This is the second part of the special section, edited by Professors Margaret Whitehead and Göran Dahlgren, on the equity impacts of different health care systems, which includes studies conducted within the framework of the Affordability Ladder Program.

THE DYNAMICS OF GENDER AND CLASS IN ACCESS TO HEALTH CARE: EVIDENCE FROM RURAL KARNATAKA, INDIA

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In the early 1990s, India embarked upon a course of health sector reform, the impact of which on an already unequal society is now becoming more apparent. This study sought to deepen understanding of equity effects by exploring gender and class dynamics vis-à-vis basic access to health care for self-reported long-term ailments. The authors drew on the results of a cross-sectional household survey in a poor agrarian region of south India to test whether gender bias in treatment-seeking is class-neutral and whether class bias is gender-neutral. They found evidence of "pure gender bias" in non-treatment operating against both non-poor and poor women, and evidence of "rationing bias" in discontinued treatment operating against poor women overall, but with some differences between the poor and poorest households. In poor households, men insulated themselves and passed the entire burden of rationing onto women; but among the poorest, men, like women, were forced to curtail treatment. There were economic class differences in continued, discontinued, and no treatment, but class was a gendered phenomenon operating through women, not men.

India liberalized its economy in 1991 and embarked upon a course of health sector reform. The impact of such structural reforms on an already unequal society is now becoming clear through a small but significant body of research. We have evidence of worsening inequalities in health care access (1), as well as estimates of the magnitude and distribution of catastrophic out-of-pocket payments (2–4).

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In-depth poverty studies (5–7) and development journalism (8) also point to the fact that spiraling out-of-pocket payments, mainly for drugs, may be an important reason why households are falling into poverty.

Few studies explore whether and how financial barriers to health care are differently experienced within and between households. Yet, comparative analysis of national data for India between 1986–1987 and 1995–1996 showed that household responses to spiraling health care costs were differentiated by both gender and economic class (1). It has been argued that when health care becomes expensive, women are adversely and disproportionately affected because of their subordinate positions and tenuous access to the resources required to obtain health care (9, 10). Despite this, we have no clear understanding of how gender and class operate when health care becomes unaffordable, or whether all of the manifest differentials between women and men are due to a single type of gender bias.

It is often assumed either that gender differentials are a consequence of poverty/unaffordability or that they result from traditional beliefs and practices that are independent of economic factors. Our argument in this article is that both processes may be at work in many situations. Gendered practices resulting from biased values and norms may function to limit treatment for women, whether or not the household is able to afford health care. But gender bias may also take the form of rationing health care differently for women and men (girls and boys) in situations of poverty or growing resource constraints. We refer to these two forms of gender bias as *pure bias* and *rationing bias,* respectively.

Rationing is usually an institutional mechanism intended to ensure a particular distribution of scarce resources across households, independent of their productivity or economic contribution. Typically, the distribution objective is to ensure greater equity. However, we argue that rationing can be conceptualized to have other aims as well.

We use the term "rationing" to refer to the way in which households with limited resources distribute curative health care among sick members. Standard economic theory analyzes how economic agents make choices among alternatives, to maximize utility when resources are limited. In normal situations, households make consumption choices on the basis of their preferences and a budget constraint imposed by household income. However, when the commodity in question is health care, consumption choices may become income inelastic. That is, households may continue to buy health care even when they cannot pay for it from their own resources. Alternatively, members of a household may ration care by refusing to acknowledge an illness, by denying or delaying care, by securing health care of poor quality, by lowering spending or the use of resources, or by discontinuing treatment even when the health problem persists.

For decision makers in the household with limited resources, a distribution that reflects hierarchies based on gender, age, or life-cycle status may well be a way of sustaining power relations within the household, besides being the path of least resistance. If this is plausible, then one would expect systematic differentials by gender in the extent to which, and manner in which, the health needs of different household members are met. One would also expect that as resource constraints eases either over time for a given household, or as one moves from poorer to better-off households, the extent of rationing bias would tend to diminish.

