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TITLE: Women’s contribution to sustainable development through work in health: using a gender lens to advance a transformative 2030 agenda

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Women’s contributions to sustainable development through work in health: Using a gender lens to advance a transformative 2030 agenda

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Executive summary
As the backbone of health systems and a key labour and economic sector, the health workforce is important to sustainable development. In most countries, women’s share of employment in the health and social sector is much higher than their share of employment in the economy as a whole. Across a sample of 123 countries, women constitute an (unweighted) average of 67% of health and social sector employment compared with 41% of total employment. Thus one can say that by drawing women into the labour force, the health sector contributes to the goal of full, inclusive employment (SDG 8).

However gender biases persist within the health workforce. Health systems rely heavily on unpaid and informal work, but fail to recognize or value it. Shortfalls in the supply and quality of the health workforce create demands for unpaid or informal healthcare work that disproportionately fall on women and girls. For example, in Spain, 88% of all health work is unpaid.

At the same time, gender biases persist within paid employment. Work in health care, as is also the case in other care-areas, is poorly paid compared to jobs in other sectors with similar qualifications. Often, male health workers earn more than their female counterparts, especially in higher-income occupational categories. Women are underrepresented in positions of leadership and decision-making relative to their share of employment in health. In addition, physical and sexual violence and harassment, and increasingly targeted attacks in humanitarian settings, continue to pose an important risk to health workers – one to which women are especially vulnerable. Strong labour rights can help address some of the gender biases that exist.

While the health sector plays a positive role in drawing women into employment, it could make a larger contribution to sustainable development by addressing persistent gender biases and recognizing and valuing women’s unpaid and informal work. Specifically, countries should:

- **build upon the evidence base on women in the health workforce to better inform policy.** Gender-disaggregated data and dynamics in the health workforce are underexplored; and women’s unpaid and informal healthcare work is poorly covered by official statistics.
- **work across sectors to recognize and reform unequal or discriminatory laws and institutions.** Choices on how men and women engage in health work are structured by larger social processes and biases, replicated in institutions and laws. Progressive labour, wage and social protection policies can help narrow inequalities by gender. Similarly investments in inclusive education systems, improved infrastructure and basic services can provide women with the skills, mobility and time needed to engage in the labour market.
- **address gender and diversity biases in health systems.** A number of countries have been successful in recognizing and remunerating care work outside of the formal sector. Moreover,
WHO normative standards, for example, on workplace violence and international recruitment of health personnel provide countries with important guidance on how to address issues that are particularly relevant for women.

Introduction and outline of methods
As the backbone of health systems and a key employment sector[1], the health workforce is important to sustainable development. However, it is not a gender-neutral terrain. Significant occupational segregation occurs by sex and institutionalized hierarchies are prevalent within and across these occupations, particularly in terms of pay rates, career pathways and decision-making power. Many of these inequalities stem from gender biases in health systems and in the societies and institutions that support and surround them.

In and of themselves, gender biases undermine the achievement of gender equality (SDG5) and inclusive growth, full employment and decent work (SDG8). They also create systemic inefficiencies in health systems by limiting the productivity, distribution, motivation and retention of female workers – a large share of the health workforce [2,3]. A focus on gender equality can help countries effectively remedy these problems and act on the mandate to increase health financing and recruitment, development training and retention of the health workforce (SDG 3c).

Despite the importance of gender dynamics in the health workforce, gender issues are rarely given heed in health systems design [4]. This brief will draw on relational and structural theories of gender to cast light on unaddressed issues within health systems and the institutions which support them. While recognizing that gender is a social process affecting both men and women, this brief will focus primarily on female health workers.

It is important to recognize that gender inequalities in the health workforce are neither static nor universal [3]. They are embedded in particular contexts and shaped by health system design, the national political economy and culture. Relational theories of gender recognize that gender is a social process that is inextricable from “economic relations, power relations, affective relations and symbolic relations; and [that it operates] simultaneously at intrapersonal, interpersonal, institutional and society-wide levels” [5]. Health systems, and women’s individual experience within them, shape and are shaped by processes operating on multiple levels. Their position along other axes of inequality – such as race, ethnicity, socioeconomic class – intersect with gender to create new hybrid identities and structures that inform their individual (intersectional) experience [6].

