Health care reform presents an opportunity to ameliorate long-standing inequities in existing health systems – or inequitable “policy legacies”. Conversely, reforms may introduce new inequities. This chapter argues that policy legacies are gendered in crucial ways, and that reform is most likely to take place in moments of perceived “crisis” in which epistemic communities play an influential role. In this context, the keys to gender equitable health reform are the ability to overcome previous, gender-inequitable policy legacies and epistemic communities that hold principles compatible with gender equity and which are integrated with members who are conscious of how health systems can shape gender equity. The salience of these twin elements is illustrated through a case study of Peru’s health reforms of the 1990s and early 2000s.

When health insurance coverage is left to private insurers to decide what shall be covered, more often than not, women’s health care needs – from birth control,
cervical cancer care to childbirth coverage – are considered “additional needs” that require extra fees if they are offered at all (e.g. Pollack 2002, Ewig and Hernández 2009, Ewig and Palmucci 2012). When health systems in poor communities are re-structured to provide incentives for families to bring children in for well-baby care including nutritional assessments and vaccines, more often than not, these incentives rely on mothers or other female caregivers to take responsibility for this carework (Ewig 2006, Gideon 2008, Molyneux 2006). When fees for basic health services are introduced, these serve as a barrier for women to access health care, more so than for men, because women’s reproductive health requires more routine visits than men’s, and these costs can become especially problematic if within the family the male is the primary cash-earner and disapproves of his wife or female partner seeking care (Ewig 2006; Gómez Gómez 2002, Nanda 2002). In some contexts, such as Peru or Guatemala where indigenous women are less likely to speak the language of health care workers, economics and gender may intersect with racial/ethnic barriers. For example, when incentives for greater productivity were introduced into Peruvian state health worker contracts, this resulted in a toxic mix where personnel used racism and linguistic barriers to justify health care interventions without proper consent in order to achieve health care “productivity” goals (Ewig 2006b). For all of these reasons, the ways in which health care systems are structured – insurance systems, fees, the range of services offered, patient health care incentives and work structures and regulations – matter for gender equity. These matter for the quality of care provided; for the economic, geographic and cultural access to the services themselves; and for the additional family carework
burden that women largely shoulder. Ultimately, these structures matter fundamentally for women’s dignity and well-being.\(^1\) While these are the specific ways that health structures may shape gender equity, one can also identify race, class or age based inequities perpetuated by specific health system structures, many of which also intersect with each other and with gender equity.

While we have significant and growing evidence of how health care systems may impact gender and other forms of equity, fewer scholars have considered the gendered politics of health reform processes.\(^2\) When health care reforms are undertaken, these present both an opportunity and a risk in relation to gender and other forms of equity. Reforms may be an opportunity to address and ameliorate long-standing inequities in existing health systems – or inequitable “policy legacies”. Conversely, reforms may (wittingly or unwittingly) introduce new inequities. Key to a reform process that successfully addresses gender inequities is careful attention to the design of policies with gender equity in mind. Thus, as I have argued elsewhere, once health sector reform is on the political agenda, two elements are essential for successful, gender-equitable policies: the ability to overcome previous, gender-inequitable policy legacies and the integration of the policy reform itself with a consciousness of how health care can be structured to best prevent inequities (Ewig 2010). This is, however, more easily said than done. Policy legacies, by definition, are difficult to change, while gender-equitable design requires not just the integration of traditionally insulated and technocratic reform teams with members that advocate for gender equity, but also over-arching policy principles that are compatible with gender equity.
This chapter focuses on gender and the politics of health sector reform with the objective of outlining both the barriers and keys to gender equitable health sector reform once reform is on the political agenda. Opportunities for gender equitable reforms arise when the opportunity for reform itself arises, and when epistemic communities engaged in the reform process hold principles compatible with gender equity and are integrated with team members who are conscious of how health systems can shape gender equity. I begin by defining policy legacies, outlining the barriers that these may pose to reform, and how policy legacies themselves can be gendered.

Overcoming policy legacies is not easy. More often than not this requires some kind of “crisis” that spurs policy-makers to look outside their typical policy repertoire for alternative policy solutions. I then turn to the issue of reform principles and the integration of reform teams with members conscientious of gender equity. I argue that, in this regard, epistemic communities matter significantly. These communities often obtain greater influence in times of crisis or flux; thus the principles of and participants engaged in an epistemic community matter for whether or not gender equitable policies will be considered at the time of reform. I end by illustrating my argument with an account of how the health reform process played out in Peru in the 1990s.