In any given situation, *both* pure bias and rationing bias may be at work and difficult to disentangle empirically. In our ongoing work, we are developing techniques for doing this (11). In this article, however, we attempt to draw inferences for the presence of the two types of gender bias and to explore the ways in which gender and class interact. Such interactions are important because apparent class differences may not be gender-neutral, and gender differences may not be class-neutral. Research studies that encounter this question are often at odds with each other. For instance, Mumtaz and Salway (12) suggest that gender and class converge in Pakistan to disproportionately disadvantage poor women, while Zaidi (13) and Ahmed and colleagues (14) argue that, in Bangladesh, gender fades into insignificance in the presence of economic class. Our approach in this article is to test gender and class interactions quantitatively, thereby adding to the weight of evidence. Adopting an approach similar to that specified in the Affordability Ladder Program (ALPS) framework (15), we focus on long-term illnesses and examine two extreme forms of rationing: discontinuation of treatment and non-treatment for different household members.

METHODS

Research Setting

The research is set in Koppal, a drought-prone agrarian district of rural Karnataka in south India. Koppal is characterized by poverty and is deeply divided on the basis of gender and caste. Income security is the prerogative of the few who own large tracts of irrigated land or hold regular jobs. Class underpins gender, most clearly evidenced in nutritional norms favoring boys in poorer households, although the economic contribution of girls to the household may be substantial. Gender bias also exists apart from class and caste, in terms of ascribing lower value to the lives and well-being of girls and women.

Health care in the district is delivered by a combination of an informal sector consisting of healers and unqualified practitioners of allopathic medicine, a small profit-oriented private sector that is concentrated in small towns, and a government sector that functions at a suboptimal level. Most forms of health care have to be purchased out-of-pocket. Supplier-induced demand is limited to injections; high-tech medicine does not exist.

The Survey

The results are drawn from a cross-sectional survey, conducted in 2002, that documented intra- and inter-household differences in treatment-seeking, expenditures, and burdens during pregnancy and short- and long-term illness. A household census preceding the survey in 60 villages enumerated 15,358 households, which formed the sample units in a unistage-stratified sampling frame. The villages affiliated to the same primary health center constituted a stratum. Within each stratum, households were first grouped by religion-caste and then by a measure of economic class. A sample of 12.5 percent of all households was drawn from each stratum in a circular systematic manner after a random start. The survey thus enumerated 1,920 households, which included 12,328 individuals.

Definitions of Variables

The survey adopted a social definition of illness, because people in poor rural settings have their own cultural explanations for health conditions that do not neatly fit into biomedical categories (16). Qualitative research conducted before the survey also revealed that medical diagnosis in this area is variable in quality, unwritten, and often not communicated to sick persons. The survey therefore used the notions of duration and severity to differentiate among illnesses. The cut-off used to separate short- from long-term illness was three months. Severity for long-term ailments was measured in terms of difficulty in going to school, doing housework or other work, and earning income.

Our definition of "treatment" included all actions taken to alleviate illness symptoms, including self-care and medication by relatives, friends, or unqualified providers. Therefore, "non-treatment" refers to no attempt whatsoever to reduce symptoms.

Our proxy for economic class was average per capita monthly consumption expenditure, as incomes are difficult to estimate in an agrarian context and may be underreported. Such expenditures included imputed values of subsistence agricultural produce. Arguably, intra-household bargaining would result in unequal resource allocations and expenditures (17–19). Nonetheless, for the sake of simplicity, per capita expenditures were calculated by dividing the average monthly consumption expenditure for each household by its size. The data were cross-checked by comparing their distribution with corresponding data from the country's National Sample Survey. Within households, earners were defined as members who engaged in wage work or self-employment for the greatest part of a year before the date of the survey.

Statistical Analysis and Interpretation

The analysis encompasses two stages: first, a descriptive analysis of cross-tabulated data; then, logit regressions using two models. Model 1 tests the independent effects of gender, class, and other relevant explanatory variables on treatment-seeking; namely, continued, discontinued, and non-treatment. This model indicates only whether gender and class are independently significant without telling us any more about how they relate to each other. To study these interactions we use model 2, with non-poor men as the reference group and dummies for non-poor women, and for poor men and women. All odds ratios are adjusted for age and severity.

We use population estimates rather than sample totals in the cross-tables and regressions, as ours was a stratified random sample. The estimates were computed by weighting the data for each household by the probability of its selection. The robust standard error was used to correct for any heteroskedasticity while calculating p values. The results were generated using STATA (version 7).