In this brief, we look to the Sustainable Development Goals for a gender and human rights framing, as adopted by 193 countries in September 2015 [44]. As such, the brief explores trends in women’s work in health as they relate to the achievement of the SDGs, focusing on SDG 3 (Good Health and Well Being), 5 (Gender Equality), and 8 (Decent Work and Economic Growth) in particular. Ending discrimination (SDG 5.1) is an important cross-cutting theme of the brief.

This brief outlines challenges to progress that arise from: gaps in the knowledge base on gender, gender biases in workforce policies and practices in health systems, and gender biases in the institutions that support and surround health systems. After summarizing actions underway and previous efforts it presents recommendations for progress in these three areas and explores challenges related to implementing these recommendations.
To support this analysis, a desk review of literature on women’s work in health, covering over a 100 articles, chapters, books and reports, was carried out; this drew on an earlier review of 175 sources [7]. To complement this qualitative literature review, sex-disaggregated data on women in the health workforce were gathered from several international organizations (e.g., WHO, ILO, OECD, European Commission). Current trends and issues were mapped onto the Sustainable Development Goals through a careful review of the Goals, targets and indicators. Finally, the literature was surveyed for possible gender-transformative solutions that are in line with the SDGs.

Findings
It is important to highlight that significant gaps exist in the evidence base. Gender dynamics in the health workforce are underexplored [4]. Much of women’s work in health is unpaid or in the informal sector and, as such, is poorly covered by official statistics.

1. Health systems need to recognize and value the contribution of unpaid and informal female health workers
SDG target 5.4 calls on countries to value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family.

Health systems rely heavily on unpaid or informal work, but fail to recognize or value it. For example, in Spain, 88% of all health work is unpaid [8]. A study of volunteer caregivers in 6 African countries found that only women made up the majority of such workers (81%) and only 7% of volunteers received a stipend [9].

Shortfalls to an available, accessible, acceptable and quality health workforce create demands for unpaid or informal healthcare work that disproportionately fall on women and girls due to the unequal division of care responsibilities at the household and community levels. Such informal care work is typically poorly regulated and poorly paid (or not paid at all). For example, domestic, informal and home health workers are often excluded from protective labour regulations [2], reducing progress on SDG 8.

Informal and unpaid care work reproduces hierarchies not only across gender but also across class and race, with low-income, minority and immigrant women doing the bulk of unpaid and informal care work [10]. Women’s informal care buffers weaknesses in the health care system and may hide the extent to which these systems are inefficient and create medical poverty traps [3].

2. As a major employer of women, the health sector supports the goal of full, inclusive employment
SDG 8 calls for sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. Looking at women in the health workforce, SDG 8 overlaps with SDG 3c, which calls for an increase in health financing and recruitment, development training and retention of the health workforce and SDG 5.1, which provides a mandate to end all forms of discrimination against all women – in this case discrimination against women in the HWF.
In terms of the quantity of employment, as a major employer of women, the health sector contributes to the goal of full employment and decent work for all (under target 8.5). In most countries, women’s share of employment in the health and social sector is much higher than their share of employment in the economy as a whole (see figure 1). Across the countries shown below, women make up an (unweighted) average of 67% of health and social sector employment compared with 41% of total employment. This is true in countries and regions with both high and low overall rates of female employment. While certain exceptions exist, for the most part, the health sector has a disproportionate impact on increasing women’s representation in the workforce. This in turn helps to ensure women’s full and effective participation in political, economic and public life (under target 5.5); reduce poverty and hunger by allowing women to gain livelihoods (SDG1 and 2); and reduce inequalities by sex and improve equal opportunities (under SDG 10).

Figure 1. Women’s share of employment in the health and social sector versus total employment (%), by WHO region, average values for the period 2005-2014

Over time, women’s representation in the health sector has increased. In many countries, nursing and midwifery have long been female-dominated occupations [3]. However over the past few decades, women have also been entering medical school in growing numbers and making up a growing share of physicians; for example, across the OECD, the female share of physicians has grown from an average of 29% in 1990 to 45% in 2013 [45].

Structural and relational factors shape women’s engagement in the labour market in general and in health in particular. A variety of factors operate at multiple levels:

- **Women’s employment in general** is restricted by the uneven division of care and domestic work within the household, restrictive norms about women’s role in public life, mobility restrictions based on safety or lack of transportation, unequal legal rights and opportunities for education, etc. Equitable progress in these domains can encourage greater labour force participation. That said, high rates of female labour force participation cannot be blindly accepted as normatively good; female labour force participation may reflect an involuntarily decision taken in order to survive extreme poverty [11].

