanelled public and private hospitals. Doctoral research was undertaken between 2015 and 2018 to study the gendered dimensions of the scheme's design, implementation and impact. Findings indicate a number of exclusions and gender-based barriers to women benefitting from the scheme. In spite of both sexes having comparable enrolment rates, the study revealed a lower share of insurance claims from females than males. This was especially surprising as women had equal rates of hospitalization to men for sex-neutral illnesses. The design of the scheme was found to exclude financial protection for non-communicable diseases, SRH procedures (except hysterectomies) and other secondary or outpatient care procedures frequently sought by women. Due to lack of documentation, women were at risk of being excluded from scheme entitlements even within male-headed 'enrolled households'. The study found insurance-based mechanisms distorting public health-care systems on which the poor, women and marginalized sections of society depend in several ways. The nature of paid/ unpaid care work and the bargaining position of women within the household determined their utilization of scheme benefits. Ineffective awareness generation, inequitable distribution of hospitals, cherry-picking, information asymmetry and lack of effective grievance redressal formed the health system barriers for women. By accentuating existing barriers or imposing new forms of barriers to access, the publicly financed health insurance scheme was thus found to be gender blind rather than gender neutral (RamPrakash 2018).

BOX 4:**Detentions of women in hospitals for non-payment of fees**

“In some parts of the world it is common practice for patients to be detained in hospital for non-payment of healthcare bills. Such detentions occur in public as well as private medical facilities, and there appears to be wide societal acceptance in certain countries of the assumed right of health providers to imprison vulnerable people in this way. The true scale of these hospital detention practices, or ‘medical detentions’, is unknown, but the limited academic research to date suggests that hundreds of thousands of people are likely to be affected every year in several sub-Saharan African countries and parts of Asia. Women requiring life-saving emergency caesarean sections, and their babies, are particularly vulnerable to detention in medical facilities. Victims of medical detention tend to be the poorest members of society who have been admitted to hospital for emergency treatment, and detention can push them and their families further into poverty. They may also be subject to verbal and/or physical abuse while being detained in health facilities. Such detentions occur in public as well as private medical facilities, and there appears to be wide societal acceptance in certain countries of the assumed right of health providers to imprison vulnerable people in this way. The practice of detaining people in hospital for non-payment of medical bills deters health-care use, increases medical impoverishment and is a denial of international human rights standards, including the right not to be imprisoned as a debtor and the right to access to medical care.”

Source: Yates et al. 2017: 1.

3.1.2 Demand-side financing (DSF)

Given the challenge of OOPs and other barriers to accessing care, there has been increasing attention to addressing these through demand-side financing (DSF). The past two decades have witnessed increasing use of DSF, a form of targeting within universalism, as a mechanism for improving utilization of under-used services. This is best exemplified by the increased attention being paid, starting in the MDGs-era, to the need to improve access to a subset of services for specific populations. DSF programmes aimed at reducing maternal mortality (MDG 5) through cash transfers and vouchers are perhaps the most widely implemented interventions across several regions. The underlying assumption is that

the potential beneficiaries of the scheme face mainly financial barriers including transport costs and opportunity costs of time relating to household responsibilities, including care for dependents and income generation.⁵⁴ At the same time, the incentives also seek to address non-financial barriers relating to perceptions of a lack of need or demand for services on the part of women and their households.

The ILO’s 2015 Social Protection Report concluded that DSF has increased utilization of health services, resulting in improved maternal and child health (MCH) outcomes.⁵⁵ Table 3 presents the key findings from a systematic review of the enablers and challenges underlying the effectiveness of DSF in the context of MCH.⁵⁶

54 Hunter and Murray 2017.

55 ILO 2014.

56 Hunter and Murray 2017.

TABLE 3:

Factors enabling and challenging DSF for improving access to MCH services

DSF is successful in improving access when:	DSF is less successful in improving access when:
<ul style="list-style-type: none"> • Accompanied by investment in health facilities or staff [see Box 1 on Rwanda] • Well-supported and supervised community-based workers • Attention to programme eligibility in terms of beneficiaries • Size and timing of cash payments • Adequate package of entitlements (including transport costs) in voucher schemes. • Participation of community leaders and women’s groups in awareness raising. 	<ul style="list-style-type: none"> • Insufficient attention paid to vulnerable and marginalized groups (e.g., migrants, young and multiparous women) in terms of inclusion criteria and distribution mechanisms of benefits • Lack of investment in improving service delivery, quality of care, availability of staff • Staff charge informal fees once at the facilities • Perceived poor behaviour of staff at participating facilities • Overly bureaucratic process for determining eligibility • Poor awareness of the programme among target groups.

Source: Hunter and Murray 2017.

In addition to improvements in access to and uptake of services, cash transfer programmes can also reduce gender poverty gaps and increase women’s access to personal income.⁵⁷ These findings are important for their potential to improve women’s status within the household as well as decision-making over household resources and sexual and reproductive health care. At the same time, equally important but neglected by donors, programmes and researchers are the following questions. To what extent does DSF:

1. perpetuate and reinforce gender norms and stereotypes (e.g., holding women primarily responsible for the health and well-being of their children)?
2. undermine solidarity by placing individual responsibility on the recipients, who are primarily women?

These questions demand prioritized investigation, recognizing that in societies with high gender inequality, maternal mortality not only arises because

of poor financial access but is located and constructed in social, economic and cultural institutions, both formal and informal, that undervalue women and girls. In such instances, tackling the proximate financial and geographic barriers on the patient and service delivery side are insufficient. This requires multi-sectoral policies and interventions across the SDGs (combining poverty alleviation, food security and nutrition, safe housing, gender equality, female education, secure employment, etc.), anchored within a rights-based approach to health and gender equality.⁵⁸

In sum, financing mechanisms are primarily designed around risk protection addressing financial barriers arising from economic exclusion at the household level. Moreover, they do not pay explicit attention to gender and other markers of exclusion and discrimination (race, caste, ethnicity, origin, religion, etc.) in either design, implementation or impact. Women, particularly those who are poor and marginalized, continue to experience financial barriers in accessing health services and, when they do access care, bear

57 UN Women 2015b.

58 OHCHR 2010.

OOPs particularly for services relating to their sexual and reproductive health-care needs. Practices such as detaining women in hospitals (maternity and other) on grounds of non-payment of user fees continue in many contexts in violation of women’s human rights. Unless attention is paid to other forms of exclusion besides economic in their design, DSF and similar forms of targeting within universalism will be less effective and equitable in improving access for vulnerable and marginalized groups.

