

# Employment based health financing does not support gender equity in universal health coverage

Health financing and entitlement systems linked to employment can disadvantage women, argue **Lavanya Vijayasingham and colleagues**

**G**lobal commitments to improve women's access to healthcare have been made repeatedly, most recently through the sustainable development goals and the 2019 political declaration on universal health coverage. These commitments echo the vision of the 1995 Beijing Declaration to ensure that women access equitable, appropriate, affordable, and quality healthcare throughout their life. Yet, 25 years later, women remain disproportionately underserved, and their basic health needs remain unmet.

In low and middle income countries, 45 million pregnant women (37%) have no access, or inadequate access, to antenatal care, 214 million women (13%) who want to avoid a pregnancy are not using modern contraception, and 266 000 women die from highly preventable cervical cancer (90% of the global mortality of

the disease).<sup>1</sup> In high income countries women forgo healthcare because of cost—for example, 26% of women in Switzerland and 38% in the United States.<sup>2,3</sup>

In addition to the general challenges that impede universal health coverage, women's access is further constrained by health systems and the broader political economy, which mirror and reinforce restrictive gender norms, unequal power relations, and systemic discrimination.<sup>4</sup> Women's higher unpaid care work, lower income, and often limited decision making power over household resources and their own healthcare, converge to create significant barriers to healthcare.<sup>4</sup>

These dynamics are exacerbated when healthcare financing and entitlements are linked to employment, as women experience unequal and disrupted participation in employment. Health financing mechanisms based on employment can translate gender disparities in employment into unequal healthcare access, further disadvantaging women.

## Employment based health financing schemes

Employment based health financing includes any form of health financing or entitlements that are linked to a person's employment status and type. Typically, pooled contributions from an employee, their employer, and/or the state are channelled to service providers for a defined set of health entitlements to the contributing individuals, and sometimes their dependants. Such schemes include mandatory contributions to national social insurance (Thailand), enrolment of informal and non-standard workers (that is, part time and casual employment) in health insurance schemes (Ghana, Vietnam), and voluntary or semi-mandatory provision of health insurance by employers to their labour market (US). Examples of health insurance provided by employers include the medical scheme for South Africa's government employees with five levels of benefit packages, in which entitlements

(beyond the basic package) are linked to paid premiums<sup>5</sup>; and the policies of the US for provision of healthcare only to full time employees who work for employers with more than 50 full time staff.<sup>6</sup>

There are many criticisms of employment based health financing. Firstly, it suggests that healthcare is an employment benefit, rather than a human right. Secondly, by tying healthcare entitlements to employment status or linked contributions, it undermines the goal of universal health coverage to progressively ensure equity and continuous access to high quality healthcare. In some cases, people in higher level positions are given more healthcare entitlements or can pay higher insurance premiums to receive better quality and more expensive healthcare. Ideally, arrangements for universal health coverage should start with poorer populations who have higher unmet health needs.<sup>7</sup> Although countries may combine employment based health financing with fully subsidised care for vulnerable groups, there is a higher risk of excluding people who fall into, or move between, different categories of entitlements, such as those who are defined by socioeconomic status, poverty lines, and pregnancy status. Lastly, as a source of health revenue, employment based health financing is unstable, fragmented, and inequitable, particularly during economic crises.<sup>8,9</sup> During the covid-19 pandemic in the US, about 47.5 million people lost access to employment linked healthcare because of a job loss in the family. As of May 2020, 27 million of them were likely to remain uninsured owing to ineligibility for other health schemes.<sup>10</sup>

Universal healthcare entitlements, mandatory inclusion in national schemes, general tax contributions for resource pooling, and a move away from voluntary or contributory schemes that are linked to benefits entitlements are recommended for countering these challenges.<sup>11</sup> There has been resistance towards this shift, however. Employment based health financing

