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

UN WOMEN

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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

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