



Economic and gendered impacts of the healthcare workforce

Evie Browne
University of Sussex
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Question

What are the economic development and women's rights impacts of women in the healthcare workforce? Has this been impacted by increasing the number of girls in primary/secondary education?

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The K4D helpdesk service provides brief summaries of current research, evidence, and lessons learned. Helpdesk reports are not rigorous or systematic reviews; they are intended to provide an introduction to the most important evidence related to a research question. They draw on a rapid desk-based review of published literature and consultation with subject specialists.

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1. Summary

There is general agreement in the literature that getting more girls into school and into higher education should lead to more women in the healthcare workforce, particularly focusing on getting women into better jobs. However, this is not supported by much explicit evidence. It is a causal assumption made by policymakers and donors. There is little evidence to suggest that women in the healthcare workforce have made strong contributions to economic development beyond that of the health sector as a whole. This may be because it is too difficult to separate out different demographic groups' contributions. There is some evidence that women's presence as workers and leaders has improved attitudes about women and is making some progress towards women's rights. It is unclear to what extent this is due to efforts to increase girls' schooling, as few studies examine this causal link. Women are battling an extremely patriarchal work environment and the literature makes strong recommendations that structural and institutional elements are improved, in order for women to reach their economic potential.

The evidence base is strong in some areas, such as girls' education and gender discrimination in the workplace. However, it is mostly weak on drawing causal links from education, through work, to economic development. It may be impossible to provide strong evidence for this chain. The literature reviewed here is approximately half policy and advocacy reports, and half academic, peer-reviewed articles. In low- and middle-income contexts, the literature largely focuses on Sub-Saharan Africa and the Middle East.

The World Health Organisation (WHO) is currently conducting research on healthcare workforces' contributions to economic development, and is developing a framework for pathways to development. This counteracts older arguments that health investment is a drag on the economy. Within the health sector globally, women make up 67 per cent of the employees. The WHO speculates that investment in health employment will thus disproportionately benefit women, and increase gender equality.

Women in the healthcare workforce continue to face discrimination, including gender pay gaps, segregation into lower-paid, lower-status jobs, and lack of career progression. The literature identifies strongly that these gender biases must be addressed for women to develop. There is no clear evidence about the link between getting girls into school and their entry into the healthcare workforce, however, the literature does identify that lack of education is a barrier to entry. Articles specifically recommend that training and education institutions must take account of women's family and childcare needs in order to support them through their training.

It is unclear to what extent women's employment in the healthcare workforce contributes to economic development. There is some evidence to suggest a correlation, and strong rights-based reasons to continue to invest in women. Much of the literature focuses on barriers to women in the workforce, rather than tracing benefits (beyond rights-based equality). The Human Resources for Health (HRH) literature pays limited attention to gender analysis, which results in a lack of data from which to build evidence-based policy (Newman, 2014).

Education may not be the answer for increasing women's participation, job share, and economic value. This short review highlights that mentoring, for example, may be a more effective route to increasing women's promotion prospects. In addition, the persistence of the gender pay gap even when accounting for seniority and qualifications suggests that it cannot be changed with better-qualified women, but only through attitudinal change which increases the perceived value of women as workers. The healthcare system remains gender-biased and unsupportive of

women's specific needs, and until those structural changes are made, education alone cannot catapult women into economic success.

2. Economic impacts of healthcare workforces

In the last few years, there has been increasing interest in looking at the health sector as a contributor to economic growth. There is a debate around whether the health sector is an 'unproductive' sector, that is, one which is a cost to the state (Buchan, Dhillon, & Campbell, 2017, p.180). Older economic models, relying on data from high-income countries, show that the health sector has a 'cost disease', meaning that it is a drag on productivity and growth. However, recent World Bank research¹ has shown that this is not necessarily the case for low- and middle-income contexts. It suggests that countries with more developed health systems also have higher manufacturing productivity (Buchan, Dhillon, & Campbell, 2017, p.181). This suggests that improved health systems in low- and middle-income countries have higher impacts on economic outputs, thus contributing to conventional measures of economic growth, such as Gross Domestic Product (GDP). The World Health Organisation's (WHO) Global Strategy on Human Resources for Health: Workforce 2030, adopted in 2016, signalled a shift away from thinking of healthcare systems as a necessary cost, towards thinking of them as a necessary contributor to economic and societal wellbeing (Buchan, Dhillon, & Campbell, 2017, p.xvi).

Drawing on this line of thinking, the UN established a High-Level Commission on Health Employment and Economic Growth in March 2016². It is chaired by representatives from the WHO, International Labour Organisation (ILO) and Organisation for Economic Co-operation and Development (OECD). The Commission considers health employment as a key pathway to decent work and economic growth (WHO, 2016, p. 15), as well as a core investment in social welfare. Its stated policy aims are to change mindsets of leaders who think that investment in the health economy and health workforce is a drain on the national economy, and to assert that investment can create inclusive economic growth (WHO, 2016, p. 16).

