

Accelerating action towards universal health coverage by applying a gender lens

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There is a burgeoning movement towards universal health coverage (UHC) – both at the national and the global political level – that seeks to ensure that all people everywhere receive the health services they need without experiencing financial hardship. The 25 wealthiest nations all have some form of universal coverage, as do several middle-income countries, including Brazil, Mexico and Thailand, and lower-income nations, such as Ghana, the Philippines, Rwanda and Viet Nam, are working towards achieving UHC.¹ Action to accelerate work towards UHC is also taking place at the global policy level as evidenced by the 2011 World Health Organization Resolution on UHC, the 2012 United Nations Resolution on UHC and the inclusion of UHC in debates on the post-2015 agenda.

In many ways the UHC movement builds on the 1978 Declaration of Alma Ata, which reaffirmed that health is a human right and identified primary health care as the means for attaining “health for all”. However, UHC does not necessarily guarantee universal access to health services. Thus, as countries develop strategies for transitioning towards UHC, it is critical that government leaders and policy-makers take into consideration the unique health needs of women, who make up 51% of the world’s population and 60% of the world’s poor. Biological and gender-based differences between women and men result in differences in health risks, disease incidence and health service needs. For example, women are 1.2 times more susceptible to infection with the human immunodeficiency virus (HIV) than men and this difference is even more marked in adolescence.² Gender-based differences exist in terms of access to and control of household resources; power and decision-making within and outside the home; and roles and responsibilities within the family, the community and the labour market.

In addition, in some places women are less able to move about than men because of social norms that prohibit them from travelling alone, lack of money for transportation or the opportunity cost associated with travel time. All of these gender-related factors have a decisive influence on health-seeking behaviour, health status and access to health services. Millennium Development Goal Three – to “promote gender equality and empower women” – seeks to address the barriers that hinder equal access to health services for men and women. Thus, if countries are to accelerate action towards achieving UHC and meet their targets for increasing access to health services, it is imperative to pay attention to the differential health needs of women and men, and especially to women’s health needs beyond those related to childbearing.

Two other forces, in addition to the biological and gender-based differences already mentioned, make it important for policy-makers to incorporate women’s health needs into UHC schemes. The first is the demographic transition, in which decreased rates of birth and death result in delayed childbearing and smaller family size and in longer life expectancy. This transition means that an increasing number of women will have to care for their children and elderly parents, and possibly even their grandparents, simultaneously. This expected increase in women’s role as caretakers and “invisible health workers” for the growing elderly cohort – in addition to the intrinsic value of a woman’s health – is yet another reason why governments should apply a gender lens to the design of their universal health systems, thereby optimizing the effectiveness of these systems.

A second force is the epidemiological transition and the concomitant growth in the incidence of noncommunicable diseases, especially among women. Cardiovascular disease (CVD)

is commonly viewed as primarily affecting men, yet it is the leading killer of women worldwide. More than 80% of the 9.1 million annual deaths in females due to CVD will occur in low- and middle-income countries.³ Similarly, breast cancer is the most common cancer among women worldwide. According to estimates, there will be 1.7 million cases in 2020 – a 26% rise in incidence relative to 2009 – and most of them will occur in developing countries.⁴ Research shows that although smoking is known to account for 50% of lung cancer cases in women worldwide, smoking rates in women in less developed countries are projected to increase from 12% in 2010 to 20% in 2025. By contrast, smoking rates in men have peaked globally.³ With regard to stroke, the third leading cause of death in the United States, women have different risk factors than men, including pregnancy, oral contraceptive use and the use of exogenous hormonal treatment for menopausal symptoms. Women who have suffered a stroke are usually left with poorer outcomes and greater mental impairment than men and therefore have a greater need for rehabilitative care.⁵ For these reasons, it is critically important to view UHC systems through a gender lens when setting priorities and developing a benefit package. Doing so will ensure that the services provided for women address those health needs that lie outside the sphere of reproductive and sexual health.

Applying a gender lens

When designing an effective UHC system, it is essential to incorporate public health measures for the prevention and early detection of diseases prevalent in women, such as breast and cervical cancer and cardiovascular disease. In addition, measures to reduce risk factors for noncommunicable diseases that affect women disproportionately, such as

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physical inactivity, smoking and poor nutrition, should be planned from a gender perspective. The following are two examples of the application of a gender lens to the design of financing schemes.

Social insurance

Governments that choose to finance UHC through social insurance schemes should enrol households as a unit. In this way they would be covering all members of the family, including those with little decision-making power and few financial resources, such as women and children, as well as women working in the informal sector or in the home and hence not covered by an employer-sponsored health plan. Further, individual contributions for social insurance coverage should be progressive: i.e. women should pay less than men because they often earn less than men, and the poor – 60% of which are women – should pay a lower percentage of their income than the non-poor. Social protection schemes that cover women's preventive and curative services should seek to eliminate or at least reduce out-of-pocket spending on health and to remove the formidable financial barriers that prevent more women than men from accessing needed services.

General taxation

Alternatively, governments that choose to finance UHC systems through general taxation make health services available to all citizens free of charge at the point of delivery. As in the model of social insurance described in the previous section, under a taxation system viewed through a gender lens, taxes would be progressive. In either case a life-course approach, with attention to gender-based differences in health risks, health-seeking behaviour and response to treatment in a given setting, should be the basis for determining the services covered under UHC. Such an approach would take into account the health needs of women beyond reproduction through the establishment of various preventive and curative services, including those for the control of noncommunicable diseases that are on the rise among women. In countries where gender-based discrimination prevails, UHC designed with a gender lens would help to reduce the adverse health effects of gender-based differences in risk and treatment.

Conclusion

Efforts to mainstream gender into programmes and institutions in the 1990s

were more successful in form than in substance. Although many nongovernmental organizations succeeded in including gender awareness as a cross-cutting element in their programmes, there are very few examples of system-wide initiatives in which gender-based differences in health were considered.⁶ Many UHC systems have attempted to address women's unique health needs by removing user fees and including reproductive health services in their benefits package. However, more can and should be done. The flourishing movement towards UHC presents governments with an opportunity to include women centrally in their plans to initiate or accelerate action towards attaining UHC. At present, no government in the world is systematically applying a gender lens to its UHC system. Attention to the persistent differences between men's and women's health risks, health status and access to services will improve the performance of UHC systems. Without an explicit focus on the holistic health needs of women beyond their reproductive role, UHC targets will not be met. In addition, systematically including women's health needs when planning UHC systems will further bolster women's empowerment and overall economic development. ■

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