**Gendered Policy Legacies and Health Sector Reform**

Past policies create interests, institutions and norms that are difficult to change. Thus, policy change is not simply the act of introducing a new policy onto a political agenda and garnering support; it is also a process of overcoming interest groups,
institutions and norms associated with and supportive of the old policy structure. Decades –sometimes centuries– of policy continuity are not easily undone. This is the fundamental contribution of those that have developed the concept of “policy legacies”; previous processes of policy development serve to create an entrenched policy context that, more often than not, serves as an important barrier to change. Paul Pierson was the first to elaborate the concept of policy legacies, the different possible types of legacies, and how these might operate (1994). Perhaps the most important type of policy legacy is “interest group legacies”; societal groups that benefit from a specific set of policies. The benefits may range from the directly material to access to power, and the group will seek to defend these benefits in the face of reforms. Other legacies may be in the form of institutions; state or private institutions that become the scaffolds of a public policy are not interest groups but are institutions with budgets, personnel, physical spaces and institutional identities that have vested interests in defending their own survival. Finally, there are what Pierson refers to as “learning legacies” and “lock-in” effects; these are essentially norms and expectations, the first primarily applicable to policy makers and the latter to publics, with regard to how policies are traditionally organized and delivered. Following Pierson, a host of authors have used the concept of policy legacy to help explain resistance to social policy reform in a range of contexts from Western Europe and the United States (Pierson 1994, Huber and Stephens 2001, Hacker 2002) to Latin America, Asia and Eastern Europe (Brooks 2009, Dion 2010, Haggard and Kaufman 2008, Pribble 2013).
What most authors that work within a policy legacies framework do not recognize is the fact that these policy legacies are not simply upholding an entrenched set of policies, but that they also uphold an entrenched set of privileges, privileges that often reinforce gender, race and class distinctions. As I have argued elsewhere (Ewig 2010), policy legacies are themselves gendered, raced and classed. The policy status quo often grants material, social, or political privilege unevenly across key axes of societal power. Thus, policy legacies often seek to protect not just generic material benefits or access to power, but gender, race and class privileges in particular.

A discussion of the specific kinds of policy legacies that health sectors can generate helps to illustrate. The health sector is possibly the most likely policy sector to develop strong policy legacies. The very complexity of health services yields multiple layers of providers, from primary clinics to sophisticated hospitals, with insurers, pharmaceutical companies and health supply and equipment purveyors further enmeshed in the overall system. Health systems also employ large workforces of health care professionals, and serve a range of beneficiaries. Each of these possible constituent groups: insurers, pharmaceutical and supply companies, health professionals and health care beneficiaries are all potential interest group legacies; each may have an interest in maintaining the status quo – from insurance rates to beneficiaries’ desires for a particular genre of treatment. Within the context of a political project of reform, reforms often provoke these constituencies to organize as interest groups – patient group advocates, health sector unions, insurer lobbies are just a few possible examples.
These interest group legacies are usually the most vocal and visible opponents of reforms.

Existing institutions, too, may become vocal opponents of reform. In health systems with largely public provision, state health institutions (Ministries of Health, Social Security Health Institutes, National Health Services) have vested interests in maintaining a stake in the national health system, be it from the vantage point of maintaining political influence within the state itself or from the vantage point of protecting their budgets and workforce. In states that grant a role for the private sector in health provision, these too generate institutions, as well as interests. These may be networks of providers or insurers that seek to maintain influence in policy discussions as well as defend their own material stake in the sector.

