# DELIVERED BY WOMEN, LED BY WOMEN: THE FUTURE OF GLOBAL HEALTH LEADERSHIP

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2020 will go down in history as the year a global pandemic infected around 100 million people worldwide and caused the deaths of nearly 2 million. History, however, is not generally written by women, and there is a danger that history will not record the extraordinary contribution made by the women who comprise 70 percent of health workers and have been on the pandemic frontlines delivering care and saving lives, putting their own health and safety at risk. When the story of the pandemic is written, the credit may go instead to the men, who hold 75 percent of senior decision-making roles in health, even though they are in a minority in the sector. Even more concerning, the world may once again miss an opportunity to leverage women's important contributions to the health sector by restoring gender equity in the many emerging jobs in the sector and increasing their role in leadership positions. Women in Global Health, a

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global movement campaigning for gender equity in global health leadership, is launching a Gender Equal Health and Care Workforce Initiative in 2021 in partnership with the Government of France and World Health Organization, convening governments and international organizations to leverage commitments for safe and decent work, equal pay, and an equal say in leadership for women in health and social care.

## Women Deliver Health Systems Led by Men

Health is one of the biggest and fastest growing economic sectors, employing 234 million people worldwide, the majority being women. Women know best the health systems they run, providing essential health services to around 5 billion people. They are 80 percent of the world's nurses and 90 percent of the frontline health workers. Langer et al. estimate they contribute around $3 trillion to global health every year, half as unpaid work. Women are the backbone of global health; without their paid and unpaid work there would be no health systems or global health security. COVID-19 has made that clear. But the talent, knowledge, and commitment women in health bring to work has not guaranteed them an equal seat at the decision-making table. Women still deliver health systems led by men.

Women start as the majority of front-line workers and then mysteriously fade out of sight as we climb the global health power hierarchy. In 2020, for example, Women in Global Health research found women headed only 23 percent of country delegations to the World Health Assembly, the same percentage as 5 years earlier and only a slight increase on 2005, 15 years earlier, when the percentage was 19 percent. Fewer than 5 percent of Fortune 500 companies in the health sector have female chief executive officers (CEOs). A study by Global Health 50/50 of 200 organizations influential in global health found in 2020 that 73 percent of chief executives were male. Only 5 percent, however, were women from low- and middle-income countries, highlighting the particular marginalization of women from less well-resourced countries. In the year when the Black Lives Matter movement gained global prominence, women from racial and ethnic minorities were also particularly absent from health leadership, while often representing the majority in lower status and lower paid health and care roles.

## COVID-19: Once Again, Women Deliver Health Systems Led by Men

When the global pandemic hit in 2020, the "male leadership default" button was activated. Early in the pandemic, Women in Global Health noted that the media was not inviting expert women to comment in the same numbers as men and that COVID-19 decision-making bodies were often heavily skewed in favor of men. In response, we joined with WCAPS (Women of Color Advancing Peace and Security) to crowdsource a list of 100 women experts in health security. We knew women experts were out there and wanted to challenge the assertion that "there were no qualified women." Nevertheless, despite an oversupply of qualified women, Women in Global Health's research found 85 percent of COVID-19 national task forces (out of a sample of 114) had majority male membership. Although women are the majority in the profession, they tend to be clustered into lower status roles and held back in their careers by policies that do not support the family responsibilities that fall disproportionately to women, by discrimination and bias towards men who are seen as "natural leaders."

## We Have Everything to Gain From Gender Parity in Health Leadership

When women are systematically passed over for promotion and feel marginalized from decision-making in the health systems they know best, morale is likely to be low and attrition high. This has serious implications for a sector already facing shortages of trained staff in almost every country. According to the World Health Organization, demographic changes and rising demand for health are projected to drive the creation of 40 million new jobs by 2030 in the global health and social sector. In parallel, an additional 18 million health workers will be needed in low- and middle-income countries, to achieve the U.N. Sustainable Development Goals and Universal Health Coverage. The global mismatch between health worker supply and demand is both a cause for concern and a potential opportunity, particularly for women. When medicine was first formalized as a profession, it was established by men for men, with barriers to entry excluding women. Women battled their way into the profession and are now the majority of physicians, nurses, midwives, and dentists under the age of 40. There is no shortage of women wanting to enter health and social care professions, and there is also no shortage of women in the pipeline for health sector leadership.