- **Women’s employment in the health sector** is restricted by the factors listed above and factors within health systems. For example, biases within human resource policies (e.g., lack of appropriate work-life balance policies) limit the retention of female workers, particularly given the psycho-social demands specific to health care providers. Health systems reliance on unpaid or informal work also limit opportunities for employment.
The degree to which these factors affect individual women will depend on their resources and capacities – which will themselves be shaped by where they fall on a variety of axes of inequality (e.g., race, ethnicity, caste, socioeconomic status, geographic location, etc.) For example, much of unpaid home care is concentrated among low-income women, who have fewer resources to purchase paid care.

3. The health sector could offer better quality employment to women

This section looks particularly at equal pay for work of equal value (under SDG target 8.5), equal opportunities for leadership and decision making (under SDG target 5.5), safe and secure working environments (under target 8.8) and the protection of labour rights (under target 8.8). In all these areas, the health sector could improve the quality of employment it offers women.

3.1 Gaps in pay persist across sector and by sex

Equal pay for work of equal value means eliminating pay gaps between individuals holding jobs that are the same or comparable worth in terms of qualifications, effort, responsibility and working conditions [12].

In most countries pay for jobs in healthcare is lower than pay for jobs with similar qualifications in other sectors. In fact, a pay penalty exists in general for care-related work (i.e., from healthcare to childcare), which remains even after controlling for the sex composition of the workforce [13,14]. As women are overrepresented in caring professions such as healthcare, they are disproportionately affected by this pay penalty.

Looking within the health sector, gender wage gaps are common. ILO data on 33 WHO Member States show that female health professionals tend to earn less than their male counterparts (see figure 2). Gaps among associate professionals also exist in most cases, however as shown in figure 2 below, women earn the same or more in 7 of 33 Member States for which data exist. The figures shown below do not adjust for individual and contextual factors that affect wages such as seniority, education, working hours, contract type, establishment type and size, region, unionization, etc.

Figure 2: Unadjusted gender wage gaps\(^1\) in mean monthly earnings among health professionals and health associate professionals, 2005-2014 (latest year for which data is available\(^2\))
The gender wage gap is calculated as the difference between average earnings of men and average earnings of women expressed as a percentage of average earnings of men (using nominal monthly earnings). Due to concerns about the quality of data, the 2012 observation has been used for Guatemala instead of 2013. Source: Author’s calculations based on ILOStat. “Mean nominal monthly earnings of employees by sex and occupation - selected ISCO level 2”

Studies that do adjust for individual and contextual factors affecting wages confirm gender-related gaps in pay. While there are a few studies that find little or no evidence of discrimination [15,16], most find significant gender gaps in pay even after adjusting for individual and contextual factors [17–22]. As shown in figure 2, gaps tend to be larger in higher-income occupational categories [17,19]. Worryingly, gaps may be widening over time [21]. A recent study of gender pay gaps in the US found that gaps among health workers were among the highest across different sectors and occupations [23].

Unequal division of care and domestic work within the household may lead women to reduce their hours and take career breaks. Biases in human resourcing policies mean these choices are unfairly penalized with, for example, unequal pay for part-time work or reduced eligibility and access to pensions and other social benefits. Time off work for childcare and other responsibility may also derail career paths, particularly if women returning to the labour market lack opportunities to upgrade skills and access positions of power. Women from minority and vulnerable groups may face structural obstacles on multiple levels, exacerbating disadvantage. For example, migrants with foreign credentials have been shown to suffer a pay penalty [50].

The discussion section below explores policies and institutions that can rectify some of the wage gaps that occur.

3.2. Women are underrepresented in positions of leadership and decision-making in the health sector

A large share of the wage gaps described above reflect women’s underrepresentation in position of power in the health sector. In terms of political representation, across 191 countries, only 51 countries had a female Minister of Health [24].

Within the health and social sector, data on a selection of high-income countries for 2007 show that in many countries women make up the majority of managers in the health and social sector but are almost
always underrepresented if one takes into account their share of total employment in the sector (see figure 3). Underrepresentation seems to be more prominent in countries with welfare regimes that attach social benefits to earnings and occupation, arguably replicating market-generated inequalities\(^1\) (i.e., Austria, Belgium, France, Germany and Italy; the Netherlands stands as an exception). This may suggest that country-wide social policies are important in determining women’s opportunities for advancement within the field of health.\(^2\)

**Figure 3: Women’s share of senior positions over their share of employment, by sector, by country, 2007**

The discussion section below explores policies and practices that can help rectifying these inequalities.