Given that class differences are not sharp in Koppal (in common with similar agro-ecological zones elsewhere in India), we use a standard classification in the regression analysis: poor (first three quintiles) versus non-poor (top two quintiles). We also analyze differences among the poor group by further separating the "poorest" (quintile 1) from other "poor" (quintiles 2 and 3).

Although we do not measure gender bias in this study, we draw inferences about "pure" and "rationing" bias from model 2. "Pure" as well as "rationing" bias could, in principle, exist among both poor and non-poor households, depending on the magnitude of health care costs. However, we expect that, other things being equal, their proportions would vary, with pure bias being higher among the non-poor as indicated by evidence of greater restrictions on the physical mobility of women in such households, greater resistance to their becoming economically independent (20), and more adverse intra-household resource allocations (21). We would also expect rationing bias to be higher among the poor for any given decision, assuming that the pressure to ration would be higher in poor households.

Given the above, two situations are of particular interest, based on our data. First, if observed gender differences for any particular decision are significant among the non-poor and not very different between poor and non-poor, this would indicate the presence of some pure bias at least among the non-poor. Second, if gender differences are limited to the poor, we would expect that the entire difference is due to rationing bias among the poor.

FINDINGS

Expressed Needs

Self-reported health needs are widespread in Koppal, as 81.9 percent of the surveyed households had at least one sick member with either short- or long-term illness, or both. There were larger proportions of persons with long-term illnesses among the non-poor than among the poor, as shown in Table 1. This could partly be due to underreporting, as the survey could not eliminate proxy respondents in the poorer households. Proxy respondents mainly listed illnesses for which treatment was sought and mainly reported for young children. While they did occasionally report for the male head of household, his wife, or an aged mother, they almost never reported for a daughter-in-law. This would be an issue for poor households, which were not only bigger but had more complex hierarchies in joint and extended-nuclear kinship structures. Marginalized individuals—and unacknowledged or untreated illnesses—in such households would have a poorer chance of being listed by proxy respondents. Therefore, the data may underestimate the magnitude of illness, and possibly non-treatment, in poor households.

Table 1

Percentage distribution of persons with long-term ailment(s), by gender and economic class

	Whether sick with long-term ailment(s)		Gender differences,
Expenditure quintiles	Sick (row %)	Not sick (row %)	p value[a]
Quintile 1 (poorest)			
Female	1,200 (8.8)	12,476 (91.2)	
Male	813 (6.3)	11,998 (93.7)	<.001
Total	2,013 (7.6)	24,474 (92.4)	
Quintiles 2 and 3 (poor)			
Female	2,405 (11.6)	18,271 (88.4)	
Male	1,754 (8.3)	19,494 (91.7)	<.001
Total	4,159 (9.9)	37,765 (90.1)	
Quintile 4 and 5 (non-poor)			
Female	2,283 (15.1)	12,814 (84.9)	
Male	1,573 (10.4)	13,567 (89.6)	<.001
Total	3,856 (12.8)	26,381 (87.2)	

Note: Totals and subtotals are population estimates.
[a]Chi-square test, $df = 1$.

Despite these reporting biases, however, the proportions of sick women were significantly higher than those of sick men in all households, whether poor or non-poor (Table 1).

Treatment-Seeking for Long-Term Illness

For long-term ailments, which lasted for two years on average, we found gender and economic class differences in treatment-seeking (Table 2), but no significant caste differences. More women than men seem never to have treated their illness, among both the poor and the non-poor. Class differences in non-treatment were apparent among women, but rarely among men. However, treatment being discontinued despite persistent ill health seemed to vary by economic class for both men and women and by gender for some quintiles. These gender differences were not uniform across the quintiles, indicating the presence of interactions between gender and class, which we tested further with the regression analysis. Gender and class differences were also apparent for continued treatment but, again, the gender differences varied across the quintiles.