Yet, other more subtle legacies also may come into play. Policy makers may display preferences for particular policy approaches that fit with past experience. For example, the historic market-orientation of US social policy made, in the case of the United States, the idea of a single-provider or a single-payer health system out of the question when President Clinton and then President Obama pursued health sector reforms. Such preferences built from past experience constitute policy-learning legacies, and can shape the range of choices that are considered politically tractable. Somewhat different are “lock-in” effects. Health sectors might, for example, offer in-home doctors visits, as is common in France, or individual choice of doctor, as is common in the US. Policies such as these may give rise to public expectations for policy continuity; reforms that attempt to change these policies may face greater resistance.
While this distinction among types of policy legacies is useful for understanding the variety of barriers these may pose to reform, it is also worth considering how these legacies may engender particular kinds of social privilege along the axis of gender in particular.\textsuperscript{3} This is perhaps most easily illustrated through interest group legacies, which may not only have vested interests in defending existing policies which might provide them material benefits or access to power, but often have interests based on their predominant class, gender or racial make-up. For example, historically largely male unions in many countries have defended the “male-breadwinner” model of employment, arguing for higher wages in order that their wives could stay out of the workforce. Applied to the health sector, in countries where social policies were largely shaped by union demands (as in the corporatist pattern common to Central Europe or the residual employer-based model of the United States, both established at the end of the 19th century) it followed that early health benefits were enjoyed primarily by workers, and wives were beneficiaries only by virtue of marriage, creating a clear gendered hierarchy of privilege. Thus, when unions become interest group policy legacies, and defend policies that promote male breadwinner privilege, they may also defend a particular gendered order.

But it is not just the interest groups that resist reform and uphold gender hierarchies; the institutions themselves do as well. A large body of feminist work on the welfare state has demonstrated how welfare state institutions not only stratify along class lines but also along gender lines.\textsuperscript{4} This also applies to health sectors, as fundamental pillars of overall national welfare systems. When health sectors are not
unified, but instead are stratified, with different public or private systems serving different classes of workers, as with systems that emerged out of historically ‘Bismarkian’ patterns of worker cooptation (such as Central Europe and Latin America), and those that evolved into more residual, market-dependent models (like the Antipode countries of the US, Australia, Canada and New Zealand) these are often stratified by gender as well. Because women are either out of the workforce altogether, or clustered in the lower-income earning and informal sectors of the labor force, they are also more likely to be relegated to poorly financed and lower quality portions of stratified health care systems (Gideon 2007, Ewig and Hernández 2009). For example, where health systems are divided between publically financed and often means-tested public systems that target the poor and pay-as-you-go state social security and/or private systems that are a worker’s benefit, women will be concentrated in the poorly-financed public systems while male workers are more likely to be in the better quality social security or private systems. When it comes to the politics of reform, the governing bodies of the social security systems, such as social security institutes, typically have more political clout. And, when these seek to defend the policy status quo, they often also hold up a gendered hierarchy of health care privilege.

Similarly, policy learning legacies and lock-in effects, although not as closely associated with a particular group of people, can have important implications for gender equity. The previous example of policy makers’ and the public’s resistance in the US to single-payer health care as “government intrusion” in this market-oriented political context serves to illustrate. By categorically opposing a single payer system, the most
gender-equitable financing option of health care was left off the negotiating table. Because women bear children and live longer than men, insurers view women as more costly. Routine reproductive health services (birth control, cervical cancer screenings, mammograms) and especially childbirth are viewed by insurers as an additional cost burden posed uniquely by women (even if these women plan to bear no children – as to insurers all women of reproductive age present the “risk” of bearing children). One solution to the higher “risks” posed by human reproduction – as is the case with all health care risk profiles – is to pool resources so that the burden is shared among a larger group, and thus the costs of these risks, when they arise, are spread thinly, and do not present a major burden for any one group. Conversely, when “risks” become perceived as an onerous cost – a more likely scenario in small pools or individual insurance markets – this provides incentives to deny particular types of coverage. Single-payer systems provide the largest possible risk pool, and thus are the most likely to ensure equity in the range of services offered, including health care services for women. Single payer systems may involve government provision of health care services, as in the National Health Service of the United Kingdom, or entirely private provision, as in Canada.

The Role of Epistemic Communities in Overcoming Legacies and Designing Equity

Given the range of possible interests, institutions and norms that constitute policy legacies and which may defend existing policy arrangements, major social policy, including health, reforms are rare. As a result of the obstacles posed by legacies, radical
reforms that eliminate old policy systems may in fact be impossible, and policy makers resort to layering new policy programs next to existing systems, a pattern seen in Brazil (Faletti 2010) and the United States between 1965 and 2010 (Hacker 2004). More radical reforms that eliminate policy legacies most often take place in contexts of a perceived crisis. It is at moments of crisis that epistemic communities become most influential. Thus, for gender equitable health reform to occur, the principles of the engaged epistemic community must be compatible with gender equity and the community must be integrated by members versed in gender equity – including what it is and how to achieve it.

