VOICE

The Crime of Gender Inequality in Global Health

There's no way we'll be able to grapple with the coming health crises unless we fix the gaping problem of women's empowerment in global health.

BY LAURIE GARRETT | DECEMBER 26, 2017, 9:36 AM

Since the Harvey Weinstein sexual atrocities first came to light in early October, nearly every day has brought news of another male authority figure who has used his power to impose himself sexually upon women, even girls. People worldwide are learning that the glass ceiling that has long held females below top leadership positions in their professions is tied to egregious sexual obstacles that women have always known about, but most men now profess shock and dismay to discover.

As the global conversation about sexual predators expands into larger issues about power and the inequitable workplace, it's remarkable to consider how gender issues play out in professions that are overwhelmingly female, yet still controlled predominantly by men. Public health is the perfect example, both of this imbalance in power in a female-majority field and of the impact that inequity has on the activities and products produced by the profession. The majority of people working in health worldwide are female — by far. But the majority of their bosses and global leadership are men.

Worldwide, women make up about 42 percent of the paid labor force, but 75 percent of the paid medical and health force in countries that provide gender breakdown data. If community health workers are added, the gender imbalance rises to as high as a ratio of 90 percent female to 10 percent male in many countries, though that element of the labor force is often uncounted and unpaid, or grossly underpaid. Whether inside hospitals, on the ground during epidemics, or in general sanitation and public health services, systems are typically strongly hierarchical — with physicians and corporate managers at the top, and community-based primary care or prevention workers at the bottom. Those top slots tend to be filled by men, while the vast ranks of front-line work have a female face.

In this post-Weinstein world that brings daily denunciations of powerful men, it is easy to forget that female advancement bumps up against glass ceilings, regardless

of such malfeasance. In the United States, where women by some reckonings earn 77 cents to every dollar grossed by male peers, pay and power comingle: attaining higher-earning jobs typically also means accessing more powerful positions in the workplace pecking order. This holds true in the European Union as well, where women earn 84 cents compared to one euro garnered by work-matched male peers. Or in Japan, where women typically earn 25.7 percent less than their job-matched male peers. Across the Organization for Economic Cooperation and Development, men earn an average of 16 percent more than their job-matched female peers — and a whopping 21 percent more in high-end jobs, such as senior management, engineering, corporate leadership, and top academic positions.

In the health world, the pay and power differentials are all the more egregious given that females make up the vast majority of the labor force: 34 percent of current physicians in the United States are female, but the balance in medical schools shows women are gaining rapidly, especially in prestigious institutions. Georgetown University in the 2015-2016 school year, for example, graduated 100 female medical students versus 92 men. All of the University of California medical schools have roughly a 50/50 gender balance. Harvard University's 2015-2016 graduating class has 77 women to 87 men; Johns Hopkins 50 women to 61 men. And the balance weighs heavily in favor of women in the nursing profession, where more than 90 percent are women in the United States.

ABOUT THE AUTHOR

Laurie Garrett is a former senior fellow for global health at the Council on Foreign Relations and a Pulitzer Prize winning science writer.

Recent studies show that female physicians earn 27 percent less than men in their same medical specialties, and male registered nurses make about $5,000 per year more than female peers. Female primary care physicians earn an average of $197,000 per year versus the average $229,000 earned annually by their male counterparts; the gender differential among specialists is a whopping $94,000.

Women are more likely than men to choose health careers, starting with their undergraduate options and continuing through post-graduate studies. In Japan, for example, 60 percent of graduates from health-related collegiate programs were women in 2012. In the United States, 79 percent of master's degrees in public health in 2016 were awarded to women, but men went on to earn far more money, according to available data. The earnings range for women with such degrees was $41,703 to $76,537, while men in the field earned between $44,477 to $86,072 — a $10,000 per year difference at the high end. Because men are more likely to attain positions of power in public health and medicine, they earn more than women and have greater influence over the directions and priorities the fields take. Women are,

of course, more likely to have time gaps in their lifetime employment due to pregnancy and childcare.

From the 1960s to the 1980s, nearly every major direction in the field of global health, including allocations of hundreds of millions of dollars given by institutions such as the Rockefeller Foundation, World Bank, and World Health Organization, were decided by a handful of Western men. Probably not coincidentally, such problems as high mortality rates associated with pregnancy received little attention, while dramatic campaigns to eradicate diseases using new scientific tools topped policy and financial interest.

Women in the field of health complain that it is difficult to have their ideas and innovations taken seriously, noting that "the chances of a woman receiving a prize was nine out of 100," an indicator of successful implementation of novel global health-related schemes. Even in fields where they outnumber men nine to one, women are less likely to have their ideas for solving health problems, such as maternal deaths, taken seriously and fully funded either by grants or awards.

Even in fields where they outnumber men nine to one, women are less likely to have their ideas for solving health problems, such as maternal deaths, taken seriously and fully funded either by grants or awards.