## KEY MESSAGES

- Progress towards universal health coverage needs financing systems that ensure women's access to equitable, appropriate, affordable, and quality healthcare throughout their lives
- Women's access to healthcare is threatened when it is linked to their employment terms, because women face more employment insecurity and transitions across their work lives, including for reproduction and unpaid care work
- Gender equitable universal health coverage reforms are needed to ensure continuity of access to high quality health benefits and financial protection during changing circumstances, such as work transitions
- Reforms should also be based on principles of accountability, non-discrimination, valuation of unpaid care work, and an evidenced based understanding of intersecting inequities

remains an important source of revenue, especially for low and middle income countries that need to mobilise additional domestic resources. It is also possible to use existing payroll infrastructures.<sup>8</sup> In countries with established employment based health financing systems, the influence of existing beneficiaries often prevents reforms of these arrangements, which continue to disadvantage women.<sup>8,11</sup>

### Unequal employment terms and unpaid care work

Gender inequalities and gaps in employment have hardly changed over the past 25 years. Globally, only 47% of women were estimated to be employed in 2019, compared with 74% of men.<sup>12</sup> With this employment gap, and a gender pay gap of nearly 20%, equality in employment has not been achieved.<sup>13</sup>

Unequal unpaid care and domestic work between men and women persists throughout the world, negatively influencing women's economic participation and opportunities. Women perform more than 80% of unpaid care work, and about 606 million women, compared with 41 million men, are full time unpaid care workers.<sup>13,14</sup>

In the formal sector, women remain over-represented in lower level positions and receive unequal remuneration for the same role, skills, education, and experience. Wider employment gaps persist for women with children.<sup>14</sup> The global proportion (about 27%) of women who are managers and in professional leadership roles has hardly changed in 30 years.<sup>14</sup> The most socioeconomically disadvantaged women are least likely to work either full time or in the formal sector.<sup>15</sup>

The informal sector provides employment for up to 90% of employed women in Africa and South Asia, and 75% in Latin America.<sup>14</sup> Typically, young (15-24 years) and older (>65 years) women are more likely to have informal work,<sup>16</sup> and they are concentrated in occupations with low pay, long hours, and insufficient or no social protection.<sup>14</sup>

These gender inequalities are likely to be exacerbated in the future. A changing global employment ecosystem based on technological disruptions, macroeconomic fluctuations, and dwindling levels of social and employment protection is reducing opportunities for long-term and secure employment.<sup>14</sup> Non-standard employment arrangements, such as part time and temporary contracts, are increasing in the formal sector.<sup>16,17</sup> Similar to informal

sector work, these arrangements usually lack health related social protection and job security, through their framing as "self-employment". Again, women are disproportionately affected. In Japan, where there is national employment based health financing, women are four times more likely to be on a temporary contract.<sup>18</sup> Women in developing countries make up one in every five crowd workers, using digital platforms for task or service based income generation.<sup>14</sup> The online "gig" economy is not expected to close gender gaps in employment or income.<sup>14</sup>

Non-standard employment arrangements are often depicted as a way to support women's engagement in paid employment by providing flexibility and enabling them to balance their economic productivity with domestic responsibilities.<sup>19</sup> Non-standard workers, however, typically have an income gap as high as 60% in comparison with full time workers, even in high income countries.<sup>17</sup> During economic crises and periods of recovery, women are disproportionately represented in involuntary non-standard employment, particularly in industries or roles that are heavily dependent on women, such as the service industry.<sup>19</sup>

### Employment based health entitlements

Socioeconomic and cultural factors influence women's ability to participate in paid employment throughout their life.<sup>15</sup> Women are less likely to have long term contracts,<sup>20</sup> and their work lives are often fragmented by transitions, owing to reproduction, care responsibilities, and voluntary and involuntary unemployment.

Employment based schemes often do not take account of these unequal trends and changes in women's employment, which often create discontinuity in coverage, benefits, and financial protection. Arrangements for universal health financing should provide continuous coverage for all people throughout their lives to meet their changing health needs. Yet, approaches to employment based health financing that visualise employment as static, rather than a trajectory, can lead to fragmented and interrupted coverage. Figure 1 draws attention to the gendered work life and women's discontinuous access to coverage, benefits, and financial protection.