3.2 Health services and delivery

Under UHC, the evidence indicates that there is often a gap between what the benefits package entitlements are on paper versus what the health system is able and ready to deliver. In this section, the evidence will be reviewed with respect to:

1. equity in access to services, with special attention to SRH services; and
2. quality of health services judged by respectful care, focusing on institutional violence as a gender and rights issue.

We focus on SRHR and institutional violence given that they disproportionately affect women and girls, particularly those who are caught at the intersections of gender and other forms of marginalization. The discussion illustrates that, unless policies and programmes aimed at ensuring access to quality health services are situated within a gender and human rights-based approach, they will fail to achieve the ambitious targets set in SDG3.

3.2.1 Equity in access to health services

In all the country cases, significant investment in service infrastructure has contributed to overall improvements in service availability and access. In Rwanda, the infrastructure designed to respond to the HIV epidemic has been scaled up to strengthen primary care and support an expanding package of health services based on need and equity. This has contributed to significant improvements in life expectancy and other health outcomes. In Brazil,

considerable progress in expanding community-based primary care was made through the Family Health Strategy.⁵⁹

However, across all the country case studies—and most notably in Brazil, Ghana and Mexico—despite significant progress towards UHC, health inequities persist across a range of services by location, socio-economic status, insurance status and type of provider (i.e., public or private), etc. In Mexico, a 2012 Health Secretariat report indicated that in almost 500 (of 2,488) municipalities in Mexico, more than 70 per cent of the population speak an indigenous language. These municipalities also had fewer health facilities, hospital beds health professionals (specialist doctors and nurses) and medical infrastructure than other municipalities. Moreover, these municipalities were 10 times more likely to have medical interns in charge of health facilities compared to others.⁶⁰ In Ghana, patients received differential treatment based on their NHIS status. Health facilities, especially private ones, had separate queues for NHIS card holders and those willing to pay OOPs from the beginning. The preference for those willing to pay OOPs was on account of delays in receiving reimbursements from the NHIS.⁶¹ In the face of OOPs, women, especially the poor, are often either discouraged from seeking or delay care and, when they do, incur significant costs.

These inequities result from a complex mix of intersecting factors. Challenges in addressing the social determinants of health and underlying factors shaping exclusion and discrimination, inadequate and poor distribution of health infrastructure in relation to health-care needs and poorly functioning health systems overall heighten discrimination, inequity and inequality.⁶² These inequities also illustrate the working of the inverse equity hypothesis.⁶³ As observed by Sen and Govender “...whenever an innovation appears on the scene, it is often the ‘haves’ who will benefit first and most, leading to an initial worsening of inequality of both access and outcomes.

59 Atun et al. 2015.

60 Government of Mexico 2012.

61 Haw 2019.

62 Fried et al. 2013.

63 Victora et al. 2000.

This worsening may last for quite a while before it is reversed. Although this hypothesis is not specific to UHC, it provides a salutary warning against assuming that universality will automatically translate into equitable access.”⁶⁴

Brazil’s *Estratégia de Saúde da Família* (ESF, Family Health Strategy) is intended to reach those hardest to reach and most marginalized. Health access and health outcomes in the country traditionally showed significant disparities by socio-economic status, gender and race. Under the ESF programme, community-based primary health care (PHC) was the key initiative for delivering UHC in the country. Evidence suggests that the PHC expansion, including accelerated expansion in poorer and more deprived areas as well as outreach services by community health workers, contributed to overall reductions in mortality for all racial groups. As a result, black Brazilians experienced a two-fold greater reduction in mortality than white Brazilians.⁶⁵

But, as noted in the country cases below, ‘essential service packages’ can be gender-biased or discriminatory when they exclude and fail to address the SRH needs of women and girls across the life-cycle. Often essential service packages include maternal health and safe delivery but exclude a broader but equally essential range of services (e.g., access to contraception, safe abortion, cervical cancer screening and treatment, adolescent health care and assistance/treatment in cases of violence including rape).

Box 5 below highlights in brief the gender inequalities in relation to access to safe delivery for adolescents in Brazil, SRH services in Mexico and legal restrictions and geographic disparities in abortion access in Thailand.

As is evident from Box 5, there are various non-financial barriers that impact on access to SRHR services, particularly those that are politically contested (e.g., safe abortion, access to contraception for adolescents). These range from restrictive laws and policies, gendered cultural norms and practices and poor-quality care. This is in effect a violation of women’s

sexual and reproductive health rights. As Sen and Govender argue, “Attention to human rights would have meant reorienting service provision as well as data gathering and monitoring systems to ‘follow’ the individual rather than the services provided, but few health reforms have taken this approach.”⁶⁶

3.2.2 The right to respectful and non-discriminatory care

There has been renewed focus on quality under target 3.8 (SDG 3). This is based on evidence indicating that despite improvements in access to essential health services during the MDG era, poor service quality remains a key barrier to reducing maternal and child mortality, particularly among those hardest to reach in LMICs.⁶⁷ Weak health systems, characterized by poorly trained staff, lack of essential inputs and poor infrastructure, particularly in lower-level facilities, compromise service delivery and ultimately both access to and quality of care.

This has translated into stepped-up calls for improving the quality of health services, as illustrated by a joint report by WHO, the Organisation for Economic Cooperation and Development (OECD) and the World Bank entitled *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage*.⁶⁸ The report indicates that while quality of care is primarily a challenge in LMICs and results in poor health outcomes, it is also a problem in high-income countries, where 1 in 10 patients are harmed while receiving health care. In LMICs, wider challenges relating to the slow pace of social and economic development spill over into the health system, where poor sanitation and lack of water continue to hamper service delivery. Even when basic infrastructure is addressed, poor distribution of health services challenges access.

With respect to gender and specifically women, the joint report indicates that, even when financial and geographic barriers have been addressed, lack of access to respectful and compassionate care and voice

64 Sen and Govender 2015: 234.

65 Hone et al. 2017.

66 Sen and Govender 2015: 230.

67 WHO et al. 2018.

68 Ibid.

BOX 5:

Inequities in service coverage and access to SRHR services: Brazil, Mexico and Thailand

Brazil

Brazil has made substantial progress in improving access to most maternal health and child health interventions and has experienced success in reducing regional and socio-economic inequalities in access to these interventions. However, age disparities persist in access to pregnancy care for adolescents and young women, even though more than 20 per cent of all infants in Brazil in 2008 were born to adolescent mothers (Victora et al. 2011). The proportion of sterilizations has decreased, yet lower-income women are more frequently sterilized. Abortions are mostly illegal, but women with more money have better access to safe abortions in private clinics. Poorer women generally self-induce abortion with misoprostol, seeking treatment of complications from public clinics (Diniz et al. 2012).