Table 2

Treatment-seeking for long-term ailment(s), by gender and economic class

	Treatment-seeking outcomes		
Expenditure quintiles	Continued treatment (row %)	Discontinued treatment (row %)	Non-treatment (row %)
Quintile 1 (poorest)			
Female	632 (49.1)	465 (36.1)	190 (14.8)
Male	494 (59.5)	296 (35.7)	40 (4.8)
Total	1,126 (53.2)	761 (35.9)	230 (10.9)
Quintiles 2 and 3 (poor)			
Female	1,428 (53.9)	887 (33.5)	333 (12.6)
Male	1,277 (70.9)	399 (22.2)	124 (6.9)
Total	2,705 (60.8)	1,286 (28.9)	457 (10.3)
Quintile 4 and 5 (non-poor)			
Female	1,610 (66.2)	592 (24.3)	231 (9.5)
Male	1,097 (70.4)	388 (24.9)	73 (4.7)
Total	2,707 (67.8)	980 (24.6)	304 (7.6)

Note: Totals and subtotals are population estimates.

Such differences are also revealed in out-of-pocket expenditures incurred for those who continued treatment. Households spent significantly smaller sums on the treatment of women than of men in all quintiles, except in the poorest (Figure 1). There were also apparent class differences in the expenditures incurred for men, while household spending on women was more variable across the quintiles. These patterns reflect differences in the quantity and quality of treatment received and providers consulted. For instance, although sick persons in all quintiles went to two providers on average, there are important gender and class differences in the types of providers they consulted (Figure 2).

Poor men approached government health workers/institutions more than did poor women, while the non-poor used private nursing homes/hospitals more than the poor. The most popular providers overall were RMPs/private practitioners (RMPs are rural medical practitioners), but even here we find gender differences in their use. Many of the RMPs/private practitioners are unqualified, but we cannot estimate how large this group might be, as sick persons themselves were not necessarily aware of whether the provider they consulted had a valid degree or not. Other unqualified practitioners such as healers and storekeepers were used less frequently by all except the poorest women.

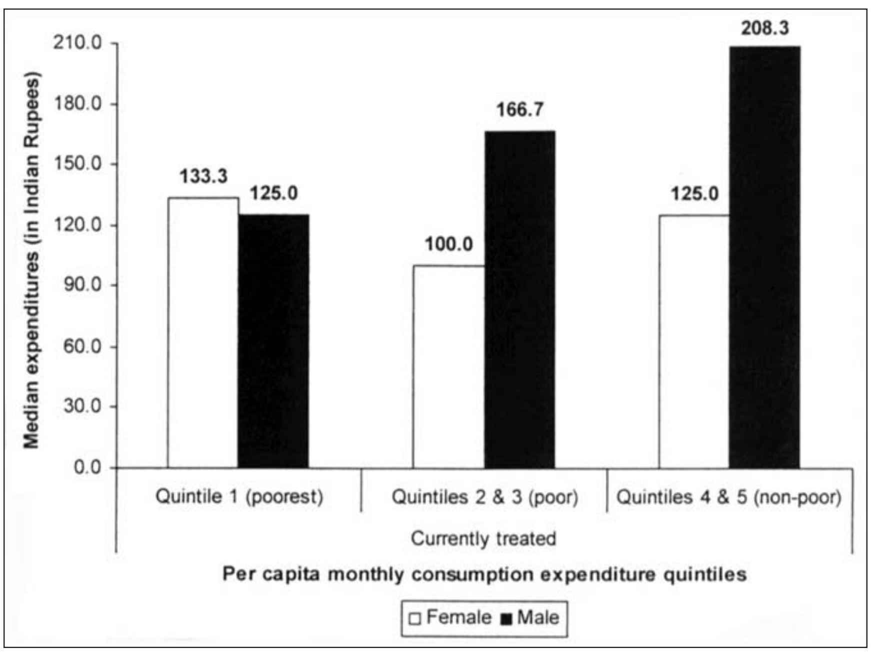

Figure 1. Continued treatment for long-term sicknesses: median expenditures incurred per month (in Indian rupees), by quintile (see text for explanation of quintile groups).