One of its first two major reports, *Health Employment and Economic Growth*, is an evidence-based review which identifies six pathways through which health systems contribute to economic growth (Buchan, Dhillon, & Campbell, 2017, p.176):

- **The health pathway:** 1) full-income; health as an intrinsic benefit or direct consumption good. 2) Health as an instrument to increase individuals' activity and productivity. 3) Increased quality and quantity of labour, and increased economic productivity.
- **The economic output pathway:** expenditure, outputs, jobs, the 'health economy', services and goods.

¹ Cited by Buchan, Dhillon, & Campbell, 2017 as Arcand JL, Araujo EC, Menkulasic G, Weber M. *Health sector employment, health care expenditure and economic growth: what are the associations?* Washington (DC): World Bank; [forthcoming]. Not available at the time of writing.

² <http://www.who.int/hrh/com-heeg/en/>

- **The social protection pathway:** employment in the health sector offers welfare benefits (sick leave, pension etc); protection against catastrophic health expenditures, which can reduce inequalities.
- **The social cohesion pathway:** jobs and access to healthcare can promote stability.
- **The innovation and diversification pathway:** new technologies; increased investment in healthcare can diversify national economies (e.g. away from exports or tourism).
- **The health security pathway:** prevention of epidemics.

The report also identifies some 'virtuous cycles' at the more individual level that result from employment in the health sector: increased savings, consumption and tax revenues (Buchan, Dhillon, & Campbell, 2017, p.190). The report goes on to identify in another chapter that good health systems encourage savings and investments, better family planning, and avoid catastrophic out-of-pocket expenses, all of which contribute to inclusive economic growth (Buchan, Dhillon, & Campbell, 2017, p.203). Employment in the health sector offers a wide variety of differently-skilled jobs, and importantly, offers jobs in rural and remote areas where other employment may be scarce (Buchan, Dhillon, & Campbell, 2017, p.206). In this way, lower-skilled workers and those in remote areas may be able to contribute to overall inclusive economic growth.

The High-Level Commission's second major report, *Working for Health and Growth*, makes six recommendations for transforming the health workforce for the Sustainable Development Goals (SDGs). One of the recommendations is to improve gender equality and women's rights (WHO, 2016, p.11):

- **Gender and women's rights:** *Maximize women's economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.*

The report does not offer specific guidance on engaging with gender issues. However, the Gender Equity Hub of the WHO³ is currently taking up the issue of women's work in the healthcare workforce. Their first report was open for consultation until June 2018. The draft report is a comprehensive literature review on gender equality within the global health and social care workforce (Gender Equity Hub, 2018). Further drafts will be forthcoming in 2018.

3. Women in the healthcare workforce

Globally, 67 per cent of workers in health and social sector employment are women (WHO Global Health Observatory; http://www.who.int/gho/health_workforce/en/). This is much higher than women's employment in other sectors worldwide, which averages 41 per cent (Magar, Gerecke, Dhillon, Campbell, 2017). However, women are significantly segregated into lower-paid, lower-status healthcare jobs, with less decision-making power than men (Magar et al., 2017). The WHO states that the gender bias in the health sector significantly limits the

³ <http://www.who.int/hrh/news/2018/GenderEquityHub-call4feedback-draft-report/en/>

productivity, distribution, motivation and retention of female workers (Magar et al., 2017). This general trend is true across all countries.

Much of the literature on this topic therefore focuses on barriers to women's employment, career progression, and ongoing gender biases. Some reports identify enablers for women's career success, or factors which enhance their ability to dismantle gendered obstacles. However, the literature review for this report found very few sources framing women's employment as having economic or rights impacts. This section picks out a few topics where these outcomes are visible.

It is worth noting that many reports also highlight the unpaid care work that women do, which constitutes a large section of global healthcare but is not formally recognised.

Gender pay gap

Female health professionals tend to earn less than their male counterparts, violating the principle of equal pay for work of equal value (SDG target 8.5) (Magar et al., 2017). The WHO suggests that this may be due, in part, to women's care responsibilities, such as part-time work or time off for maternity leave, which may result in pay penalties (Magar et al., 2017). The gender pay gap can be as high as 32 per cent (physicians), 28 per cent (dentists), or 16 per cent (nurses) (George, 2007). The pay gap persists even in jobs where there are more women than men, and even when accounting for qualifications and years in service (Gender Equity Hub, 2018). The Gender Equity Hub paper suggests that a strong explanatory factor is whether or not the employee is a woman, as education, qualifications, seniority, specialty, and hours worked do not change the pay gap. Nonetheless, there is other research which suggests that other factors also contribute to the pay gap, particularly choice of specialities.