Though there have been two female WHO directors-general since its 1948 inception, the balance of power remains decidedly tipped toward men. One measure of that power is the constitution and leadership of delegations to the annual World Health Assembly, the governing body of WHO and health's power center in the United Nations. In 2005, only 16 percent of the national delegations were led by women, rising to 23 percent by 2015. Over that period, female leadership at the assembly fell from 10 percent down to 5 percent for the nations in the Middle East.

"In thinking about the future of global health leadership, I ask my peers in global health, particularly the men, to think about why men control the majority of public health decisions and how best to change that to ensure that women also progress as leaders in the field," health consultant Nina Schwalbe, who served as acting chief of health at UNICEF, recently wrote.

Women in the field are starting to get publicly pissed off. A new organization, Women in Global Health, has formed to address these issues. In October, more than

400 health leaders — mostly women — from 68 countries and representing more than 250 organizations and institutions, gathered at Stanford University to debate the reasons for gender disparities in the field and suggest solutions. The inaugural 2017 Women Leaders in Global Health Conference last month published a "Call to Action" delineating seven issues the high-level professionals want improved.

Beyond such fairness and finance issues, these gender disparities have enormous consequences for public health and medical care, in particular for the size of the health care labor force and the nature of issues that gain attention in the form of policy priority and resources. To put it bluntly, the quality of your care — in a clinic, hospital, pharmacy, or dentist's office — depends on the resolution of the gender imbalances in health and medicine.

To put it bluntly, the quality of your care — in a clinic, hospital, pharmacy, or dentist's office — depends on the resolution of the gender imbalances in health and medicine.

There Aren't Enough Health Care Workers in the World

Depending on who is doing the counting, and what factors are included in their tally, the world is currently short 18 million doctors, dentists, nurses, community health workers, technicians, optometrists, lab workers, public health experts, and other health care workers. Worse, achieving the lofty United Nations Sustainable Development Goals by 2030 will require adding another 40 million health professionals to the global labor pool. Bad as this gap is, it will only worsen in coming years as an increasing percentage of the global population advances into senior ages, needing closer and more complex care. Moreover, rising prosperity, with more nations entering the ranks of middle-income countries, means swelling demand for improved clinical care and essential public health services, such as clean water and uncontaminated food.

The WHO issued a large analysis in 2013 of the global workforce, concluding that the gap between rising medical and public health needs worldwide and available skilled personnel was so severe that it represents the primary stumbling block to implementation of universal health coverage. The report noted that there has been an enormous growth in the numbers of low-skilled community health workers and midwives, especially in poor countries, but, "There is a current deficit of about 7.2 million skilled health professionals." A projection model driven by population growth would lead to a global deficit of about 12.9 million by 2035."

A 2013 national survey showed the United States has 809,000 clinically practicing physicians, with shortages affecting the quality and access to patient care felt most acutely for primary care in rural and Southern areas. By 2025, it is projected that the United States will need 90,000 more physicians than current medical school matriculation can produce. Changes in immigration law under the Donald Trump administration, coupled with tax reform provisions that would affect how students' loans and scholarships are paid for and taxed, could further diminish prospects of reaching America's physician-needs levels.

The Tax Cuts and Jobs Act passed by Congress just days before Christmas eliminates certain tuition tax deductions families have long used to offset college costs. It changes tax deductions on donations to universities and revenues colleges earn from their endowments — constrictions that two deans of schools of public health tell me will severely reduce fellowships and financial aid for graduate and medical students. Though provisions that would have taxed fellowships and student financing for graduate and medical students were eliminated in the final hours of the bill's debate, medical schools may be hard-hit by the bill's repeal of individual deductions for medical expenses — a measure that experts predict will change patient choices regarding elective treatments and ultimately lower revenues for teaching hospitals, which typically handle a larger share of the nation's poorer and middle-class patients.

The deficit is even more pronounced on the nursing side, where the federal Bureau of Labor Statistics estimates more than 1 million jobs will be vacant by 2022 due to a combination of inadequate nurse-training programs, limits on immigration for foreign-trained workers, burnout of the overworked existing labor force, lack of adequate pay, and rising needs for the aging American population. According to the American Nursing Association, some 700,000 nurses will retire over the next seven years, while support for schools of nursing nationwide has plummeted 30 percent since 1971, forcing educators to turn away nearly 80,000 worthy applicants annually.

Similar crises face the health labor force all over the world. Richer countries are compensating for inadequate numbers of personnel by poaching doctors, nurses, dentists, and other health workers from middle-income countries like Thailand, the Philippines, India, and Caribbean nations. Those countries, in turn, lure personnel from poorer places like South Africa, Sri Lanka, Guatemala, and Vietnam. And patients throughout the entire chain, from specialty hospitals in Manhattan down to unsupplied clinics in rural Indian villages, suffer. According to multiple studies by such august institutions as the World Bank and Harvard University, worldwide need for health care workers, especially skilled personnel, cannot be met in the first half of this century unless millions more can be trained and those who have skills can be retained in the labor force.