Unpaid care work is not always as valued as paid work in employment based models. Some countries have separate schemes for formal sector workers and their dependants, including spouses who

engage in full time unpaid care work. In Vietnam, dependants are not covered in the compulsory employment based national scheme, but they can enrol in a voluntary scheme, with fewer entitlements, that is also offered to informal sector workers.<sup>21</sup> In Thailand, there are differences in coverage and benefits for dependants across schemes. The civil servant scheme includes coverage for members' parents, spouses, and up to two children.<sup>22</sup> The scheme for private sector employees, however, excludes dependants, who are covered by the universal coverage scheme for the rest of the population.<sup>22</sup>

Within these systems, employment or movement across formal, informal, and non-standard roles typically changes entitlements to healthcare. In Mexico, for example, there are distinct health access schemes for formal and informal sector employees. More women than men in Mexico become unemployed, and more often. Within a single year women can move between the formal and informal sectors and between employment and unemployment.<sup>23</sup> These changes influence women's entitlement to high quality healthcare, which consequently affects their health.<sup>24</sup> The same situation has also been documented in South Korea, where women are over-represented in non-standard work.<sup>19</sup> The national health financing system distinguishes between formal sector full time, part time, non-standard, and temporary workers, and those with contracts in a single organisation for less than 24 months.<sup>25</sup> A South Korean study found that non-standard workers are among those who were more likely to have unmet healthcare needs due to the economic burden of care provision.<sup>26</sup>

Women in low and middle income countries with employment based health financing schemes, such as Ghana and Kenya, tend to take part in lower income, informal, or small business work. Their income is more unpredictable and less sustainable than for men, and they are less able to make regular contributions to maintain their insurance coverage.<sup>27</sup> In Ghana, although enrolment is mandatory for both formal and informal sectors, not all of the informal sector is enrolled. About 80% of the national workforce work in the informal sector,<sup>28</sup> but this sector accounts for only about 30-35% of the national insurance annual membership.<sup>29</sup> A study on women porters reports that only about half of the participants had insurance

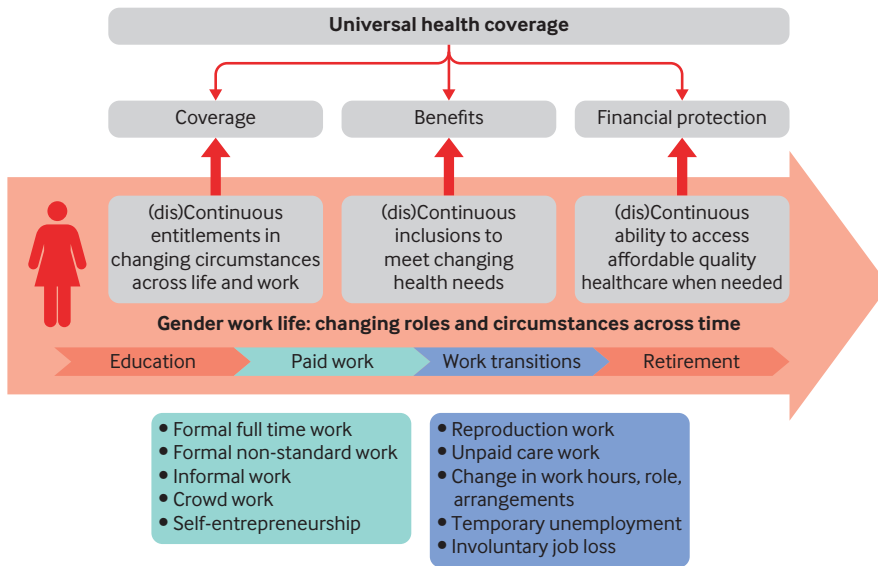


Fig 1 | Gendered work trajectories and continuous universal health coverage

and not all sought healthcare when ill or injured, primarily because they could not afford it.<sup>30</sup> In the absence of coverage, healthcare is either foregone, or funds to pay for healthcare costs are found through informal loans or the sale of assets.<sup>28</sup>