Jobs which tend to be occupied by men are also the jobs which are better paid, with more room for promotion and progression (George, 2007). There are many subtle and unconscious biases that affect how women and men choose particular specialities or career paths, channelling women into lower-paid, less prestigious, public sector, part-time jobs (Gender Equity Hub, 2018). The more female-identified an occupation is, the lower the wages (Newman, 2014). In the health workforce, an increase of 1 per cent more women can have an 8 per cent decrease in the wage rank (Newman, 2014).

A study of the Netherlands, USA and Sweden shows that the gender pay gap actually increases with levels of education – highly educated women have the least parity with men's wages (Evertsson et al., 2009). The wage gap widens with levels of education and seniority. The more education a man has, the more he gets paid, but the same is not true for women (Gender Equity Hub, 2018).

The difference in pay between men and women is a fundamental inequality. It also suggests that simply getting women into the workforce is not enough to compensate for systemic and ingrained gender inequalities. Lower wages despite good education also suggest that women do not necessarily benefit economically (as much as men) from being employed. The right to work is an intrinsic good, but as it currently stands, women may not be gaining economically. Getting rid of the gender wage gap could halve women's poverty, increase their social security, and encourage them to stay in work (Gender Equity Hub, 2018).

Women in leadership

A strong section of the literature flags women's under-representation in positions of power as a problem preventing gender equality. Women are poorly represented in healthcare top institutions, thought leadership, policy fora and decision-making positions (Dhatt et al., 2017). Aside from women's right to inclusion, research on women's leadership from other sectors shows that there is a financial loss when women are not participating equally (Dhatt et al., 2017). In the few positive examples of women who have reached top levels in healthcare, enabling factors have included family support and manager support (Dhatt et al., 2017).

A study on Lebanon (Tlaiss, 2013) examines the barriers and enablers for women's leadership in healthcare. It mentions education as a challenging factor, as most women in the study were well-educated. Tlaiss (2013) highlights how this challenges the assumption that women do not achieve managerial roles because they lack the education and experience. Instead, it suggests that women are not promoted to leadership roles because of patriarchal gender bias. The women themselves felt that their strong educational attainments qualified them for leadership positions.

The Gender Equity Hub's draft consultation paper (2018) highlights that mentorship is a key component of improving women's leadership (as opposed to access to education).

Girls in school

Much literature identifies barriers to education for girls, but hardly any provides evidence on the links from education to employment. The *State of the World's Mothers* report (Geoghegan, 2010), along with other major reports, links education with enlarging the pool of potential health workers, as well as better health outcomes for the children of educated mothers. The High-Level Commission recognises the educational barriers preventing entry into the healthcare workforce. Increasing access to education, quality of education, and reducing costs are all recommended actions for increasing the number of people in the workforce (WHO, 2016, p.36).

Occupations that require fewer years of schooling or lower qualifications have higher proportions of female employees (George, 2007), indicating that women may choose these over longer, more difficult courses. The reasons given are usually that these choices leave more time for girls' family responsibilities, or the jobs are considered appropriate for girls. However, these occupations may not lead to the leadership positions which could change gender relations, or perhaps could even entrench gender-segregated occupations.

A study from high-income contexts (USA, Netherlands and Sweden) shows that more educated women are more likely to be employed, and more likely to be employed in higher-earning jobs (Evertsson et al. 2009). Only 60 per cent of women with less than high school education are employed, compared to 82 per cent of college graduates. In comparison to men's employment, women are employed less: the lowest educational group are employed at 60 per cent the rate of men, while the highest educational group are employed at 80 per cent the rate of men. Occupational segregation also narrows at the higher education levels.

The Save the Children *State of the World's Mothers* report (Geoghegan, 2010) recognises that the lack of girls' education prevents them from entering training schemes to become healthcare professionals, or even non-professional community health workers (CHWs). CHWs perform vital basic healthcare functions in remote and rural communities. This report argues that girls do not

need to be highly educated to be CHWs, but that policies need to be adapted to support shorter training periods and lower qualifications, in order to encourage girls to train for these positions.

Other literature also strongly supports the idea that education and training needs to accommodate gendered needs, specifically women's childcare and family responsibilities. A barrier to lifelong learning or professional development is that trainings often cannot accommodate women's family responsibilities (Gender Equity Hub, 2018). Care obligations can result in implicit or explicit discrimination preventing women from attending training or school (Gender Equity Hub, 2018). Pregnancy and other family commitments have a strong impact on women's ability to complete their education, as these are often penalised (Ng et al., 2012). Pregnant or returning students may face extra fees, falling behind, and family duties play a major role in accounting for attrition rates in pre-service education (Ng et al., 2012). High-income study authors speculate that an important causal factor of women's employment is the affordability of child care (Evertsson et al. 2009). Where the state provides child care, this has the most effect for lower-educated women, for whom child care would be a larger proportion of their lower earnings. The provision of low-cost childcare therefore encourages lower-educated women into work. They conclude that gender inequality is worse for lower-educated women, and more equal for higher-educated women.