Mexico

Under *Seguro Popular* there has been significant progress in insurance coverage, in access to health services and in reducing the prevalence of catastrophic and impoverishing health expenditures, especially for the poor. However, inequalities persist in relation to sexual and reproductive health services. Services (prevention, early detection and treatment) relating to cervical cancer are unevenly distributed across the country, with incidence and death rates remaining higher in the poorer, southern states than elsewhere (Andión Ibáñez et al. 2015).

Thailand

In Thailand, almost all relevant SRH services envisioned in the Programme of Action of the International Conference on Population and Development (ICPD), including treatment of reproductive tract cancers, have been included in the UHC benefit package (Tangcharoensathien et al., 2015). However, access to safe abortion is a challenge. Although abortion is legally restricted, both safe and unsafe abortions are widespread across all socio-economic groups. Many take place in private sector facilities, in unmarked abortion clinics or by self-induction. Factors influencing access to abortion services include the socio-cultural and religious beliefs and attitudes of providers and politicians as well as service availability including service providers. The majority of providers are located in Bangkok, which is a barrier for women living outside the capital. The case of Thailand illustrates that legal reforms need to be accompanied by improvements in availability and acceptability of safe abortion services to improve access (Arnott et al. 2017).

in decision-making during service delivery not only affects women's experiences of services but also has implications for health outcomes. This is evident from numerous countries including India, where an increase in institutional deliveries from 14 per cent to 80 per cent had ambiguous results in terms of maternal and child mortality because of poor quality of care.⁶⁹

Quality health care has measurable characteristics: effectiveness, safety, people-centredness, timeliness, equity, integration of care and efficiency.⁷⁰ Through a human rights lens, the AAAQ approach links quality to availability, accessibility and acceptability of services.

69 Ng et al. 2014.

70 WHO et al. 2018.

Acceptability is a critical dimension of effective coverage in the context of SRH; in other words, "SRH services must be acceptable to consumers, culturally appropriate and be sensitive to vulnerable groups".⁷¹ It goes beyond availability and accessibility to encompass cultural acceptability and respectful care free of discrimination based on gender, culture or religion.

At its core, acceptability deals with the relationship between health workers and patients. As noted by Govender and Penn-Kekana, people's experiences of the health system are shaped by the nature of their relationship with health-care workers. In turn, health-care workers' attitudes and behaviours are

71 Kähler et al. 2017: 5.

shaped by the social context in which they live and work.⁷² The gaps between the provider and patient with respect to gender, class, caste, ethnicity and other social stratifications (i.e., the social distance) are important in shaping the interaction. Gender roles, norms and relations, which are context-driven, shape perceptions, experiences and ways in which women and men as health-care users define their health and health needs. As is well established in the literature across a diverse range of settings, this in turn contributes to gender-based differences in treatment-seeking behaviour and communities' interaction with the health-care system across a range of conditions and services. Health workers, particularly those operating at the 'coal face' of service delivery, are central for providing quality, safe and effective health care and being responsive to communities and patients' needs. Their attitudes are therefore an important piece of the puzzle for facilitating access, particularly for the most marginalized and vulnerable.

Research from several countries indicates that women and girls suffer discrimination, violence, abuse and disrespect in health-care institutions, particularly in relation to maternity care and access to contraception.⁷³ As noted by Sen et al. "Across Latin America and in India, systematic documentation of religious, ethnic and racial minority women's interactions with providers speak of the 'triple burden' they face when seeking institutional childbirth".⁷⁴ Box 6 describes institutional violence in health facilities in Brazil and Mexico.

The Joint WHO/ OECD/World Bank report acknowledges the role of poor quality of care in maternal and neonatal mortality and specifically recognizes that a "growing body of research on respectful maternity care indicates that women experience poor interactions with health care providers and exclusion from care decision-making and are often not informed about the details of their care".⁷⁵ However, the report does not make the link between the right to health

BOX 6:

Institutional violence: Undermining quality of care and access in Brazil and Mexico

Brazil

An evaluation of the quality of abortion care for women admitted to public hospitals in three of Brazil's state capitals (Salvador, Recife and São Luís) found that it was far below the standards set by the Brazilian Government and pain management was frequently inappropriate. It also found other forms of discrimination, such as the postponement of curettage until night shifts. Continuity of care and provision of post-abortion contraceptive information were also almost absent. Abuse and disrespect in health care has been recognized as a form of institutional violence. The Perseu Abramo Institute report, based on interviews with 2,365 women and 1,181 men in urban and rural areas in all Brazilian states, reported that 53 per cent of women who were hospitalized for complications of abortion reported some form of violence from health-care providers (women and men), including refusal of information, failure to obtain consent, delay and neglect in assistance, being threatened with prison and verbal abuse. Among women asked about such violence during childbirth, 25 per cent reported some form of violence (27 per cent in the public sector and 16 per cent in the private sector), including verbal abuse and abuses such as refusal of pain relief and painful, repeated vaginal manipulation. Women at the top of the social hierarchy (white, married, with higher education) were less vulnerable to but not free from such violence (Diniz et al. 2012).

Mexico

In Mexico, institutional violence is a serious challenge for all women, especially indigenous women. A 2013 study of Jalisco in the north-west indicated that Huichol Indigenous reported abusive behaviour by local health personnel (Castro et al. 2015a). It has been argued that these forms of institutional violence are "embedded in both the country's medical education system and in the hierarchical power structures within hospitals. Discriminatory actions by medical providers certainly reflect personal prejudices, however, they also stem from the medical field's overarching norms that all too often portray women as inferior or undeserving of medical citizenship and other rights" (ibid.: 107).

72 Govender and Penn-Kekana 2008.

73 Maya et al. 2018; Sen et al. 2018; Solnes Miltenburg et al. 2018.

74 Sen et al. 2018.

75 WHO et al. 2018: 34.

TABLE 4:
Availability of health workers (density per 1,000 population) across country cases

Health worker density per 1,000 population	Brazil (2013)	Ghana (2010)	Mexico (2015)	Rwanda (2015)	Thailand (2015)
Nursing and midwifery	7.444	0.998	2.645	0.832	2.294
Physicians	1.852	0.096	2.231	0.064	0.47

Source: WHO Global Health Observatory 2018.

and the right to quality care as the critical linchpin for mobilizing policy and action towards arresting maternal and neonatal mortality. Consequently, it falls short in terms of recommendations and policy directions vis-à-vis the obligations of the state that are required for addressing issues of violation and inequality.

