Alison Leary: Why won't workforce policy makers tackle gender inequality in healthcare?

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Leaving gender and gender inequality out of the strategic plan for the NHS workforce is seriously misjudged, says Alison Leary

As the NHS's ever present workforce crisis seems to deepen, one of its ameliorants, the recent publication of the People Plan from NHS England, has had a mixed response. It makes inroads into some important workforce issues, such as wellbeing, and recognises other problems that have been rarely acknowledged in strategy, such as bullying.

One area that it stays away from is gender equality. Given that the NHS's workforce is 77% female, you would think that gender and gender equality would be an important consideration and a subject worth tackling, but the People Plan does not mention gender at all.

A few years ago, I co-authored a study that showed being male in a predominantly female profession (nursing) had advantages in terms of pay and progression. This was not a new finding, and women working part time seem particularly disadvantaged—often taking lower paid jobs to obtain hours that allow them to meet their obligations outside of work, such as caring responsibilities. A recent report on GPs demonstrated that there is a stark gender pay gap in their salaries too, some of which is accounted for by women being more likely to work part time. This is known as the "sticky floor" in terms of career progression and it holds women back.

I raised this omission in the People Plan on social media, but was challenged by some people who pointed out that the plan does talk about flexible working and people (women) should insist employers meet this obligation. This statement alone makes several assumptions. One is that only women want flexible working, and another is that women feel comfortable asking for employers to be accommodating. Judging from my inbox each week and the women I hear from, many don't or are given short shrift when they do.

Healthcare as a sector tends to devalue traditionally female work, including the work of historically female professions. This is both structural and cultural. The emergence of tariffs, such as "payment by results," in England, rewarded activity rather than results. It didn't value the work as measured by care delivered or outcomes achieved. Much of the effort of healthcare is focused on joining up activities, and organising as well as delivering care, but these efforts are omitted from tariffs or included only as "hotel services"—these examples of complex care, such as case management, were simply described as an overhead. Unfortunately, this caring work had little value according to the management accountants that were commissioned to do endless workforce reviews to save costs. Electronic patient record systems don't record vigilance, rescue work, empathy, or the coordination of care.

The same goes for the value we place on certain leadership characteristics, which can hurt women's career progression. The recent "more diverse" most influential list from HSJ included women, but

the only nurse included, a profession that is 89% female, was a man. A recent report by the NHS Confederation shows how the NHS's structure and culture still disadvantages women reaching board level positions. Twenty nine per cent of medical directors are women, as are 25.3% of chief finance officers, despite both having majority female workforces. The report recommends challenging leadership styles so that the stereotype of masculine white leadership becomes more inclusive.

Some of the issues women face are well hidden and manifest in microaggressions that are harder to quantify—for example, women in medicine being less likely to be called by the title Dr and the use of possessive pronouns towards predominantly female professionals ("my nurse" when referring to colleagues) is common. However, some of it is more overt. A recent retention initiative by Health Education England offered childcare incentives to GPs but not to GP nurses, even though both are facing chronic shortages and have retention problems. Other studies have found marked differences in pay and conditions, such as maternity leave, across the workforce. Essentially, a role that undertakes complex, knowledge intensive work, but which is traditionally female, is still valued less in terms of pay, benefits, and opportunity than a traditionally male one.

The burden of caring in health and social care is still seen as women's work (even when men do it) and as such has suffered at the hands of policy makers who do not see its value. What follows across the spectrum of healthcare is retention problems, a hollowing out of services, a perception of "low value" work, and a de-professionalisation agenda that prioritises the most hands for least money. This devaluation sees the belief that anyone can do anyone else's work persist—providing care doesn't require a complex education, just being the right kind of person who can deliver tasks. When professionals are undervalued and treated as disposable, it means serious issues like assault, bullying, and safety concerns are underreported because no one will take it seriously anyway. Poor workplace experiences mean that people simply leave.

To say that gender is not an issue in healthcare is misjudged, and to deny that the worth of traditionally "women's work" is not as valued is at best an oversight, and at worst insulting to the millions of women who have contributed to the NHS. To leave gender out of the strategic plan for the most valuable resource the NHS has seems more than an oversight. I fear that it's been put in the too difficult box; perhaps fear of equal pay claims and the prospect of facing up to some ugly truths means it's easier to look away. In a workforce that is 77% female, we can no longer ignore the experiences of women in healthcare and the injustices they still face, no matter what job they do.

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