These findings suggest that lack of education appears to be a barrier to entry into training programmes, but the literature strongly emphasises the gender bias within programmes as a factor which prevents women's decent employment. Although girls may be well-educated and ready to train, the training facilities often do not support women's specific needs.

Violence and harassment

The literature consistently highlights violence against women and girls as an ongoing hazard for women in the healthcare workforce, especially sexual harassment (e.g. George, 2007). The current report does not review this area, but it is worth mentioning as a cause of job dissatisfaction and possible exit from the workforce, and as highlighting continual discrimination and harassment of women.

4. Results from women's employment in the healthcare workforce

The comprehensive, evidence-based WHO report concludes strongly that investment in Human Resources for Health (HRH) will deliver good returns for the SDGs, women's economic empowerment, and inclusive economic growth (Buchan, Dhillon, & Campbell, 2017, p.xix). The High-Level Commission estimates that an investment into education, health and social services of 2 per cent of GDP could result in increased employment rates, of which 59 to 70 per cent of the new jobs would go to women (WHO, 2016, p.25). This increases inclusive economic growth, as investment in other sectors would not create as many jobs for women, and would also perhaps increase gender inequality. WHO suggests that the health sector contributes to women's empowerment, participation in economic and political life, and reduces poverty by contributing to livelihoods (Magar et al., 2017). The WHO therefore takes a strong position that investment into the healthcare workforce disproportionately benefits women, as well as improving health outcomes.

Aligned with the WHO's health pathway, there is a strong literature on how female health workers have contributed enormously to better health outcomes, and therefore, to economic development. The Save the Children *State of the World's Mothers* report (Geoghegan, 2010) identifies that CHWs with little formal education and limited health training have been able to significantly improve maternal and newborn care.

Some evidence suggests that women in leadership roles tend to make policies which are supportive of women and children, such as girls' education, drinking water and maternal health (Downs, Reif, Hokeroro, & Fitzgerald, 2014). While the evidence base is not strong, there is a pattern in the literature suggesting that women in health leadership roles will support policies which contribute to improving women's rights and gender equality (Dhatt et al., 2017).

Women's presence as health workers has also improved public attitudes and perceptions of women's abilities, rights and contributions (Geoghegan, 2010). For example, seeing women as mobile, effective, employable and autonomous improved views on women in Bangladesh (Geoghegan, 2010).

In line with the WHO's suggestion that employment in healthcare may offer social protection, a study by Gupta and Alfano (2011) reviewed gendered access to non-monetary benefits across six countries (Chad, Côte d'Ivoire, Jamaica, Mozambique, Sri Lanka and Zimbabwe). The benefits included meals and housing allowance, paid vacations, health insurance, and training. The results do not show any conclusive gender imbalance, instead, a complex mix of context-specific and gender-differentiated access to opportunities emerged. The only significant gendered finding is that female nursing and midwifery personnel are less likely than their male peers to access in-service training, possibly as a result of gender bias devaluing women's contributions and professional development and growth.

A brief report from Goa, India shows that 41 per cent of female medical graduates were no longer practicing medicine five years after graduating, in comparison to an overall figure for men and women of 25 per cent (Kamat, & Ferreira, 2014). This higher percentage result for women appears to be related to marriage, child-rearing, other family commitments, and migrating abroad. More than 50 per cent of this group expressed no interest in returning to the profession. As this is a brief quantitative survey, it does not provide information on attitudes and reasons for leaving medicine. It suggests that trained women in India do not see the medical profession as a viable career choice.

These findings present a mixed view. There is little evidence to suggest that women in the healthcare workforce have made strong contributions to economic development, beyond that of the health sector as a whole. This may be because it is too difficult to separate out different demographic groups' contributions. There is some evidence that women's presence as workers and leaders has improved attitudes about women and is making some progress towards women's rights. It is unclear to what extent this is due to efforts to increase girls' schooling, as few studies examine this causal link.

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Key websites

- HRH Global Resource Center: <https://www.hrresourcecenter.org/>
- WHO Global Health Workforce Network: <http://www.who.int/hrh/network/en/>
- WHO Global Health Workforce Alliance Knowledge Centre: <http://www.who.int/workforcealliance/knowledge/en/>
- Health Policy and Planning journal: <https://academic.oup.com/heapol>
- Human Resources for Health journal: <https://link.springer.com/journal/12960>
- Research in Gender and Ethics: <http://resyst.lshtm.ac.uk/rings>
- Women in Global Health: <http://www.womeningh.org/>

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