In sum, and despite significant progress towards UHC, inequities in access to services often persist along a range of intersecting dimensions including gender. Focused strategies to reach the most marginalized—can improve access to essential service packages for vulnerable groups. However, such packages can themselves be gender-biased or discriminatory. They need to include not only maternal health and safe delivery but also a broader range of essential services. There is growing evidence that poor quality of services, including disrespect and abuse in maternal care, is a driver of maternal mortality and morbidity, and can keep women from accessing services, especially women who are poor and marginalized.

3.3 The health workforce

The Global Strategy on Human Resources for Health: Workforce 2030⁷⁶ and the report of the United Nations High-Level Commission on Health Employment and Economic Growth⁷⁷ represent bold and unprecedented calls to action advocating for increased investments in human resources for health (HRH). This comes at a time when there is also recognition that HRH are a key part of resilient, people-centred health systems and essential to achieving UHC.⁷⁸ These global calls

for action are necessary and urgent responses to addressing the critical shortage of HRH in terms of both numbers and quality globally—but more acutely experienced in LMICs—as posing a severe challenge for the functioning of health systems.⁷⁹

3.3.1 Number and distribution of health care workers

Equitable access to health care depends not only on the number and quantity of health workers but also their distribution. The density of health workers measured by their number per 1,000 population is a gauge of their availability. Table 4 indicates the density of health workers (nurses, midwives and physicians) across the country case studies.

While there are more severe shortages in Ghana and Rwanda for both types of health workers compared to Brazil, Mexico and Thailand, inequalities in the distribution of the health workforce are present in all countries, challenging access for certain groups of the population based on geographic location and socio-economic status.

For example, despite relatively favourable availability of health workers overall, Brazil suffers from their unequal distribution. Health workers are concentrated in the richest sections of the country, leading to reduced access for the poorer regions and populations. This has persisted despite major health reforms focused on improved access to health services for the poor.⁸⁰ Similar problems are experienced in Thailand, where inequities in the distribution of health workers occur by geographic

⁷⁶ WHO 2016.

⁷⁷ High-Level Commission on Health Employment and Economic Growth 2016.

⁷⁸ WHO et al. 2018.

⁷⁹ WHO 2016.

⁸⁰ Sousa et al. 2012.

BOX 7:**Influence of gender on professional and personal experiences of health workers**

- Workforce structures and hierarchies
- Client-provider relationships
- The female composition of the workforce, particularly at the primary level
- The experiences of female nurses, community health workers and home carers, including the unpaid, underpaid, unsupported and disproportionately female workforces that often constitute the informal care economy
- The ways in which (especially) female workers' normal life experiences (for example, pregnancy, childcare) become problematized due to their incompatibility with male work models that do not take life course events into account
- Access to non-pecuniary rewards, continuing education and professional training
- Differences in wages
- Disparities in workplace safety knowledge
- Health worker mobility
- Perceptions of health and quality of life among health workers.

Source: Newman et al. 2011.

location (between capital city and other provinces) and between public hospitals and private facilities.⁸¹

Turning to countries with lower health worker density, the challenges are expectedly more acute. In Ghana, for example, despite a free Maternal Health Care Policy, poor access and low levels of utilization are a challenge especially for poor and marginalized women in the informal economy.⁸² This is driven in part by the concentration of doctors and university-trained nurses in the two major metropolitan areas, to the detriment of remote and rural districts.⁸³ In Rwanda—after the genocide resulted in many trained health workers fleeing the country—there is a shortage of competent trained health-care providers.⁸⁴ One of the interventions used by the Ministry of Health to overcome this was task-shifting and introducing community health workers in the context of HIV scale-up.⁸⁵

81 Sakunphanit 2016.

82 Alfors 2013.

83 Rachel et al. 2013.

84 Binagwaho et al. 2013a.

85 Shumbusho et al. 2009.

The above discussion (i.e., availability of health workers) primarily speaks to the formal economy of care and does not take account of the large numbers, particularly of women, who are involved in unpaid and poorly paid health work in families and communities, caring for ill family members or as community health workers or volunteers (i.e., the informal care economy). The health system is deeply gendered in terms of its composition, its professional hierarchies and seniority and ultimately the experience of the health system, both informal and formal and paid and unpaid (see Box 7).

Globally, although women account for 70 per cent of workers in the health and social sector, they are disproportionately located in nursing and midwifery, with male workers comprising the majority of physicians, dentists and pharmacists.⁸⁶ In sub-Saharan Africa, 68 per cent of community health workers are women, mostly young and mostly unpaid.⁸⁷ Although women often comprise more than two thirds of health workforces, they occupy lower-status health occupations and are poorly represented among more highly trained professionals and in positions of

86 Boniol et al. 2019.

87 ILO 2018.

management.⁸⁸ The under-representation of women in positions of leadership needs to be addressed through gender-transformative policies addressing gender biases and inequities in education and the health labour market.⁸⁹

3.3.2 Gender-based violence in the health workforce

There are numerous issues relating to gender discrimination and inequality that both challenge the personal and professional experience of health workers and often have adverse implications for service delivery and performance. However, given the focus of the paper and constraints of space, we will focus on one of the most critical but least addressed issues facing health workers: gender-based violence.