Remarkably, none of these major reports issued on the health care worker crisis mention the gender distribution of the labor force, failing to note the tremendous disincentives women have for staying on the job. The reports (which are mostly authored by men) largely underscore low morale and the inability to retain trained health workers as key obstacles to filling the needs levels in every nation on the planet. None of the reports note, for example, that women are likely to take time off after giving birth, only to discover that their jobs are no longer available, or that possibilities for advancement in the ranks are closed off to them: Essentially, they pay a price for birthing children. None note burnout among female nurses and community health workers, many of whom feel they have no possibility of advancement despite strong job performance.

Women in Global Health Leadership Make a Real Difference

There is evidence of striking differences in emphasis for public health and medicine based on leadership gender. Female health leaders promote access to contraceptives, empowerment programs for girls, women's rights to family planning and maternity care, safe abortions, and protecting environmental assaults on children's health. When more women are in government, the health and education of children rises in priority for legislation and financing. A survey of the OECD nations found that female leadership in all levels of governance, including health, is the primary driver for classic public-goods financing — meaning things like an increased focus on public schools, hospitals, clean water, and sanitation programs.

There is evidence of striking differences in emphasis for public health and medicine based on leadership gender.

Women are also smart, accountable managers. According to the New York-based stock analyst company MSCI, putting more women on the boards of directors of major companies, philanthropies, universities, and other institutions results in resounding improvements: "Companies that had strong female leadership generated a Return on Equity of 10.1% per year versus 7.4% for those without," and tended to encounter fewer legal conflicts and government scrutiny for possible malfeasance. MSCI found a direct correlation, for example, between decreased bribery and increased female board leadership.

According to the International Monetary Fund and the World Bank, nearly all achievements in economic development for poor and middle-income countries hinge on improvements in gender equity and leadership. Last year, South Africa's

President Jacob Zuma and France's then-President François Hollande issued the U.N. High-Level Commission on Health Employment and Economic Growth — the only such document calling attention to the crisis in health labor that specifically addresses gender issues. It calls for the world to: "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."

That's a start.

Sex and the Glass Ceiling

The list of men publicly accused since early October of sexual misconduct in the workplace has grown so long that we've all lost count. The #MeToo "Silence Breakers" are *Time* magazine's Person of the Year, and tens of thousands of tweets from all over the world reveal sexual predators and debate gradations of misbehavior. The public is increasingly wondering how to score the moral and legal differences between the likes of former Alabama senatorial candidate Roy Moore and orchestra conductor James Levine (both accused of forcing their sexual demands on teenagers) versus retired public radio host Garrison Keillor and former President George H.W. Bush, both allegedly having pinched adult women's butts during a photo shoot.

There is a wide moral and legal gap between rape and unwanted kissing, soliciting 14-year-old boys and girls for sex versus pinching a 40-year-old woman's rear end. A serial abuser like Harvey Weinstein clearly stands on far shakier moral ground than a crude prankster. Sadly, the gradients of immorality are likely to be decided by lawyers, corporate human resources departments and legislative ethics committees — places where fear of lawsuits, politics, and male interests dominate.

We are at a public moment unlike any we have ever seen, with the president of the United States a confessed pussy-grabber and tens of thousands of women all over the world stepping forward to denounce their assailants. Institutions of gravitas are shaken to their cores: the Metropolitan Opera Company, the Nobel Prize, the *New York Times*, and the boardrooms of Silicon Valley. As Melinda Gates put it, "From board rooms to presidential palaces to mats spread on the ground in the world's poorest villages, the message from women is the same: *Me too. Me too. Me too."*

Lost behind the lurid details of talk show hosts' erect penises and Hollywood's "casting couches" are the occupational realities most women face every single day, affecting their and their families' lives: job equality, glass ceilings, access to health care, and the gender imbalance in power.

The great primate researcher Frans de Waal did a series of "fairness studies" on monkeys, as he described in an entertaining TED talk, putting animals side by side, separated by clear glass. The female animals perform a task and are rewarded with food. One consistently receives delectable grapes as reward, the other undesirable cucumber slices as payment for identical task performance. When the cucumber-receiving monkey realizes her peer is getting better grape-pay she rebels, throwing the vegetable away, howling and pounding the glass. This sense of reciprocity and fairness has been shown in similar de Waal experiments done on a range of primates, birds, and other species. It is in our DNA: Whether we are chimpanzees, pigeons, or people, we know when we're getting screwed.

Global health seems a fitting place to start developing genuine systems of gender reciprocity and fairness. Well-managed and staffed public health and medical care are in all of our interests. Fairness and leadership are concepts we all understand but find difficult to implement in practice. Surely, we can start down the implementation road to leadership and fairness with professions that are already overwhelmingly female. And maybe, once the 90 percent of America's nurses have equal pay and power with their 10 percent male counterparts, we can take on more ambitious targets, like legislatures, oval-shaped offices, and the boardrooms of the Fortune 500.

Laurie Garrett is a former senior fellow for global health at the Council on Foreign Relations and a Pulitzer Prize winning science writer.

TAGS: FOREIGN AID, HEALTH, WOMEN