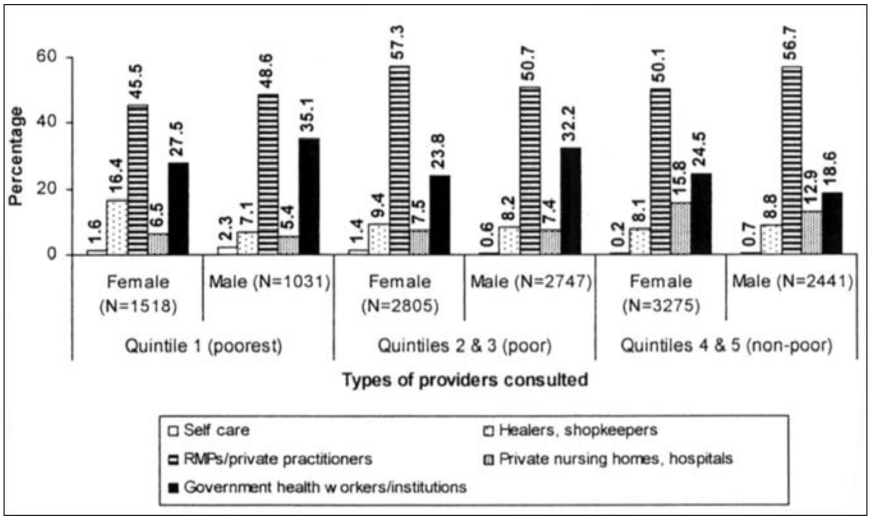

Figure 2. Percentage share of provider visits by sick persons continuing treatment, by gender and quintile (see text for explanation of quintile groups). RMP, rural medical practitioner.

Non-treatment. Gender and class were significant predictors of the likelihood of non-treatment, as shown in model 1 (Table 3). Women were three times more likely than men to never treat their illness (odds ratio (OR) 3.23); the poor were 1.55 times more likely to never treat than the non-poor. However, the apparent class differences in non-treatment were themselves differentiated by gender, as shown in model 2 (Table 4).

Compared with non-poor men, poor women were four times more likely to never seek treatment (OR 4.47); even non-poor women were twice as likely to never treat (OR 2.75). In contrast, poor men were not significantly different from non-poor men (Figure 3). Thus, the significant class differences in the likelihood of non-treatment, as indicated by model 1, were entirely due to differences among women ($p < .05$). Poor women were less likely to be treated than non-poor women and all men. Non-poor women, although better off than poor women, were also significantly worse off than all men. Furthermore, the magnitude of these gender differences did not vary between poor and non-poor households. This finding suggests that gender differences in the likelihood of non-treatment may be a function, at least in part, of "pure" bias that stems from lower value placed on the well-being of women. To the extent that there is rationing of health care, it seems to particularly affect poor women rather than poor men.

Other variables significantly and independently influencing the likelihood of non-treatment were illness severity and income-earning (model 1; Table 3). The

Table 3

Likelihood of continued, discontinued, and non-treatment for long-term ailments: estimates of odds ratios (model 1)

	Logit regression	Multinomial logit (continued treatment = 1)	
Independent variables[a]	Continued treatment = 1; otherwise = 0	Discontinued treatment = 2	Non-treatment = 3
Age	1.00	1.00	1.00
Severity	1.12**	0.93	0.78***
Income-earning			
Income earner	1.00	1.00	1.00
Non-earner	1.51***	0.67***	0.62**
Household headship			
Head	1.00	1.00	1.00
Non-head	0.79	1.59**	0.61*
Sex			
Male	1.00	1.00	1.00
Female	0.66***	1.22	3.23***
Economic class			
Non-poor	1.00	1.00	1.00
Poor	0.69***	1.44***	1.55**
Sample size	1,316	1,316	1,316

Note: Model 1 tested the independent effects of explanatory variables on treatment-seeking.

[a]Severity is number of difficulties caused by the illness; economic class: poor, quintiles 1–3; non-poor, quintiles 4 and 5).

*$p < .10$; **$p < .05$; ***$p < .01$.

more severe the illness or the greater the number of difficulties experienced, the lower was the likelihood of non-treatment (OR 0.78). Non-treatment was also lower among non-earners (OR 0.62). One explanation for this may be that for earners, the opportunity costs of treatment-seeking in terms of time and income foregone may be prohibitive, especially in a place like Koppal where services are sparse and of poor quality. Thus, some earners may never seek treatment. Disaggregated analysis by gender and class indicates that women-earners in

Table 4

Likelihood of continued, discontinued, and non-treatment for long-term ailments: estimates of odds ratios (model 2)