Nurses are three times more likely, on average, to experience violence in the workplace when compared to other occupational groups.⁹⁰ Of concern is the finding that they are subjected to verbal and physical abuse so frequently that these events are often accepted as 'part of the job'.⁹¹ In India, the prevalence of workplace violence against resident physicians in a tertiary facility was estimated to be 56-75 per cent.⁹²

Violence against health workers was reported in all case studies.⁹³ Such violence is committed by patients and their relatives and also—particularly emotional abuse and sexual harassment—by hospital co-workers. In several countries (although this is not true for all), a pattern seems to emerge whereby patients and their relatives are the main perpetrators of physical violence while staff are the main perpetrators of psychological violence. In Thailand, 72 per cent of cases of physical violence were committed by patients and the majority of cases of verbal abuse were committed by staff.⁹⁴ Further, female health workers not only experience higher rates of violence but also suffer greater physical and psychological harm from such violence.⁹⁵ In Mexico, younger health workers reported more abuse, and health workers who were separated or divorced and had suffered physical/sexual abuse during childhood were associated with physical/sexual abuse in adulthood.⁹⁶

Violence in the health system and specifically gender-based violence—despite its implications for the working environment, job satisfaction, patient outcomes and ultimately the performance of the health system—is an under-recognized and under-studied area. It requires critical attention in the context of

BOX 8:

Workplace violence and gender discrimination in Rwanda's health workforce

An investigation of the link between workplace violence and gender among health workers in Rwanda found that violence was experienced by 39 per cent of the health workers sampled, with similar rates of verbal abuse, bullying and physical violence among women and men and higher rates of sexual violence among women. These findings suggest that workplace violence is an occurrence that most health workers may feel they can or must live with, almost as a normal part of the job, but that the experiences of bullying and sexual harassment are more likely to result in a female health worker leaving a job. Gender inequality at work (unequal treatment and unequal access to jobs) was associated with increased odds of workplace violence. Gender-based violence at work emerged as one component of wider gender discrimination that reduces women's employment opportunities, penalizes them for their biological reproductive role and limits their economic freedoms. The gender-sensitive, multisectoral recommendations made by the stakeholder institutions and recent changes in Rwanda's labour law to address workplace violence are promising steps towards a goal of making the health sector safer and more gender-equitable for its workforce.

Source: Newman et al. 2011.

88 WHO 2019.

89 WHO 2019.

90 ILO 2003.

91 Speroni et al. 2014.

92 Tanu et al. 2016.

93 Díaz-Olavarrieta et al. 2001; ILO 2003; Newman et al. 2011; Tanu et al. 2016.

94 di Martino 2003.

95 WHO 2019.

96 Díaz-Olavarrieta et al. 2001.

advancing the health and rights of women as health workers in addition to being clients in the health system.

3.3.3 The informal/unpaid care economy

Alongside formal health-care delivery is the informal/unpaid care economy. The responsibility of caring, whether it is for children, the sick or the elderly, has traditionally across all societies fallen on women and girls. This was particularly severe in the wake of the HIV/AIDS epidemic, where in the context of weak and severely under-resourced health systems, girls and women often had little choice but to interrupt their education and employment in order to care for the ill.⁹⁷ As Langer et al. argue, “when care for the ill interrupts paid employment, it also contributes to the care giver experiencing isolation, burnout, and health problems”.⁹⁸

As noted by the ILO, as populations age—a phenomenon first in high-income countries but now increasingly so in LMICs—the burden of care for the elderly, as well as for household members who are ill (short-term or chronic) or with disabilities, often falls on women and girls.⁹⁹ A study of the determinants of informal care supply for older adults in Yucatan, Mexico, found that almost 80 per cent of caregivers were women and less than a quarter were men, with girls more likely to take on the role as caregivers.¹⁰⁰ A larger proportion of men in comparison to women worked while providing care, and women provided more hours of care work per month on average than men. The burden of unpaid care work is a barrier to women entering the labour force. It is reported that in 2018, more than 600 million working age women (compared to 41 million men) said that they were not able to do so because of unpaid care work. The ILO has called for urgent action to prevent a looming global care crisis.¹⁰¹ This is not only a crisis from the perspective of loss of economic empowerment for women but it also shifts the burden of care—including both financial and time costs—onto households. Thus if the burden of unpaid care work is to be addressed in the

context of UHC, it will require substantial investments in health systems, particularly in areas of long-term and palliative care, guided by principles of solidarity and integrating gender into policy and programme implementation.

In sum, the health workforce is deeply gendered in terms of its composition, its professional hierarchies, seniority, pay and conditions of work. It includes both formal and informal, paid and unpaid workers, with women typically being at the lower ends of the workforce hierarchy. Moreover, women and girls are disproportionately represented in unpaid health-care work. Violence against health workers, particularly those operating at the front line, is a growing challenge and remains largely under-recognized and unaddressed. This requires both urgent and critical attention in the context of advancing the health and rights of women as health workers.

3.4

Access to essential medicines and health technologies

The *Lancet* Commission on Essential Medicines Policies indicated that “Globally, a quarter of all health expenditure is on medicines. In many countries, the main source of financing for medicines is direct payment by the individual and households—this source is both highly inequitable and inefficient, and its reduction is a key target for UHC.”¹⁰² In the context of UHC, multiple health financing schemes imply variations in benefit schemes including access to medicines and health technologies. This is the case in Mexico, where drug coverage differs by social health protection scheme.¹⁰³ It was found that between 78 and 89 per cent of beneficiaries of private and public-sector insurance schemes received their prescriptions free of charge compared to only 60 per cent of beneficiaries covered under *Seguro Popular* (generally covering poorer population groups).

97 UNESCO 2010.

98 Langer et al. 2015.

99 ILO 2018.

100 Angst et al. 2019.

101 ILO 2018.

102 Wirtz et al. 2017: 1.

103 OECD 2016.

Equally concerning is that expenditure on outpatient medicines is a major driver of catastrophic health spending.¹⁰⁴ In India, health-care expenditure on medicines is the single largest component of total OOPs.¹⁰⁵

A review of the literature for this paper indicates significant evidence gaps. These include lack of national-level data that examine and estimate the burden of health expenditure on medicines. There was little research that examined how access to medicines differed between women and men and the role of gender therein. An important question is the extent to which the rationing of health resources within households might mirror gender, age and other hierarchies in determining differential access to medicines. One of the few studies that examined women's access to drugs, and specifically continuous prescription drugs for a group of chronic diseases, was one from Brazil.¹⁰⁶ It found that higher access was associated with residence in a rural area, having higher socio-economic status and suffering from one or two chronic diseases. These are critical areas of financial protection that need ongoing monitoring.

The challenge of gendered access to essential medicines and health technologies is best exemplified with respect to sexual and reproductive health (SRH). Poor sexual and reproductive health constitutes a substantial proportion of the disease burden globally and specifically in LMICs. Despite this, access to essential medicines and products for SRH is often not available. This is best illustrated in terms of access to contraception and safe abortion services.