Several authors have argued that radical social policy reform processes require some form of crisis in order to spur reform in the first place (Weyland 2002, 2006, 277; Haggard and Kaufman 2008, chapters 5 and 7; Orenstein 2008, 61; Ewig 2010). In the case of health sectors, the existing health system must be viewed as failing in some way; perhaps it is viewed as fiscally unsustainable, or woefully inadequate in its reach. “Crisis,” especially in the social policy realm, is not necessarily an empirically measurable phenomenon but is more often a matter of perception and political context. For example, the fact that Colombia’s health care system historically reached less than 15 percent of the population for much of its existence was a crisis in empirical terms, but one that endured for years because key political actors did not perceive it as a problem. Lack of access to health care became a “crisis” that induced political change only once Colombian social movements succeeded in framing social inequalities – including lack of access to health care – as the root of Colombia’s long-standing internal conflict.
crisis is perceived as grave enough, or if existing institutions or structures are perceived to be part of the underlying problem causing the crisis, then policy makers may act against policy legacies and move toward a radical reform agenda, rather than relying on past policy-learning legacies and simply making adjustments, but not significantly restructuring existing systems. Of course, reformers may not succeed in their objectives due to policy legacies, but there must be an impetus to provoke a reform effort in the first place.

Once politicians are willing to look beyond their own national, historical policy context for solutions to a crisis, what reform will they choose? Given the conditions of uncertainty provoked by crisis, politicians in crisis contexts are more likely to seek advice and information from epistemic communities (Haas 1992, p. 15; Hall 1993; Zito 2001). Defined by Peter Haas, an “epistemic community is a network of professionals with recognized expertise and competence in a particular domain and authoritative claim to policy-relevant knowledge within that domain or issue area” (1992, p. 3). The professionals that make up an epistemic community are usually embedded in both international and state bureaucracies and interact with one another as part of a transnational network centered on a particular policy domain. These professionals share: a set of normative and principled beliefs; a set of causal beliefs; specific notions of validity and a common policy enterprise, usually to address a particular problem (Haas 1992, p. 3). Their reliance on expert knowledge is what makes these professionals, and their networks, distinct from other transnational networks (Cross 2013, p. 143). Epistemic communities can be highly influential by outlining for policy makers the
“salient dimensions” of a policy problem and the “chain of events”, or cause and effect, likely to proceed from a particular policy option. They are particularly influential in complex policy areas where information is more difficult to sort and weigh (Haas 1992). Finally, for epistemic communities to have influence, they also must “have ready access to decision-makers” and little competition from other competing actors or epistemic communities (Cross 2013, p. 145).

The complexity of the health sector, coupled with its dense national and international bureaucracies (the variety of national bureaucracies that may regulate or provide health care, coupled with international institutions like the World Health Organization (WHO), the World Bank and others) make it a policy domain where epistemic communities tend to be rooted, and where their advice is often sought out by policy makers. Yet, in health sectors and other policy areas, there are often competing epistemic communities, with differing sets of normative, principled beliefs, and with differing degrees of influence at any one moment (Cross 2013; Orenstein 2008).

The principles of an epistemic community may set constraints or provide opportunities for gender equitable policy change. This is because problems become defined in ways reflective of the principles of the epistemic community, with prescriptive solutions that follow-on these definitions. For example, if an epistemic community committed to market-based principles is relied upon to provide expertise in a given setting, the market itself is likely to be viewed as part of any solution. Given its emphasis on markets, and less on social or political factors, gender equity is less likely to be recognized as an issue except through the lens of cost-benefit. For example, “costly”
reproductive health care is less likely to be covered. And, women in families are more likely to be seen as potential “free” labor for ensuring greater benefits at reduced costs. Without an explicitly feminist critique within this epistemic community that points to the long-term costs of not covering reproductive health care (for example, excess morbidity) or an accounting of the time loss to women’s productivity of additional carework, gender inequitable reforms are more likely to prevail. Yet, more than needing a gender lens to sort through costs and benefits more broadly conceived, a cost-benefit approach is simply less open to understanding the social, cultural and political nature of gender equity. For example, it is less likely to recognize the power inequalities within families that are reinforced by upholding traditional gender roles.

