Why WHO needs a feminist economic agenda [1]

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Excerpts from introduction

In September, 2019, Alan Donnelly and Ilona Kickbusch called for a chief economist at WHO. Such a position, they argued, would enable WHO to better advocate for greater recognition of, and thus action on, the interdependency of health and the economy. We support this proposal: recognition of the interdependence of health and the economy is vital for WHO to achieve its mandate: "the enjoyment of the highest attainable standard of health…without distinction of race, religion, political belief, economic or social condition". Given this mandate, WHO should be more ambitious than the appointment of one economist. A more strategic and enlightened approach, especially in the aftermath of the coronavirus disease 2019 (COVID-19) pandemic, would be for WHO to embrace and articulate a feminist economic agenda.A feminist economic agenda interrogates power dynamics and peoples' relative access to and use of wealth and resources. A feminist economic lens that incorporates intersectionality must address the power dynamics between genders and acknowledge the power relationships between nation states, ethnicities, ages, abilities, and other dimensions of diversity, and how they are interconnected with gender inequality and the economy.

A feminist economic approach is consistent with how public health is taught and sometimes practised: that health, and access to health care, is interdependent not only on the economy but also on all other social and commercial determinants of health. WHO has estimated a shortfall of 18 million health workers by 2030, largely in low-income and middle-income countries. Women comprise more than 70% of the global health workforce, but WHO research into the state of gender equity in the health workforce has revealed systematic gender biases, inequities, and discrimination.

A feminist economic approach recognises the systems of disadvantage and discrimination that lead to this inequality. Minority ethnic status, class, education, and sexuality determine who is represented in unpaid community health-care worker roles. The unpaid and low paid labour of women has contributed to profits for private health-care providers and saved the bottom line of health spending in national budgets: capitalism and patriarchy combine to systematically undervalue social reproductive labour—ie, unpaid care roles as women's work.

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[2] https://doi.org/10.1016/S0140-6736(20)30110-0
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