Globally, 190 million women of reproductive age worldwide who want to avoid pregnancy are not using a modern contraceptive method, and this gap is most acute in sub-Saharan Africa.¹⁰⁷ This unmet need is experienced most acutely by adolescent, migrants, urban slum dwellers, refugees and postpartum women.¹⁰⁸ Lack of access to contraception leading to unplanned pregnancies is linked with increased risks of maternal

and early child mortality. Evidence from India and Kenya indicates that poor households spend a significantly higher proportion of their income on reproductive health care (including contraception).¹⁰⁹ More specifically, high costs of contraception—including informal payments¹¹⁰—are a barrier to accessing contraceptive and family planning services for especially vulnerable populations.¹¹¹ Across many countries, although contraception is included in the health benefit package, this does not translate into actual availability and access. Contraceptives in low-income countries are often funded primarily through users themselves and donors.¹¹² Women bear a significant share of the financial burden of contraception. In Guatemala, for example, stockouts of contraception in state-contracted facilities force women towards the private sector and higher OOPs. More than 63 per cent of the financing of contraception there is out of pocket.¹¹³ Across Latin America, despite family planning being integrated and included within health benefit packages, users—especially the poor and marginalized—continue to bear OOPs when seeking services.¹¹⁴

Unsafe abortion is the fourth leading cause of maternal mortality globally and occurs mostly in LMICs.¹¹⁵ In countries with restrictive abortion laws, medical management of abortion through the availability of misoprostol has expanded access for women wanting to terminate a pregnancy.¹¹⁶ Medical abortion is preferred for various reasons including that it “does not involve hospitalization and surgery, allows for early abortion, it preserves privacy, allows for self-agency, can be organized to fit the woman's daily routine and is more affordable than surgical abortion”.¹¹⁷ In low-resource settings, WHO guidelines recommend that abortions can be provided at primary care level and by non-physician providers.¹¹⁸ The combination

104 WHO and World Bank 2017: 38.

105 Sakthivel Selvaraj et al. 2012.

106 Katrein et al. 2015.

107 UN DESA 2019.

108 WHO 2018.

109 Haghparast-Bidgoli et al. 2015.

110 Informal fees are payments made by patients to their health-care provider that are over and above the official cost of services.

111 Tumlinson et al. 2020.

112 Grollman et al. 2018.

113 Health Policy Plus 2016.

114 Fagan et al. 2017.

115 Ganatra et al. 2017.

116 Subha and Ravindran 2015; Aiken et al. 2017.

117 Ramos et al. 2015: 5.

118 WHO 2015.

of mifepristone followed by misoprostol for the medical management of abortion was added to the complementary list of WHO's essential medicines in 2005 as important to decrease maternal mortality and morbidity due to unsafe abortions.¹¹⁹ In contexts where medical abortion is permitted, there is a need for research on how to improve access (i.e., availability, acceptability and affordability) for particularly vulnerable and marginalized groups.

In sum, expenditures on medicines are an important contributor to catastrophic health expenditure. However, evidence on the role of gender in determining access to medicines and health technologies and the financial burden of payment is currently very limited. Access to essential SRH medicines and technologies such as contraception and safe abortion services is often inadequate. These are areas that require further study and evidence, particularly country-level data.

3.5 Governance

In recent years, as efforts to strengthen health systems and health service delivery in the context of UHC and the 2030 Agenda have gathered momentum, governance and specifically accountability have begun to receive increasing attention. Governance is a cross-cutting building block of the health system and is defined in terms of 'stewardship'. It calls for strategic policy frameworks combined with effective oversight, regulation, incentives and accountability.¹²⁰ More recently, health system governance has been described as "an aggregation of normative values such as equity and transparency within the political system in which a health system functions".¹²¹ Much of the focus remains on monitoring improvements in service delivery and health performance judged by improved access and quality of care. As McGinn et al. argue, "It is precisely at the service delivery level where failures in government policy, financing, management, and administration are felt most acutely

by citizens, through the absence, or poor quality, of certain services, including respectful care".¹²²

While there are several aspects of governance, we will focus on accountability because (a) it is inextricably linked to gender, human rights, transparency and participation; and (b) it is central to the 2030 Agenda and more recently to the work of the Commission on Information and Accountability for Women's and Children's Health¹²³ and the International Accountability Panel.¹²⁴

A systematic review of accountability relating to SRHR found that there were five health areas of focus:¹²⁵ maternal, neonatal and child health services; HIV services; gender-based violence; lesbian/gay/bisexual/transgender access; and access to reproductive health care in general. Key strategies for building accountability in SRHR include performance,¹²⁶ social¹²⁷ and legal,¹²⁸ and key instruments include citizen report cards, community scorecards, social audits, budget analysis (see Box 9) and participatory output monitoring.¹²⁹

From a gender, equity and empowerment perspective, processes and systems that build accountability into the health system are essential for advancing the health and rights of women and girls. Murthy defines it as "...the processes by which power holders in the health sectors engage with and answer to citizens, and enforce actions in such a manner to reduce gender inequalities in health and address gender-specific health concerns and rights of women and men".¹³⁰ However, as Waldman et al. observe, "there has been little work which brings together these two

119 Gill et al. 2019.

120 WHO 2000.

121 Balabanova et al. 2013.

122 McGinn et al. 2015: 30.

123 United Nations Commission on Information and Accountability for Women's and Children's Health 2011.

124 IAP 2018.

125 Van Belle et al. 2018.

126 In relation to service, managerial, administrative or programmatic issues (ibid.).

127 In relation to capacity of communities to demand improved service delivery and provider responsiveness through raising community awareness and voice (ibid.).

128 In relation to holding the government accountable to wronged citizens and communities (ibid.).

129 Ibid.

130 Murthy 2007: 7.

BOX 9:**Community scorecards and budget analysis: Instruments for building accountability in Ghana and Mexico****Scorecards and social accountability for improved maternal and newborn health services in Ghana**

In response to limited availability of quality emergency obstetric and newborn care (ONC), the MamaYe-E4A programme initiated a pilot intervention using a social accountability approach (that is, when ordinary people or civil society are involved in how the accountability operates) in two regions of Ghana. Through the use of scorecards to assess and improve maternal and newborn health services, the intervention study evaluated the effectiveness of engaging multiple health and non-health sector stakeholders at district level to improve the enabling environment for quality emergency ONC. It concluded that social accountability initiatives have great potential to create a culture of accountability for improved quality of care in maternal and newborn health.

Source: Blake et al. 2016.