Independent variables	Logit regression: Continued treatment = 1; otherwise = 0	Multinomial logit (continued treatment = 1): Discontinued treatment = 2	Multinomial logit (continued treatment = 1): Non-treatment = 3
Age	1.00	1.00	1.00
Severity	1.11**	0.94	0.79***
Income-earning			
Income earner	1.00	1.00	1.00
Non-earner	1.49***	0.68***	0.64**
Household headship			
Head	1.00	1.00	1.00
Non-head	0.80	1.60**	0.61*
Gender and class subgroups			
Non-poor men	1.00	1.00	100
Poor men (pm)	0.90	1.07	1.33
Non-poor women (npw)	0.87	0.89	2.75**
Poor women (pw)	0.52***	1.54**	4.47***
Tests: Class differences			
Among women: coeff.(pw) = coeff.(npw)	***	***	**
Among men: coeff.(pm) = 0			
Tests: Gender differences			
Among non-poor: coeff.(pw) = 0			**
Among poor: coeff.(pm) = coeff.(pw)	***	**	***
Between poor and non-poor[a]: coeff.(pw) – coeff.(pm) = coeff.(npw)	**	*	
Sample size	1,316	1,316	1,316

Note: Model 2 tested interactions using non-poor men as the reference group, and dummies for poor men, non-poor women, and poor women. Economic class and gender were dropped to avoid multi-colinearity. Severity is number of difficulties brought on by the illness; economic class: poor, quintiles 1–3; non-poor, quintiles 4 and 5.

[a]The test was modified for continued treatment of long-term ailments to coeff.(pm) – coeff.(pw) = coeff.(npw), because a priori, coeff.(npw) > coeff.(pm) > coeff.(pw).

*$p < .10$; **$p < .05$; ***$p < .01$.

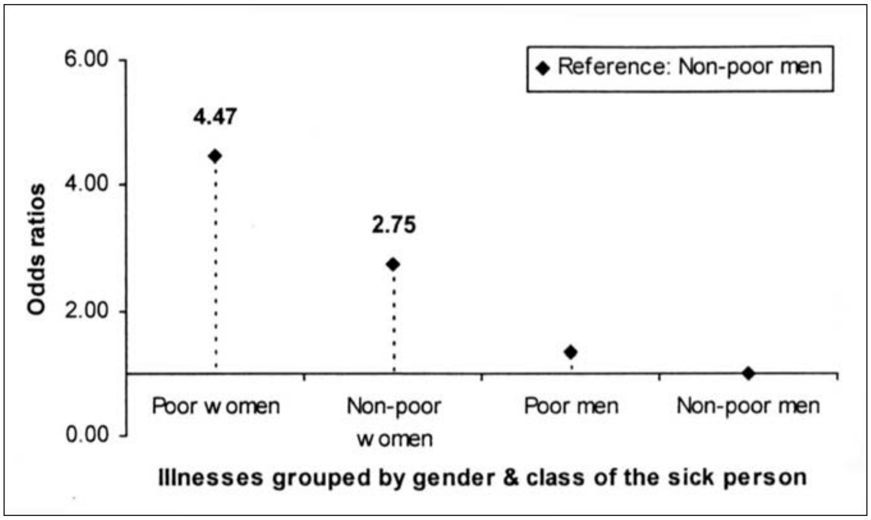

Figure 3. Never-treated long-term illnesses: age- and severity-adjusted odds ratios ($p < .05$).

non-poor households were the earners less likely to be treated than non-earners; income-earning made no difference to the likelihood of treatment for poor women and all men. Probing further, we find that most non-poor female earners belonged to nuclear households that had no other adult women with whom they could share their burden of (productive and reproductive) work. Thus, with no one to substitute for them in the household—given that men seldom participate in housework—and with no possibility of opting out of housework either, non-poor women may be choosing to opt out of treatment instead.

Discontinued Treatment. The decision to discontinue treatment despite not having recovered was significantly influenced by class: being poor significantly increased the likelihood of discontinuance (OR 1.44; Table 3). Gender was not a significant predictor in model 1, but the results of model 2 reveal a significant gender effect among the poor (Table 4). Figure 4 shows that non-poor women and poor men were as likely as non-poor men to discontinue treatment; only poor women were significantly more likely to do so (OR 1.54). There were highly significant class-based differences—with the poor more likely to discontinue treatment than the non-poor—but these were confined to women alone ($p < .01$). Gender differences were significant among the poor ($p < .05$) but not among the non-poor, indicating the presence of rationing bias against women among the poor. However, the interaction term testing explicitly for gender differences between the poor and non-poor was only weakly significant ($p = .07$).