Given the potential influence of epistemic communities over the direction of health reforms, integration of these communities with members that incorporate an understanding of gender equity in health systems into their repertoire of expertise is an essential prerequisite for gender equitable reforms. But, again, this is easier said than done. By their very nature, epistemic communities tend to be closed networks. Specific, often unspoken, credentials are required. Haas speaks of epistemic communities as networks of “scientists” or “social scientists” (1992). In the health domain, this usually translates into a minimum of a medical degree or public health professional degree. Sometimes demographers or health economists with higher degrees may also participate. Moreover, an individual must achieve a particular stature within their bureaucratic entity before they will be perceived as a relevant “expert”.
Credentials coupled with professional position can serve as important barriers to entry, for any individual, and to those with an interest in gender equity in particular. Nurses, for example, are predominantly women and often witness and experience gender inequities on the job. Yet rarely are their nursing credentials viewed as sufficient expertise in health epistemic communities. At the same time, as with all professional organizations, women often face discriminatory obstacles to reaching upper tier professional positions. This is not to imply that expertise in gender equity is or ought to be an exclusive domain of women, but life experience often does make gender equity more salient to women, and thus an information domain of greater interest. Yet, women are less numerous in those top bureaucratic positions and their credentials less recognized.

The principles of the epistemic community may also attract particular kinds of participants. Those that are centered on economic solutions, for example, will tend to be dominated by economists that have historically eschewed gender as an important domain and which is a profession dominated by men. Moreover, the likely bureaucracies within which an epistemic community based on these principles would be housed (Ministries of Finance, the World Bank or the relevant regional development banks) tend to be staffed by men and have historically been resistant to specific calls for gender equity (Kuiper and Barker 2006). By contrast, those epistemic communities that are rooted in public health, or rights-based principles will have different member and institutional profiles. While still male-dominated, the health professions have become more gender-integrated than economics, as have health ministries and international
health organizations, like WHO. Rights-based principles, too, tend to invite broader domains of expertise and may be rooted in not just national health ministries but potentially other bureaucratic domains, like women’s ministries. Moreover, international institutions like the United Nations (UN) are the locus of rights-based ideals. UN entities include WHO, but also the variety of UN offices such as UN Women (and its predecessors) and the UN’s variety of special rapporteurs.

**Gender and Health Sector Reform in Peru**

Peru’s health reform process of the 1990s is illustrative of the importance of both policy legacies and epistemic communities in shaping gender equity. Peru had, like most nations, very durable policy legacies from its long history of health policy formation, and these legacies had created their own gendered inequities. The dual economic and political crises of the early 1990s served as a trigger to initiate reforms of the health system. As with reform processes in economic and social policy sectors across the Latin American region, the political process itself was highly insulated within government bureaucracies, with little room for influence by actors in broader civil society. Yet, those that desired reform – the President and his close advisors – did not have a roadmap; old policy patterns seemed to have contributed to the crisis, so they searched for new solutions. It is in this context that two epistemic communities competed for influence over the reform process: the neoliberal and the rights-based approaches to social policy reform. Of the two, the neoliberal approach clearly
dominated, but the rights-based one unsuccessfully attempted to influence reforms to the government’s family planning program.

Peru’s health system dates to the late 19th century when coastal, white political leaders worked to establish a basic public health infrastructure serving primarily the poor, indigenous population and targeting women in particular. These elites were influenced by the Lamarkian view of eugenics predominant in Latin America at the time that sought improvement of the race not through biological means, but through social change that they believed could lead to racial betterment (Stepan 1991). In 1908, Peruvian intellectual Francisco Graña coined the term autogenia, a Peruvian version of eugenics that sought to improve the “race” internally through raising health and nutritional standards (de la Cadena 2000, p. 17). Women, due to their biological and social reproductive roles, were the primary focus of these early health initiatives, given that they were seen as the vehicles through which hereditary or acquired characteristics could be cultivated (Stepan 1991, chapter 4; Zulawski 2007, chapter 4). Public health expansion was also motivated by desires to increase economic development; expanding mining and agriculture sectors required a larger and healthier labor force (Mannarelli 1999, Contreras 2004). Health facilities in isolated regions, such as the Amazon, also served a third objective of “civilizing” indigenous populations. The resulting loose network of government and charity health posts, clinics and hospitals were basic in nature. Thus, Peru’s public health system was established on highly gendered and racialized principles – national improvement and economic growth would depend on
increased population, and a racially transformed population. Both objectives depended intimately on women’s reproductive capacities.