Budget analysis for accountability for maternal health in Mexico

In Mexico, two civil society organizations (CSO) partnered to track government budgets, specifically monitoring how federal allocations are used at the local level for maternal health. The CSOs were Kinal Antzetik, a grassroots CSO with a strong health promoter and indigenous network, and Fundar, an organization experienced in budget analysis and federal-level advocacy. This process of tracking relies on data provided by government institutions and is supported by the Federal Access to Information Law. Data obtained through budget tracking was complemented with interviews and field observations to determine whether and how the allocated funds were actually spent to improve local services. This information was reported back to the federal level and used for advocacy by Fundar at the state level for improved transparency. This process contributed to providing evidence that could influence decision-making in the executive and legislative branches of government as well as strengthened CSO networks' ability to influence public policy while contributing substance to public debate through media collaboration. Knowledge of earmarked federal budgets has become a tool to demand service provision at the community level.

Source: MacArthur Foundation 2012: 6.

bodies of work [i.e. gender and accountability] from a health systems strengthening perspective; and this is an important gap that needs addressing".¹³¹

The expanding focus on accountability offers an opportunity for building gender analyses into intervention programmes to shed light on critical gaps identified by Waldman et al., including "how gender and accountability interact, what mutual benefits and tensions exist, and what opportunities there are for developing gender-transformative accountability processes that address and transform unequal gender norms, roles, and relations at all levels".¹³² This also sug-

gests the potential of the health system to take the lead in advancing gender and social transformation.

3.6

Health information systems

To be able to effectively monitor UHC progress and broader health systems policy and programmes by gender—and specifically for women, adolescents and girls—sex-disaggregated data are required. This entails health information systems that collect and track civil registration and vital statistics by gender, income, age and location. However, as argued in the joint United Nations Children's Fund (UNICEF) and WHO report on *Tracking Progress towards Universal Coverage for Reproductive, Newborn and Child*

¹³¹ Waldman et al. 2018: 81.

¹³² Ibid.: 82.

Health, “...lack of timely data and major data gaps preclude disaggregation for better targeting of programmes and services to the populations most in need. The gaps are particularly serious for causes of death, quality of care, nutrition programmes, adolescent health, and financial and health system inputs.”¹³³

In the context of the MDGs and now Agenda 2030, global multi-institutional collaborations such as Countdown to 2030¹³⁴—charged with tracking

maternal, new-born and child survival for more than a decade—have been key in monitoring progress. A key challenge in all countries is the national civil registration and vital statistics system.¹³⁵ Experts in gender and human resources for health have also argued for more research and sex-disaggregated data to strengthen understanding of gender as it affects health workers, especially in developing countries. These enormous gaps in data quality and what gets collected, analysed and monitored is a cross-cutting challenge across all the building blocks.

¹³³ UNICEF and WHO 2017: 2-3.

¹³⁴ Global collaborations of academics, governments, international agencies, health-care professional associations, donors and CSOs that focus on monitoring and reporting coverage levels of effective interventions and health system functionality, as well as health policies, financing and equity.

¹³⁵ These are used to record vital events such as births, deaths and marriages.

4.

IMPLICATIONS FOR RESEARCH AND POLICY DIRECTIONS

4.1

Evidence and research directions

A worrying finding from the literature search for this paper is the evidence gaps in several areas. We have identified four broad types of gaps:

- Overall lack of sex-disaggregated data with respect to several health systems building blocks, most notably on access to medicines and on the health workforce, especially unpaid health-care work.
- A dearth of evidence on the impact of UHC reforms in terms of building access analysed along lines of gender and intersectionality.
- Weak inclusion of gender- and rights-based approaches under-scored by principles of solidarity in terms of the design of both UHC financing and governance and accountability mechanisms.
- Insufficient context-relevant implementation research of what works in health systems to strengthen policies and programmes across the six building blocks, especially with a gender focus.

Research agendas must be derived through participatory processes and meaningful engagement of key stakeholders including those hardest to reach (i.e., women, adolescents and marginal, vulnerable and key populations) and civil society, in addition to governments, researchers and regional and global partners.

Given the central importance of sexual and reproductive health (SRH) for achieving UHC, research agendas will have to be built around a framework that embeds gender and SRH within UHC objectives. They must take account of specific issues such as accountability, quality of care and inter-sectoral action, which are necessary for addressing the underlying social determinants of health.

4.2

Policy directions

This review of the current evidence on the implications of UHC through a gender lens has important policy implications for the health system. Policy directions are identified below.

4.2.1 Health financing

- Adopt and implement intersectional approaches that pay attention to gender, vulnerability and marginalization in the planning, design and implementation mechanisms for funding health systems.
- Ensure that such approaches address gender and other drivers of inadequate resources within households and across different types of families.
- Secure sustainable domestic and international financing to achieve full access to a comprehensive sexual and reproductive health package.

- Enact legislation that bans the practice of detaining women in hospitals for non-payment of fees, especially for maternity care, and provides them with free health services.

4.2.2 Health services and delivery

- Ensure that the range of services packages go beyond maternal health and family planning to a comprehensive set of SRH services, including sexuality education and treatment for survivors of violence including rape.
- Design and implement gender-sensitive codes of conduct and training programmes for provider-patient interaction to ensure it meets the respectful care, quality, clinical, ethical and specific needs of all people based on human rights standards.
- Track and monitor service coverage and access for especially politically sensitive services such as SRH through implementation of accountability mechanisms for existing human rights commitments.

4.2.3 Health workforce

- Implement international agreements that protect and promote the economic and labour rights of health-care workers as formal sector workers in terms of pay and working conditions, including by establishing supportive working and living environments and opportunities for professional growth, paying special attention to those working at the front-line (i.e., community care workers, traditional midwives, caregivers in the informal economy).
- Recognize the rights and perspectives of community health workers (CHWs) and take steps to protect and promote their labour rights, including appropriate remuneration, written contracts specifying roles, safe and decent working conditions, training, supportive supervision and career advancement opportunities.

- Prioritize the elimination of workplace violence in health-care settings through revising labour law and other legislation and introducing special legislation where necessary that complies with human rights standards and ensuring the enforcement of such legislation.

- Recognize within the health system the significance and burden of unpaid health-care work on especially women and girls, take steps to measure and monitor it and ensure its integration in the analyses of health systems and public policies towards UHC.

4.2.4 Medicines and health technologies

- Ensure that governments implement policies that reduce the amount of out-of-pocket spending on medicines and health technologies.
- Invest in health systems capacity to monitor and track expenditure on medicines, especially essential medicines, in both the public and private sectors, disaggregated between prepaid and out-of-pocket expenditure as well as by sex.
- Ensure that essential SRH medicines on the WHO Model List of Essential Medicines are included in national essential medicine lists, aligning with the global commitments to access to UHC and SRH.