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\(^1\) Examining the institutional logic of welfare states (i.e., how the responsibility for welfare is divided between the state, the market and the family), Esping-Andersen categorized countries as “social democratic” (largely Nordic), “liberal” (largely Anglo-Saxon) and “conservative” (continental European) [25]. This categorization has been critiqued and expanded upon by several authors, but in general revisions have produced similar country groupings.

\(^2\) That said, countries choice of social policies is embedded in their particular socio-cultural context and political economy.
3.3 Violence, harassment, and work-related stress are important risk for all health workers, especially women

In terms of offering safe and secure working environments, women’s work in the health sector falls short of the objectives under SDG target 8.8 and 5.2.

Violence and harassment, as understood in SDG 5.2, are risks for health workers, particularly nurses and community health workers working [26,27]. In addition to being problems in their own right, violence and harassment increase absenteeism and reduce workforce retention, motivation, and the quality of services provided [26]. In some countries, problems of violence and harassment are particularly rampant in rural and remote areas, which may exacerbate uneven distribution of health workers. Disturbingly, targeted attacks against health workers have also increased in recent years, leading to the adoption of a UN Security Council Resolution strongly condemning attacks against medical personnel [46].

In addition, stress, fatigue and a high workload are common complaints in the sector [28]. Unequal division of care work within the household can exacerbate these problems, with female health workers having the double duty of caring for patients at work and family members at home. This contributes to poor mental and physical health. Lack of appropriate work-life balance policies and conflicts between work and family demands have been shown to increase healthcare workers stress levels [29].

3.4 Strong labour rights can promote greater gender equality

Freedom of association and the effective recognition of the right to collective bargaining is internationally recognized as a fundamental labour right. Collective bargaining coverage is associated with higher wages, less wage inequality, shorter working hours and, in some cases, increased provision of training [30–33]. As such collective bargaining has the possibility of addressing many issues that affect female health workers. In addition, agreements may explicitly target gender issues: for example, a recent review of industrial relations in Europe found that trade unions in several countries had successfully advocated for policies on greater work-life balance and reduced gender pay gaps in the health sector [28].

However structural disadvantages may mean that vulnerable workers such migrants and women are less willing or able to exercise voice [34]. It is important that unions and professional associations actively recruit women and cover a wide enough range of interests that they are able to promote the welfare of all health workers and their patients.

Discussion

Challenges

While the health sector plays a positive role in drawing women into employment, it could make a larger contribution to sustainable development by addressing persistent gender biases and recognizing and valuing women’s unpaid and informal work. To achieve the targets under SDG 3, 5 and 8, a robust gender (and equity) analysis and compelling response is called for. While obtaining data and conducting

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3 The ILO Declaration on Fundamental Principles and Rights at Work recognizes three other fundamental principles and rights at work: the elimination of (1) discrimination, (2) forced or compulsory labour and (3) child labour.
analyses in underexplored areas is challenging – especially given the likely implications for overarching policies on accountability, nondiscrimination and equality – a gender responsive and equity enhancing approach is indispensable.

Here, we will focus on three areas of action: (1) building the evidence base to inform sound gender-sensitive policy; (2) addressing gender and diversity biases in the health sector; and (3) addressing gender and diversity biases through an all-of-government approach.

**Action underway and previous efforts**
The challenges outlined here are not new. They are recognized by the 193 countries that endorsed and adopted the SDGs. For instance target 17.18 calls countries to build the evidence base on inequalities with disaggregated data; targets 5.c, 10.3 and 16.b call countries to address gender bias and other forms of discrimination at large through laws and policies that are non-discriminatory and gender equal; finally target 3.c and 5.4 recognize deficiencies in health care and the care economy, calling for increased financing of health systems, the valuation of unpaid care work and better recruitment, development, training and retention of the health workforce in developing countries.

1. **Building the evidence base on women in the health workforce**

More and more countries are collecting disaggregated data with the aim to monitor health inequalities. Significant gaps, particularly in country-capacity, remain in collecting analyzing, interpreting, reporting and using data. Within the health sector, there have been commendable efforts to explore health inequities and the social determinants of health. Some countries like Mexico have even begun monitoring and evaluating policy solutions in these areas [35]. Less explored are the gender dynamics and gender disaggregated data across occupations, within both the formal and informal health workforce and the broader health economy. This requires a health labour market perspective, contextual analysis, and the use of mixed methods with a focus on intersecting inequalities. Nonetheless, the issue is gaining attention, with recent adoption of WHO National Health Workforce Accounts as a concrete step forward [2,36,47].