The intersecting influence of other factors and inequities, such as chronic illness and disability, also affects women's continuous access to healthcare through these schemes. Health status and functional impairment influence changes and transitions in employment, even at milder stages of illness.<sup>31</sup> Women with disabilities often have a dual disadvantage from their gender and disability, resulting in their over-representation in low paying, less prestigious, less autonomous, and more stressful jobs than women without disabilities, and men with disabilities.<sup>32</sup> Additionally, a study of employed women with breast cancer in the US found that those who depended on their employer for health insurance were less likely to reduce work hours than employed married women who depended on their spouse's healthcare coverage.<sup>33</sup> These dynamics have implications for clinical outcomes. Although social protection for illness or disability can provide a buffer against these risks, many countries with limited resources in Asia and Africa lack such schemes and systems<sup>34</sup>

**How do we achieve gender equity?**

The path towards achieving universal health coverage must include gender and other equity considerations beyond socio-

economic position and income.<sup>35</sup> Transitions in employment status, income, life roles, or other life circumstances should not change an individual's access to adequate high quality and timely healthcare (fig 1). We suggest some health financing design principles to support this shift (box 1).

In countries where employment based health financing is already established or is being considered to mobilise more resources for domestic health financing, adequate safety nets must be provided to ensure equity and continuity in coverage, benefits, and financial protection. At a systems level, it is necessary to prioritise reforms towards mandatory, universal, and primarily tax-based financing approaches that separate entitlement to health benefits from contribution. Options could include pooling employee and employer contributions with non-contributory funds from government revenue.

Inherent gender based biases and discrimination must be dealt with, by valuing care and childbearing equally to productive paid work. Premiums should be regulated and affordable, and parallel non-contributory schemes should provide access to equal and high quality care.<sup>8 11</sup> Existing health financing systems may also

need to be redesigned to provide adequate coverage, benefits, and financial help for those who are employed through informal and non-standard work arrangements. Some countries with established schemes of employment based health financing have implemented mechanisms to deal with elements of gender inequity and discrimination. For instance, in 2012 the European Union established a ban on gender discriminatory pricing strategies within health insurance plans.<sup>36</sup> Similarly, in the US, equal levels of premium and benefits must now be offered to all workers across all levels of positions and salaries, regardless of gender.<sup>37</sup> Such regulations and accountability systems, built on principles of non-discrimination, are critical to promote the achievement of gender equity in health access.<sup>11 35</sup>

Finally, there are considerable evidence gaps in understanding the implications of employment insecurity and transitions for women's healthcare access, especially beyond reproductive health. The health financing literature is heavily focused on systems and processes, with considerably less attention paid to people. In low and middle income countries and fragile settings, there is even less analysis and fewer interventions to deal with gender inequities, or examine how they intersect with other factors, such as age, ethnicity, religion, disability, marital status, sexual orientation, and migration status. These gaps need to be considered to inform health financing policy.

**Conclusion**

Many employment based health financing schemes are likely to favour men and can undermine progress towards gender equitable universal health coverage. We cannot proceed with business as usual in countries that are building their health financing systems on inequitable entitlement. Continuing on this trajectory will exacerbate gender inequities. Well designed health financing policy and systemic reforms are needed to deal with systemic gender inequality and improve healthcare access. The global urgency for these reforms is clear at this time. The gendered effect of the covid-19 crisis, including its effect on unequal care

**Box 1: Equity and gender principles for guiding transformation of health financing**

- Continuity, coherence, and portability across schemes
- Accountability towards universality, equity, and non-discrimination
- Valuing unpaid care and childbearing
- Updated and evidence based design and monitoring

burdens and employment, could be the external shock and trigger needed to produce a change and the introduction of wide reaching reforms to deal with the gendered inequities of healthcare access across lifetimes.

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