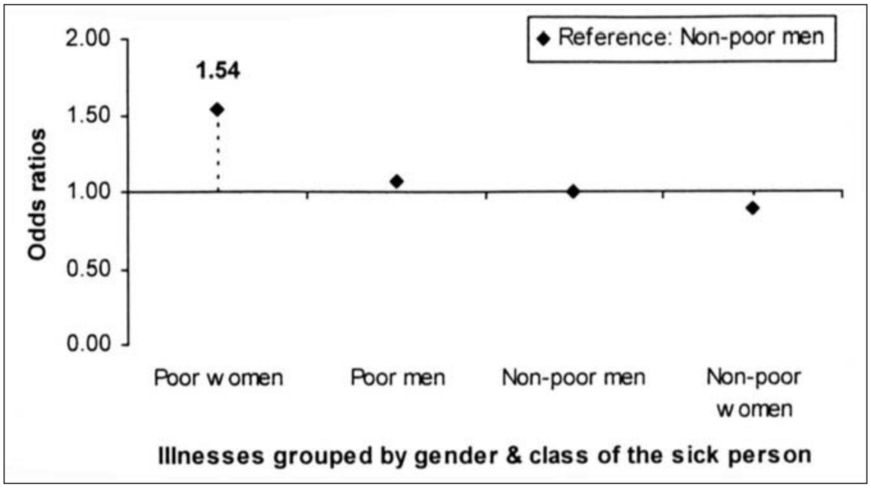

Figure 4. Discontinued treatment for long-term illnesses: age- and severity-adjusted odds ratios ($p < .05$).

To explore this apparent anomaly, we split the poor quintiles into two sub-groups: poor (quintiles 2 and 3) versus poorest (quintile 1); we then conducted regression analysis with dummies for women and men in quintiles 1, 2 and 3, and 4 and 5. The results show that gender bias in rationing varied between households in quintiles 2 and 3 and those in quintile 1. Men in the poorest households were worse off than those in poor households ($p < .01$), as well as the non-poor ($p = .05$). There were no significant differences between the poorest men and women, and none between those at the top of the economic spectrum. The main source of gender difference among the poor seems to have come from quintiles 2 and 3 ($p < .05$), which was significantly different from the top quintiles ($p < .05$). This disaggregated analysis clearly shows that rationing within households of quintiles 2 and 3, through discontinued treatment, was gender-biased. Men in such resource-constrained households remained unscathed, unlike women who bore almost the entire burden of rationing. In contrast, among the poorest households (quintile 1), where perhaps women cannot be pushed any lower, rationing also affected men, thereby reducing the extent of the gender difference. Put differently, both the poor (quintiles 2 and 3) and the poorest (quintile 1) rationed health care; among the former, the burden was borne almost entirely by women, whereas in the latter, both men and women had to cut back on their needs.

Apart from economic class, which was gender-biased, there were other variables that independently influenced the likelihood of discontinued treatment (Table 3). What mattered was whether the person was the household head or a non-earner. Non-heads of household were more likely to discontinue treatment than household heads (OR 1.59), but non-earners were less likely to discontinue treatment than earners (OR 0.67). In contrast, illness severity ceased to be significant. Thus, among those who began treatment, the decision to discontinue was made on the basis of who the sick person was, not on his or her need for care.

Continued Treatment. Model 1 indicates that women were less likely than men, and the poor less likely than the non-poor, to continue treatment (OR 0.66 and 0.69, respectively; $p < .01$). Apart from gender and class, income-earning and sickness severity mattered. Compared with earners, non-earners were 1.51 times more likely to continue treatment. The more severe the illness, the higher was the likelihood of continued treatment (OR 1.12).

Figure 5 shows that poor women were significantly less likely to continue treatment than non-poor women and all men (OR 0.52). There were significant class-based differences, with the non-poor more likely to continue treatment, but model 2 shows that these differences were confined to women alone ($p < .01$) (Table 4). Gender differences, while significant among the poor ($p < .01$), were not significant among the non-poor, and the magnitude of these (gender) differences varied significantly ($p < .05$) by class. This confirms that gender differences in the likelihood of continued treatment had an economic basis. Women had a better chance of securing treatment in non-poor households, but ended up bearing a disproportionate burden of rationed care in poor households.