2. **Work across sectors to recognize and reform unequal and discriminatory laws and institutions**

What are sometimes seen as individual choices in how men and women engage in health work (e.g., the decision of women to work fewer hours, different rates of volunteer work) are structured by larger social processes and biases in institutions and laws. A 2016 survey of laws in 173 countries finds that while support for equality is written into the vast majority of countries’ constitutions (91%), less than half of countries explicitly mandate equal pay for work of equal value (41%) or nondiscriminatory hiring based on gender (40%) [37]. Progress in these areas will be important to improving equity in the health workforce.

Labour, wage and social protection policies can help narrow inequalities by gender. For example policies and legislation on “equal pay for work of equal value” can address wage gaps across sectors, by sex and along other axes of inequality such as migrant status. They can also address less favourable treatment of part-time workers in terms of (pro-rata) pay and benefits. Such policies usually examine gaps employer by employer. This makes them powerful tools when the health workforce is concentrated under one large employer (e.g., when health services are publicly provided), but less effective when it is scattered
across many private employers. Other wage policies, such as minimum wages can also help reduce inequalities in pay. In compressing the wage structure, they reduce the magnitude of pay gaps, and, as women and other vulnerable workers tend to be overrepresented at bottom of the wage distribution, they increase the wages of women [38].

Social protection policies, such as cash transfers, can help channel resources to women in unpaid care work. Many countries compensate time dedicated to childcare in their social security systems, for example, increasing caregivers’ eligibility and entitlements for pensions [39]. In addition, labour laws that challenge the gendered division of care work within the household could foster women’s integration in and return to the labour market; for example, non-transferable parental leave for fathers challenges the idea of women that women are the natural caregivers of children.

Policies that improve basic infrastructure and services can also narrow gender inequalities. For example, policies that improve mobility (transportation services, roads, etc.) can reduce the risks and costs associated with travel thus increasing female employment and educational attendance [40]. Investments in housing and public safety could also improve the retention and distribution of female health workers; for example, one study highlights that women’s reluctance to work in rural areas has more to do with concerns about security and inadequate housing than pay [41].

Improving women’s outcome in the health workforce also has to do with designing inclusive education systems that provide, recognize, subsidize and reward investments in vocational training and in-work training.

3. Address gender and diversity biases in health systems
Countries have attempted to address gender biases within the health systems. For example, Turkey, Costa Rica and the UK, among others, have recognized the important contribution of unpaid caregivers to health systems by introducing laws and regulations that remunerate care work and provide job protection during leave for care [4]. Norway, in particular, has been successful in formalizing previously informal work in health services and care for children and the elderly, leading to an eight fold increase in formal employment in ‘care’ sectors between 1970 and 2014 [48]. Other countries have introduced better work-life balance policies for female health workers; for example, a nurses’ union in Finland increased workforce retention and improved quality of services through better working time policies (including predictable hours, guaranteed time off between shifts, and consecutive days off) [4]. Other countries still have attempted to make job evaluations gender-neutral; for example, the UK’s “Agenda for Change” covers 1 million workers in the national health system [42]. Gender-neutral job evaluations and more transparency in pay structures can build towards pay equity [12].

Efforts have also been made to address problems of retention and recognition through inclusive high-quality education and lifelong learning (SDG 4). For example, a 4-month chronic care expert training programme was established for nurses in Thailand. This helped nurses upgrade their skills and gain recognition; after the programme, “patients [grew] to view their nurses as their primary health-care providers rather than doctors” [4].

The international migration of health workers is increasing rapidly. The number of migrant doctors and nurses working in OECD countries has increased by 60% over that last decade [49]. Many are women. The WHO Global Code of Practice on the International Recruitment of Health Personnel provides
important normative guidance in this area, particularly in relation to protecting the rights of migrating health personnel.

Similarly, the Framework guidelines for addressing workplace violence in the health sector, developed by the WHO, ILO and two international trade union federations, provides important norms and standards for reducing and preventing violence and harassment.

It should be noted that much more could be done to address gender biases in the health system. For example, work-life balance measures remain rare, even among developed countries [28] and policies to remunerate unpaid healthcare work are few and far between.