More than 30 years later, between the 1930s and 1950s, union activism by workers and co-optation of their movements by government leaders lead to a layering of much more extensive and higher quality health systems next to the existing, public health structure established in the 19th century. Industrialization, migration, and urbanization led to the emergence of two new classes of workers – urban factory workers and middle-class professionals. The dominant poor/elite class division of the 19th century had begun to loosen as a new class category, the urban worker, emerged. These urban industrial workers and middle-class professionals represented a small new group of elites and a new racial group: many were mestizo, or mixed white and indigenous descent. Organized in separate white and blue-collar unions, over the course of three decades, these workers and professionals pressured Peruvian political leaders to create separate, higher quality health systems. In a co-optive pattern reminiscent of the Otto Van Bismark’s Germany, successive authoritarian leaders created first a Workers’ Social Security (SSO, Seguro Social del Obrero) system in 1936, and in 1946 a separate white-collar health and pension system, the Employees’ Social Security System (SSE, Seguro Social del Empleado). Each had separate hospitals and insurance systems, with the Employee hospital rivaling the quality of elite private hospitals. Both far surpassed the quality of the public health system run by the Ministry of Health. Eventually, in 1979, Peru’s military government combined the blue and white-collar systems. But even as late as 1995, the combined social security health system served
only 26 percent of the population while the public system served 52 percent and a full 20 percent had no access to health care at all (Ewig 2010, p. 53).

It is crucial to note the gendered and racialized nature of the separate health systems that evolved in Peru. While the public system specifically targeted women and indigenous peoples more generally, the better quality social security systems were developed explicitly for mestizo men in the formal workforce. This was primarily due to the fact that women composed just 21.7 percent of the economically active population in 1961, and 25.1 percent by 1981 (INEI 1999). But even if they were economically active, most women worked in the informal sector or as domestic workers, and the SSE and SSO initially did not cover either of these categories of workers. The gendered division of coverage was nominally improved in the 1970s when the military government incorporated domestic workers into the social security system (Mesa-Lago 1989, p. 178). However, reform was mitigated by domestic employers’ evasions of payments, greater than the already high rate by employers in general. Dependent wives comprised just 7 percent of those insured by social security in 1961, but 23 percent by 1981. The total number of adult women covered by social security was probably higher, but not dramatically so, due to the employment trends discussed previously.

For wives and common-law partners who were insured as dependents, the coverage SSE and SSO provided was extremely limited. Originally, wives of insured male workers were only covered for maternity health care – all other health care for wives was either through the public health system or paid out of pocket in the private sector. In 1975, children under one year of age were added as dependents (Mesa-Lago
1989, p. 181; Roemer 1964). Only in March 1979 did the outgoing military government, as part of consolidating the SSE and SSO systems, expand dependent coverage to cover a worker’s spouse and children under age eighteen. However, women workers were not able to carry a spouse or dependent on their social insurance policy until 1992, further demarcating the social security system as highly masculine. Together, the dual public and social security health systems reinforced gender, race and class stratification already evident in Peruvian society.

When President Alberto Fujimori urged members of his cabinet to pursue a reform of the health sector in the early 1990s, several key policy legacies stood in the way. First, unionized workers sought to preserve the benefits they gained from a separate, higher quality health system. More potent yet were unionized doctors that feared changes in salary and job security, with doctors in the social security health system reaping higher benefits than those in the public sector and boasting a stronger union. The Social Security Institute (at the time called the Instituto Peruano de Seguridad Social) feared losing institutional power in relation to the Ministry of Health, should the reform imply a unification of health systems. And, on a normative level, while beneficiaries of the social security systems had always been viewed as important protagonists that had to be negotiated with, policy makers’ view of beneficiaries of the public health continued to be patronizing.

By the early 1990s, a combination of economic crisis and civil war had led to a near collapse of the Peruvian health systems, and this in turn predisposed President Alberto Fujimori to support dramatic steps to rectify problems. But, he left the course of
action up to the policy experts in the Peruvian bureaucracy, many of whom were engaged in the neoliberal epistemic community. A health minister in Fujimori’s early administration recalled that in reaction to the crisis the president insisted “that there be health care,” but left the minister to worry about the “details” (Freundt-Thurne 1998). Thus, the reform scenario was one typical of that foreseen by scholars of epistemic communities; perceived crisis leads to a search for policy alternatives, and a reliance on experts largely working within state and international bureaucracies for solutions.