4.2.5 Governance

- Identify, collect and publish data disaggregated by sex of the gender biases and barriers that women face in engaging in different political spheres and social accountability processes, and take steps to eliminate these barriers to strengthen and ensure women's participation.
- Ensure through accountability mechanisms (e.g., community score cards, budget analysis, gender audits, health committees, patient/user groups) the full and equal participation of women and marginalized groups in all public decision-making and political processes involving the design,

implementation, monitoring and evaluation of UHC policies and programmes.

- Ensure that resources are available/ear-marked for strengthening the capacity of women and marginalized groups to participate in all UHC-related public decision-making and political processes.

4.2.6 Health information systems

- Invest in strengthening country-level capacity for monitoring and analysing relevant sex-disaggregated data along the six building blocks of the health system.

- Monitor progress on gender and rights through tracking population and service coverage, financial protection and health outcomes by stratification of the population into groups, paying attention to gender and other markers of vulnerability and marginalization.
- Strengthen country-level HRH databases beyond the more established, formal health workers (doctors, nurses, pharmacists, dentists and midwives) to better account for those less qualified (e.g., community health workers) and those in the unpaid economy.

5.

CLOSING REMARKS

Human rights and solidarity may receive attention in global and national statements of principle. However, as noted earlier, the devil lies in the detail. Unless human rights and solidarity are the pillars on which UHC is designed and implemented, policy, programme and impact attention will remain focused on improvements in addressing economic inequalities at the household level. Other markers of social exclusion and marginalization (gender, race, ethnicity, language etc.) will be either neglected or postponed.

In this paper, we have focused specifically on the challenges of ensuring that UHC policies and programmes take gender equality seriously. Our examination of country cases shows UHC policies to be seriously wanting in this regard. An analysis of all six building blocks of the health system provides the evidence base for our conclusions. But we have also pointed to the ways in which policy and programme improvements can be made so as to protect and fulfil the human rights of women and girls.

In highly unequal societies, the chasm between ‘them’ and ‘us’, the ‘haves’ and ‘have-nots—although best documented in terms of income inequality—is also pervasive across other social markers (gender, caste, race, language etc.). Irrespective of the social marker,

however, it remains a challenge to build solidarity and collective responsibility for ensuring the inclusion and prioritization of resources to those worst off. This requires a re-examination of the role of the state and its obligations in terms of fulfilling the right to health.

The right to health, guided by principles of solidarity, obliges governments to reorient public spending towards ensuring increased public spending on health and redistributing resources to those with priority needs, especially those facing intersecting inequities. Given that the health system itself often mirrors patterns of exclusion at a societal level, it has the potential to play a larger socially transformative role through tackling inequalities in health and health-care access.

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ANNEX 1:

Equity on the Path to UHC: Unacceptable Choices

Two major sets of policy directions to advance equity in UHC have both used an approach that spells out what kinds of choices are unacceptable. The WHO Consultative Group on Equity and UHC (WHO 2010a; Norheim 2015) illustrates some of the difficult real-world situations that may be faced by policymakers on the way to UHC and provides guidance, from an ethical perspective, on what would be unacceptable trade-offs. They also called for robust accountability mechanisms, including effective monitoring along the three dimensions of the UHC cube as well as the processes used. The Group argued that the following five trade-offs can be considered generally unacceptable and incompatible with fair progressive realization of UHC (WHO 2010a).

1. To expand coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing OOPs for low- or medium-priority services before eliminating OOPs for high-priority services.
2. To first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier.
3. To give high priority to very costly services (whose coverage will provide substantial financial protection) when the health benefits are very small compared to alternative, less costly services.
4. To expand coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.
5. To shift from OOP payment toward mandatory prepayment in a way that makes the financing system less progressive.

A similar approach has been taken in a recent one-pager based on the Background Paper prepared for the 3rd Annual UHC Financing Forum (Equity on the Path to UHC: Deliberate Decisions for Fair Financing), organized jointly by the World Bank and USAID. Ten unacceptable choices were identified across the three core financing functions of raising revenue, pooling funds and purchasing services (World Bank and USAID 2018b).

Raising revenue

1. Raise additional revenues for health that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer disposable income distribution is not less equal.
2. Increase OOPs for universally guaranteed personal health services without an exemption system or compensating mechanisms.

3. Raise additional revenues for universally guaranteed personal health services through voluntary, prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors.

Pooling

4. Change per capita allocations of tax revenue—or donor funds across prepaid and pooled financing schemes in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

5. Within financing schemes, change per capita allocations from higher to lower administrative levels in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

6. Within schemes or pools, change allocations of funds across diseases in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

Purchasing

7. Introduce high-cost, low-benefit interventions to a universally guaranteed service package before achieving close to full coverage with low-cost, high-benefit services.

8. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need.

9. Expand the availability and quality of key inputs to produce a universally guaranteed set of personal health services in ways that exacerbate existing inequalities unless justified by differences in need.

10. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need.

ANNEX 2:

Social Determinants of Health and Key SDGs

The following SDGs and their targets are of particular importance to the social determinants of health.

SDG 1 (End poverty in all its forms everywhere)

Target 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.

SDG 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture)

Target 2.1: By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants to safe, nutritious and sufficient food all year round.

Target 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

SDG 3 (Ensure healthy lives and promote well-being for all at all ages)

Target 3.7: By 2030, ensure universal access sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

SDG 5 (Achieve gender equality and empower all women and girls)

Target 5.4: Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

SDG 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all)

Target 8.5: By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.

**UN WOMEN IS THE UN ORGANIZATION
DEDICATED TO GENDER EQUALITY
AND THE EMPOWERMENT OF WOMEN. A
GLOBAL CHAMPION FOR WOMEN AND
GIRLS, UN WOMEN WAS ESTABLISHED
TO ACCELERATE PROGRESS ON
MEETING THEIR NEEDS WORLDWIDE.**

UN Women supports UN Member States as they set global standards for achieving gender equality, and works with governments and civil society to design laws, policies, programmes and services needed to implement these standards. It stands behind women's equal participation in all aspects of life, focusing on five priority areas: increasing women's leadership and participation; ending violence against women; engaging women in all aspects of peace and security processes; enhancing women's economic empowerment; and making gender equality central to national development planning and budgeting. UN Women also coordinates and promotes the UN system's work in advancing gender equality.



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