**Recommendations**

1. **Build the evidence base on women in the health workforce**

Before the appropriate gender-responsive policies can be identified and adopted, one must first understand the current situation in the health workforce. To monitor progress, it will be important to collect, publish and analyze disaggregated data on human resources for health (as outlined under SDG target 17.18). This data should be disaggregated not only by sex, but also ethnicity, age, class, migrant status, sexuality, etc., wherever possible, to allow for greater understanding of the intersecting effects of social inequalities.

Simply publishing statistics is not enough. These need to be analysed, reported and used to set the research agenda for human resources for health. Efforts should strengthen the collection and use of routine data at country and local levels, also drawing on evidence established in qualitative studies. Thinking about problems and constraints from a gender lens may prove to be a cost effective exercise for health systems; for instance, work-life balance policies could improve retention at a relatively low cost to health systems.

2. **Work across sectors to recognize and reform gender-unequal laws and institutions**

Healthcare is situated in a larger institutional framework. To address gender bias in the healthcare workforce, countries need to recognize and reform gender-unequal laws and institutions. Accountable, non-discriminatory institutions, laws and policies are important in their own right (SDG 16) and will also help achieve SDG 3, 5, 8 and 10.

To build supportive institutional framework, countries need to work across sectors to address intersecting axes of inequality that stop health workers from reaching their full potential. Labour market and social policies can help to reduce inequalities and address the gendered division of care. Social protection and wage policy can help reduce inequities in pay among both paid and unpaid workers. Basic infrastructure and services can help women access labour market opportunities, and inclusive systems of education and life-long learning can improve women’s career pathways and the quality of services.
3. Address gender biases in health systems

Ensure all healthcare, including unpaid healthcare, is formalized in the health workforce. Better policies on work-life balance (flexible work, regular hours, childcare, etc.), remuneration and international migration can help narrow inequalities and promote decent work (SDG 8 and 10). In particular, health systems must stop taking the male work model as the standard work model; policies that unfairly penalize career breaks and shorter working hours constrain the productivity, distribution and retention of female workers. Inclusive high-quality education and lifelong learning (SDG 4) can help address problems of retention and recognition. Violence and harassment are important issues for all health workers, especially women.

Outside of the paid labour force, countries should take steps to recognize and compensate women for unpaid or informal healthcare work. This could involve moving women into formal work and ensuring that career pathways exist.

Countries should work to understand and meet the health and social needs of migrant working in new and potentially discriminatory or isolating contexts.

In designing and adopting new policies, it will be important to adopt participatory processes and good governance practices that involve and empower women in decision making. Women are underrepresented in positions of power and decision-making from the micro to macro level (i.e., in households, healthcare setting and higher level policy debates). Ensuring women’s voices are heard and that women from diverse social and geographical contexts are involved in decision making is essential to remedying current problems that plague the healthcare workforce. Participatory designs will likely lead to more resources dedicated to upgrading the health workforce and implementing gender-sensitive policies.

Implementation considerations

In addressing gender issues in the health workforce, policy maker will face a broad range of implementation challenges. Here, we focus particularly on difficulties in ensuring that enacted law is reflected in practice. As is well-documented in the growing field of leximetrics⁴, this is not always the case; there are often significant differences between de jure and de facto practice.

To ensure that laws and policies are put into practice, it is important to give attention to process and participation, including the private sector. Clear enforcement provisions, backed by appropriately resourced and well-governed agencies (e.g., labour inspectorate, human rights commissions, counter-corruption commissions, etc.) can make an important contribution to ensuring implementation.

In addition, health workers and women in particular must be empowered to defend their rights. This requires increasing awareness of labour rights and existing gender biases, and facilitating collective action to defend these rights. In the health establishments, training on equity could bring attention to biased human resourcing practices (though it should be noted that there are few evaluations of the effectiveness of such awareness building exercises). Working within social movements and with women’s collectives can also empower women and workers to defend their rights.

⁴ A field which produces quantitative measurements of laws and subsequently analyses them against objective outcomes.
Finally, women and workers’ bargaining power can be reinforced by efforts to guarantee substantive freedom of choice. Female health workers accept unfair working conditions because their choice of alternatives is constrained. Thus it is important to evaluate the range of alternatives individuals have and their different resources enabling them to choose [43]. Upgrading women’s labour market opportunities and their access to resources will improve their situation in the health sector and serve as an engine for economic growth.
References