Two competing epistemic communities shaped the context for Peru’s health reform process of the 1990s: neoliberal development and the rights-based, human development community, with the latter rising in express opposition to the neoliberal model. The principles of the neoliberal epistemic community were based on classic economic theory, which prioritized market over state solutions to economic as well as social problems. This epistemic community was composed of a network of policy makers that spanned both national and international institutions. Internationally, this community was embedded most in the Bretton Woods institutions, such as the International Monetary Fund and the World Bank, but other international organizations as well as regional actors also played significant roles (Orenstein 2008, chapter 2). The World Bank and the Inter-American Development Bank (IADB) were the institutions most closely tied to Peru’s health reforms, through a series of reform loans. The bilateral USAID was also engaged to a lesser extent. Nationally, adherents to neoliberal principles and members of this community were embedded in key reform institutions,
such as the Prime Minister’s office, the Ministry of Economics and Finance, and the Ministry of Health.

By contrast, the United Nations prioritized human rights through its human development paradigm, which emphasizes not just economic but also social, cultural, and political dimensions of well-being (Haq 2003). As part of this focus, the UN also supported measures aimed at increasing gender equity and women’s rights, from conventions on women’s rights to the Gender-Related Development Index, which measures gender equity disparities across countries. This epistemic community arose in response to the neoliberal one, offering an alternative rights-based vision that prioritized human and social dimensions over the market. Yet, the nature of its international institutional base, UN organizations, meant that this epistemic community lacked the kinds of direct connections—such as loans and advisors—to Peru’s reforms that the World Bank, IADB and USAID had. While the World Health Organization and its regional sub unit, the Pan American Health Organization, are UN entities, in the mid-1990s these suffered from poor leadership and their principles had drifted more closely to the neoliberal epistemic community. In Peru, the rights-based epistemic community had connected most strongly with local feminist NGOs as a result of the UN sponsored World Women’s Conferences, like the 1995 Fourth World Conference on Women in Beijing, China. But it found few inroads into the Peruvian state bureaucracy; it was not as established as an “expert” community embedded in national bureaucracies to the same extent that the neoliberal community was.

Turning to the issue of the gendered nature of these epistemic communities,
very few of the members of the neoliberal epistemic community were women. When women were engaged, they tended to be contracted through the international side of the neoliberal epistemic community. The main IDAB contact in relation to Peru’s health reform was a US woman, and the main Peruvian-based representative for USAID working on health reform was a Peruvian woman. The primary World Bank contact in Washington D.C. was a Peruvian man. The lead Peruvian reformers however, located both in the Ministry of Health and the Ministry of Economics and Finance were men. One woman actively participated as part of one of the reform teams within the Ministry; but otherwise the teams were composed almost entirely of men. But more important than the gender composition of the community itself is whether or not the promotion gender equity was on the reform agenda; my interviews with key reformers indicated that it was not something that was contemplated as part of the reform effort. Nor did the major policies show any specific attention to gender equity.

By contrast, there were efforts by the rights-based epistemic community to promote gender equity in Peru’s health reform process. A very small team at the Pan American Health Organization in Washington D.C. was, at the time, promoting and supporting research that would better understand the gender effects of health reforms in the Latin American region. This office, composed of women health professionals with a very limited budget and influence, did – eventually – succeed in convincing Peru’s Ministry of Health to establish a position in the Ministry charged with integrating a concern for gender equity into Ministry health programming. While the position was promising, it was established well after the major reforms, and had little influence in the
Ministry due to major underfunding and lack of prestige. Feminist activists engaged with this rights-based epistemic community had greater success in influencing the reform process, but only in the area of family planning. As a result of Peru’s ratification of the 1994 Cairo Declaration on Population and Development, feminists had convinced the Fujimori government to establish a tripartite commission representing the state, international institutions, and civil society to chart Peru’s course for implementing the Cairo Programme of Action which affirmed women’s rights to reproductive health and well-being.\textsuperscript{13} This international program of action, directly linked to the rights-based epistemic community grounded in UN circles, offered a mechanism for feminists to engage the state in the para-bureaucratic space of the tripartite commission. In this space, they did promote a holistic approach to women’s reproductive rights.