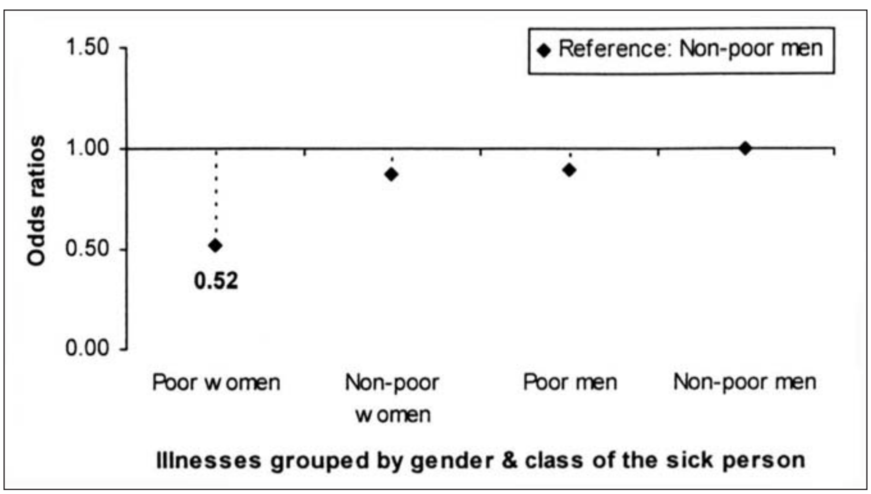

Figure 5. Continued treatment for long-term illnesses: age- and severity-adjusted odds ratios ($p < .05$).

Further regression analysis using three economic categories indicates that gender differences were significant only in quintiles 2 and 3 ($p < .01$); differences were not significant among the poorest and the non-poor. In non-poor households, economic class did not discriminate against women, who were then able to catch up with men. But in the poorest households, men were the ones who were forced to fall back to the level experienced by the women.

These results suggest that gender and economic class operate at different levels and interact in important ways. If we think of being treated at all versus never being treated as the first level, it is gender (pure bias and possibly some rationing bias) that discriminates between people; even economic class differentiates poor from non-poor women, but does not differentiate between men. Once people begin to receive treatment, economic class seems to become more important than gender per se, but even here, class bias operates mainly through women. There is significant rationing bias against women in the poor quintiles (2 and 3), but in the poorest quintile, health care is rationed for both women and men.

CONCLUSIONS

Our research highlights the ways in which households respond to health needs in poor agrarian communities where most forms of medical care have to be purchased out-of-pocket. Non-significant caste differences imply that basic access to health care in such a context is a function of purchasing power—and therefore economic class—rather than traditional discrimination or bias.

Responses to long-term ailments showed elements of class inequalities as well as both types of gender bias—pure and rationing. These class variations can themselves be properly understood only through a gender lens. Apparent class differences in non-treatment, discontinuation, or continuation of treatment were almost entirely due to differences among women rather than men. This finding has to be qualified for the poorest men who discontinued treatment at higher rates than did other men.

Rationing through discontinuation of treatment was an important phenomenon and was particularly gender-biased among poor households in quintiles 2 and 3. Men in these households seemed to be able to insulate themselves and to pass on the burden to women. However, in the poorest households, where women perhaps could be pushed no lower, men were also forced to curtail treatment. This shows just how acute the problem of health care affordability has become, and how rationing systems at work within households reproduce gender and economic inequalities.

We also found evidence of pure gender bias, which determined higher non-treatment for women in all expenditure quintiles. Thus, women were doubly discriminated against: by differentially having to bear the burdens of unaffordable health care and by adverse gender norms. All women suffer from the consequences of gender bias, but it is poor women in particular who disproportionately bear the burdens of both gender and economic class.

The foregoing analysis demonstrates how much more can be learned when a combined gender and social class lens is used to understand health inequities. Standard class analysis of the impact of economic inequality on health may miss, or even mask, the actual processes at work. This has significant policy implications for health systems undergoing reform. For instance, health insurance programs that aim to buffer poor households against rising health care costs would need to be gender-sensitive, as gender bias in treatment-seeking can persist even after the removal of economic barriers to access (20, 23). Put differently, while men appropriate the benefits of risk protection, women may continue to be excluded and marginalized by pure (and rationing) bias at work within households.

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