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Increasing women's role in health leadership will have wider potential benefits, encouraging women to both enter and stay in the profession, enabling the expansion of the global health and social care workforce needed to meet global health and development goals. Beyond that, it can create what Women in Global Health describes as the "Triple Gender Dividend":

**First**, if new jobs in health are created as decent, equally paid work with equal roles in leadership, women will fill those jobs and help end the health worker shortage. Given that women are now the majority of health workers in younger age groups, it is critical that they feel they are treated fairly at work, valued for their professional knowledge and expertise, and have an equal chance of career progression into leadership. More female role models in leadership positions will encourage other women to join.

**Second**, investing in decent work for women will enable more women to enter the formal labor force, increasing women's income and decision-making power, with a multiplier impact for children and family welfare.

**Third**, new jobs created in the health sector will drive economic growth, which will have wider economic and social benefits for everyone. The World Economic Forum has long argued that gender equality at work drives economic growth.

These are critical gains that would leave health systems more resilient and better able to face future health and economic shocks.

When women lose out in health leadership, we all lose. The gender gap in health leadership cannot simply be dismissed as a "women's problem." In a pandemic and in more ordinary times, we need all talent at the table. Women expand the agenda in health decision-making, bringing their lived experience as women and also their experience in health systems. There is evidence that enabling nurses to lead health services has led to better health outcomes, retention, and greater innovation.

It is also well documented that companies with diverse executive teams outperform competitors run by men only. We cannot fight global health challenges like

pandemics or slower burn challenges like antimicrobial resistance and obesity by drawing from half the talent pool. Diverse decision-making groups make better decisions. We want to see women at the table in equal numbers to men, including women from diverse social groups, health professions, and geographies.

## Our Vision of Future Global Health Leadership

COVID-19 has changed the world profoundly and exposed the deep inequalities, including gender inequality, that our social, economic, and health systems rest on. Four drivers now underpin our vision for equitable leadership in global health:

First, we must change the narrative and see women as drivers of global health, not solely as users of health systems. History must record, celebrate, and not erase women's contribution to confronting the pandemic. Not acknowledging that the default health worker is female means no priority is given to addressing gender inequality—workplace policies remain modeled on men's lives and personal protective equipment (PPE) remains modeled on men's bodies.

Second, women in health and social care need a new social contract. Women hold 70 percent of jobs in health but remain largely clustered into lower status and lower paid (often unpaid) roles driven by gender stereotypes that deem jobs suitable for women (nursing) or men (surgery). Women are triply disadvantaged by gender norms that attach lower social value to majority female professions, devaluing their status, and pay. COVID-19 leaves in its wake a trail of exhausted health and care workers, long-term health effects, and mental trauma. It is time to reconsider the value we put on health and health systems, and, therefore, the value we put on the women who deliver them. There is a risk that COVID-19 will reverse gains women have made in health leadership because women will leave health professions or fall back in their careers as they try to balance heavy professional duties plus an increased workload of unpaid work and child care with lockdowns and school closures. Many will need encouragement to stay in the sector. Investing in decent jobs for women in the health and social workforce is investing in global health security.

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Third, COVID-19 showed that viruses do not respect national borders and we live in an interconnected world. High-income countries do not have a monopoly on health wisdom. We need to rebalance the geography of power and leadership in global health. Women in Global Health creates a platform for women from low- and middle-income countries, and now they must be enabled to take their place in global health leadership.

Fourth, beyond gender parity in global health leadership, we need leaders of all genders to be gender transformative leaders, challenging power and privilege and promoting gender equality in health which will, in turn, promote strong, resilient health systems. Women in health want the opportunity to deliver better health for all.

## Conclusion

COVID-19 is a break in history and a chance to fix the structural weaknesses, including gender inequality, in our health and social systems so we can better withstand future shocks. This is our opportunity to rebuild global health security on a stronger and more equal foundation by ensuring that the women who deliver health and social care are leading the systems they know best.

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