Unfortunately, as I detail elsewhere (Ewig 2010, Ewig 2006b), while the letter of Peru’s resulting family policies appeared to follow the spirit of the Cairo Programme of Action – for example advancing access to contraception and autonomy in reproductive health decision-making – in practice, poor and indigenous women’s rights to make autonomous decisions about their reproductive lives were undermined by a massive sterilization campaign, covertly carried out by the Fujimori government and which for the most part did not obtain informed consent from the women subjected to sterilization. There was a divorce, in other words, between the course charted by the tripartite commission and the real policy decisions made largely in isolation by the President, Vice President and head of the Family Planning program in the Ministry of Health.
Thus, while the more gender-conscious rights-based epistemic community did attempt to influence Peru’s reforms, it lacked a strong anchor within the bureaucracy, and ties to key decision-makers, to make a real difference in policy outcomes. Moreover, while it is admirable that feminists – as activists rather than bureaucrats as is typical of epistemic communities – were able to tie-into the reform process, they did so only in the domain of reproductive rights. Their engagement with reproductive rights was a natural product of their long history of activism in relation to reproductive rights in Peru. However, most of these activists were not health system or public health experts, and the idea of integrating gender equity into the broader health reform agenda was not part of their agenda.

Ultimately, the neoliberal reforms applied to Peru’s health sector did have some unintended, gendered effects on existing policy legacies, some positive and others negative. For example, the neoliberal reform teams sought to overcome the resistance to reform of organized labor – workers and doctors – and they largely succeeded. Overcoming these interest legacies, paradoxically, opened the way for reforms that might have eased segmentation between the social security system that historically served male workers and the poorer quality public health system historically serving women and indigenous peoples. Increased funds in support of the public health system and innovative participatory programming furthered this objective and were materially important for the poor and women concentrated in the public health system. At the same time however, the reforms’ promotion of a parallel private health insurance and provider market caused increased stratification by class and gender and while the
application of market mechanisms to the public sector – such as the introduction of user fees – posed new barriers that reduced access to health care for the most marginalized. Finally, the sterilization campaigns demonstrated a persistence of broader policy legacies that treated public health clients in a patronizing manner, and which continued to utilize poor women’s bodies as a means to achieve national economic and demographic objectives.

Conclusion

Health reform represents both an opportunity to address gender inequities in health care systems, and a risk that these inequities might be exacerbated or new inequities introduced. The challenge of gender-equitable health reform is two-fold: to overcoming past policy legacies that create and perpetuate gender inequities and to integrate health reform teams – in particular the epistemic communities that may inform their decision-making – with gender-knowledgeable experts committed to addressing gender inequity. This dual challenge is not easy to achieve, as the Peruvian case makes abundantly clear, but staking out the parameters of the challenge may enlighten future efforts at reform.

Bibliography


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1 For useful overviews of gender equity implications of health systems and health sector reforms see Doyal 2000; Evers and Juárez 2002; Mackintosh and Tibandebage 2006; Sen, George and Ostlin 2002; Standing 1997, 1999.

2 Exceptions include Ewig 2008; Ewig 2010; Gideon 2006; Petchesky 2003.

3 Throughout this chapter I emphasize gender, in keeping with the focus of the volume. However, policy legacies may also be rooted in race, class, rural/urban or age divisions, among other axes of inequality.


5 See Cross 2013 for a full genealogy of the concept. See the special issue of

6 The concept of epistemic community has been stretched by several authors, equating these with transnational advocacy coalitions or with more activist-oriented networks. For conceptual clarity, however, epistemic communities are distinct from these other forms because they are specifically bound by expert knowledge.

7 See for example: Mamudu, Gonzales and Glantz 2011; Lee and Goodman 2002; Kickbush 2003.

8 Ginther and Kahn (2014, 287) note that among social science professions, economics has been the most resistant to gender equality, with a persistent 20% gap between women and men in obtaining PhDs and subsequent barriers to advancement faced by women.

9 The following is a condensed summary of the Peru’s health reform process from Ewig 2010.

10 Calculated from figures in Mesa-Lago 1989, p. 183.

11 Mesa-Lago 1989 points out that Peru was particularly restrictive in social security dependent coverage among Latin American countries.

12 Decreto Ley No. 22482, March 27, 1979.

13 Read the Programme of Action and follow-up agreements here: