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**Dissertation Prospectus**

Gender Discrimination and Inequalities in the Health Workforce and Measures which should be Taken to Improve the Situation

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Dissertation Prospectus

Introduction

Gender is one of the fundamental factors in the operation of the health workforce. Recent studies point to inequalities in employment systems, in-service education and in-service education and gender discrimination. The patients might inadequately receive the modern day critical health care needs if the inequalities and gender discrimination are not acted upon as they lead to inefficiencies in the health workforce. It was reported by Human Resources for Health (HRH) that among the Inequality and Gender Discrimination is highly affecting the students and faculty of the Health Professional Education (HPE) which are producing robust hindrances in the goals of health and development, yet, reformers pay a little attention to these gender barriers (Constance Newman, 2016).

Gender discrimination and inequality violence influence the working in a workplace environment. In Rwanda, thirty-nine percent of the health sector workers reported violence which included perpetration, victimization and multiple reactions to the violence. This lowered the odds in the working environment. Addressing these issues should be the major issue governed by the Human Resources, workplace policies, strategies, and certain laws. (Constance Newman, 2016)

The coverage of the Gender Discrimination and Inequalities at a Universal level is not easily achievable. The consideration to achieve a balance in the gender discrimination conflicts and inequality issues in the health sector is crucial (Organisation, 2005). There are various issues of Healthcare sector including Gender discrimination and inequality are highlighted and become a center of attention for the 2015 agenda for sustainable development (Sustainable Development Goals, 2019). But there is no focus on the health systems and the issues that are being faced in terms of gender discrimination and inequalities (Newman, 2014). However, there is a strong need of focus on gender discrimination in all the domains of the healthcare systems (R. Horton, 2015).

The leadership in the healthcare sector requires changes in order to include more women. Studies indicate that fifty-six percent of the total number of women leaders in the healthcare sector are experienced. However, this is subsequently more than the percentage which is found in the males to be 31 percent.Increase in government regulation makes this a distinctive advantage, as more leaders who can comprehend the clinical effects of regulations on the daily operations of healthcare organizations are needed (Fischer-Wright, 2016).

The proposed research seeks to examine gender discrimination and inequalities in the health workforce. In the U.S. labor market, women’s median earnings are less than men’s for almost all occupations, regardless of whether they work in occupations predominantly filled by men, occupations predominantly filled by women, or occupations with a mostly even number of women and men. Because gender discrimination, whether based in cultural, social, or structural issues, is so entrenched in health worker education and employment systems, gender discrimination and inequality need to be handled by reforms to health profession education (Newman, 2014). Some of the most damaging gender inequalities are developed within human resources practices because these practices affect hiring, training, pay, and promotion for women.

**Background of the Problem**

Gender inequalities in the health sector could be created through vertical (from leaders to followers or from upper management to lower management) and horizontal gender (same level; peers) discrimination as gendered practices of working life might result in inequalities. Gender discrimination and inequalities in the workplace are affecting the ways in the living of the people at all levels. (Rosemary Morgan, 2016). A number of factors reported that the gender stereotyping and the organizational factors contribute to discrimination (Bobbitt-Zeher, 2011). Human resources for health (HRH) researchers and leaders noted that gender inequality and discrimination are a key barrier in the paid workforce industry (Newman, Gender equality in human resources for health: What does this mean and what can we do? 2010) However, little is known on gender discrimination and Inequalities in the Health Workforce and Measures which should be taken to improve the Situation (Mohammed, 2009)Therefore, the study will focus on examining gender discrimination and inequalities and the workplace and suggest measures to be taken in order to improve the situation (Mohammed, 2009).

Reforms are required in the health education profession. Gender discrimination, whether based on cultural, social or structural issues is deeply rooted in the health worker education and employment systems. Therefore, the inequality and gender discrimination needs to be dealt with by using reforms to health profession education (Newman et al., 2016).

Most of the high-level gender inequalities are experienced in the human resources sector (Hing, 2015) The human resources sector is associated with hiring, training opportunities, pay, and the promotion of women (Skjeie, 2015). The organizational structures, processes, and practices that favor gender inequalities affect these practices in the human resources sector. In addition, the same organizational discrimination provides the platform in the social context where the decision makers in the organization encourage hostile and benevolent sexism (Stamarski& Son Hing, 2015).

Organizations in the healthcare sector need to carry out reforms in human resources practices in order to address the issues of gender-based discrimination. The gendered organization's theory foresees that customs that are initiated by stereotyped male and female workers will continue, with disregard to how the workforce is composed. Therefore, there is a need to change the human resources practices that are assumed to be neutral so that they may address the issues that lead to organizations being gendered (Mastracci& Arreola, 2016).

**Theoretical Foundations/Conceptual Framework and Review of the Literature/Themes**

**Theoretical foundations/conceptual framework.**

Three theoretical frameworks will be used as the basis of the research. First one is the gender at work analytical model. This framework is important in the identification of the tasks that women and men perform in the organization and the gender division of labor (Rao et al., 2016). Therefore, this framework is important in the identification and definition of the roles that each gender plays in the organization. Hence, this will be suitable in advancing the areas of research in this study.

Secondly, the study will use the theory of gendered organizations; hierarchies in organizations are gender neutral even though in the real sense they are gender biased (Mastracci& Arreola, 2016). The consequences for the whole life situation can be affected by their work life because for a majority of the people; work constitutes a major part of their life. Therefore, this theory will be significant in the study as it will assist in examining the point of departure for the gendered structures in health management.

 Finally, the third framework being the economic models of discrimination (Kim et al., 2016). The model will be significant in guiding to examine matters related to the economy that might lead to gender discrimination and inequalities at the workplaces.

**Review of the literature/themes.**

 In this section, we discuss the major themes that were from the literature that are related to the research topic:

• Women in the leadership of an Organization, Executive Roles and the barriers they are facing;). Companies that have female Chief Executive Officers or women in their management boards have been observed to perform highly in the stock market. An estimation by research shows that transitioning from a single-gender office to one that has both men and women is likely because of hoping to increase revenue by forty-one percent (Kim et al., 2016). Therefore, there is pressure to increase gender equality to promote profitability in the healthcare industry thus providing an incentive to eliminate discrimination. Women workers in the healthcare sector hold just twenty-seven percent of the hospital boards and thirty-four percent of leadership teams. This is despite women workers forming seventy-seven percent of all hospital employees (Härenstam, 2016). Male physicians earn 20-25 percent more average salary compared to women physicians, and males nurses earn about nineteen percent more on average compared to their female counterparts. The highest number of women leading Fortune 500 companies were recorded in the years 2014 and 2015, the healthcare industry, on the other hand, did not have such a trend. In the same situation, none of the forty-five Fortune 500 companies had fifty percent or more women holding executive positions in their teams, and the average number of women executives across all the leadership teams are estimated to be twenty percent (Hausmann et al., 2012). The health sector has leadership inequities that disadvantage the women in the workforce. The women face the challenge of socially developed barriers such as the glass-ceiling concept (Chisholm-Burns et al., 2017

• Functionalist perspective and Evidence supporting Gender discrimination and inequality; functionalist with respect to gender equality in the workplace view society as a compound system constituted of parts that are supposed work together in order to have solidarity and stability (Boundless, 2016). The theory insinuates that gender inequities may be a way of increasing efficiency and available resources by basing division of labor along gender basis. The U.S labor market has average earning of women being less than those of men regardless of whether the job is male-dominated, female-dominated or has a fair number of both female and male workers (Kim et al., 2016) Occupations also show wage gaps; men dominated jobs pay higher compensation compared to female-dominated jobs that require the same skills set. For example, it is reported that in the year 2016 female registered nurses earned 9.4 percent less than the male registered nurses did.

• Organizational Policies that affect Gender Inequality; A number of organizations personnel and their policies have been affecting gender inequality. The primary reason for this when seen as the gender pay gap. The organization's structure and processes are to be called for this. (MATT L. HUFFMAN, 2017)

• Inequality at the C-suite level; Despite women holding up to seventy-five percent of the jobs in the healthcare industry (Vanderbroeck & Wasserfallen, 2017) and sixty percent of managerial positions in healthcare, gender inequality is still an issue.

• Lack of gender diversity; mostly experienced in venture capital startups (Brand 2016). Brand states that people need to recognize discrimination and accept that it is more likely for a man to choose a man to work with.

• Influence of Gender inequality on Patient Care and the Population Health; Patient care is affected by gender-based discrimination. The gaps in earnings lead to people looking for employment opportunities elsewhere thus leading to costly and time-consuming turnover (Härenstam, 2016). Healthcare organizations are recognizing the positive impact of diversity in the workforce on population health. These types of organizations develop strategies that commit to ensuring diversity, having a leadership team, board of trustees, and frontline workers who represent the community that they serve (Mastekaasa, 2015).

• Gender Diversity, Inequality, and Economics; Gender diversity can result in having both positive and negative effects on the productivity of a team. However, these effects can be successfully managed (Mawn et al., 2010). The complete removal effects of gender inequality from the process of modeling the growth performance of the economy, the aggregate income in the Asian economy would be higher by six point six percent higher after a generation and 14.5 higher after two generations than the benchmark economy. Per capita income would be 30.6 percent higher and 71.1 percent more after two generations in the hypothetical gender-equality economy (Kim et al., 2016).

• Wage Gaps; the lower pay to women is independent of the career choices that women make since studies show that pay reduces when a substantial number women enter an occupation that was previously male-dominated (Newman et al., 2016). The same way, pay rises when a reason of able number men enter a previously female-dominated occupation.

* Types of sex and gender discrimination; the stereotype that women are weaker than men and thus men should hold more power over women makes women more susceptible to gender inequality in the workplace than men (Rao et al., 2016).
* Education as a solution; Despite the fact that millions of more women have joined the job market in recent years and women's educational attainment being more than men due to the consistent gender discrimination factors that relate to gender bias, women cannot salvage themselves from the wage gap through education (Stamarski et al., 2015).
* Gender at work Analytical Framework; this framework argues that reforming the unspoken, informal institutional practices that promote gender inequality in organizations is paramount to achieving gender equity for everyone (Rao et al., 2016).
* Structural Barriers; these barriers promote direct and indirect discrimination. The source of disparities is the difference in the power that female and male workers have, it is thus important to break the existing structural and organizational barriers to achieving equality (Webley, 2016).
* Proposed cultural shift; cultural shift is one of the solutions to bring equality to the healthcare through formulation of fair hiring standards and policies, creation of a safe working environment that handles issues regarding sexual harassment, and helping in making aware the ways that promote sexism and bias towards women to patients and other consumers of healthcare services (Haskins, 2016).
* Human Resource-Based Solutions; includes better use of predictive analytics to do away with gender bias and discrimination among workers (Jayanthi, 2016).Analytics may be utilized to show data in a graphical form that is easy to comprehend. As well as, statistical reports that can be used by the management in decisions regarding hiring, reviewing of policies to deal with pay gap, creating programs to better the work environment of populations that have a higher chance of leaving, and creating procedures that the evaluates the match between the applicant and employer thus eliminating the bias in hiring.

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## Problem Statement

Little is known on factors that would address the different significant gender inequalities that are in the health workforce and how the inequalities affect the health systems. The people who are greatly affected by gender inequalities in the healthcare industry could be the women workers who make up a large section of the industry but remain biased in hiring, promotion, and being compensated lower than their male counterparts do. The research will seek to examine gender discrimination and what actions may be taken to improve the situation in the health workforce. The unit of analysis will be sampled medical facilities where the ratio and the working environment of the female and male workers will be studied.

**Purpose of the study**

The purpose of this qualitative study is to examine gender discrimination and inequalities in the health workforce and the measures that can be taken to bring equality in the healthcare workforce starting from education, to leadership, and changes needed in the organizations of health systems. This study will be conducted in one of the health facilities at Tennessee, where the data will be collected from the health staff regarding the gender inequalities, and the role of leadership in the health system. For this study, the data will be collected and analyzed qualitatively. The main variables are the ratio between male and female workers and the factors bringing in inequality in the medical facilities.

**Research Questions and/or Hypotheses**

The research questions defined in this section are a breakdown of the problem being studied. The first question aims in determining whether there is a disparity in the number of men with regard to the number of women workers hence showing if gender inequities really exist. The second question wants to identify the causes that influence gender inequities in the facilities. The third try to get the source of the gender inequities and the scope that the factors influencing the inequities to have. The questions are:

RQ1: What are the levels of productivity of employees of the targeted medical facility, and how could gender discrimination effects the performance of an employee?

RQ2: What are some of the factors influencing gender inequalities across the health facilities sampled?

**Advancing Scientific Knowledge and Significance of the Study**

The study will add knowledge to the existing literature and clarify discrepancies, and attempt to fill the gaps in the literature on gender discrimination and Inequalities in the Health Workforce and appropriate measures. Moreover, this study will be linked to sustainable development goals (SDGs) that promote gender equality. As the research intends to examine the factors that influence the fragment of inequalities and the actions may be taken to improve the status of the healthcare industry workforce. Gender discrimination is deeply rooted in the healthcare industry from worker education and employment systems (Newmanet et al., 2016). The theory of gendered organizations states that some practices that are founded by people from a single gender that ensures that there is gender discrimination irrespective of the composition of the workforce (Mastracci & Arreola, 2016). The study will, therefore, lead to the identification of factors that promote gender bias in the healthcare industry and provide remedies to these issues to ensure equality. Moreover, this study offers benefits to several persons and institutions. It will assist both the policymakers in the area of the health workforce and the students of human resource management, health management among other management disciplines.

**Rationale for Methodology**

Qualitative research methodology will be used for the research. Qualitative research revolves around studying attitude, behaviors, and opinions. This methodology generates results that are non-quantitative in nature. The approach is suitable in this case since we want to study the behavior of the workforce in the healthcare sector, through the analysis of opinions and attitude. Sandelowski (2000) defines qualitative description as a study that is designed for the purpose of producing low inferences of descriptions of a phenomenon. However, this author suggests that in the qualitative description there is an attempt to ensure the originality of data through minimization of inferences. However, all studies involves interpretation (Sandelowski, 2000). Qualitative research methodology typically entails other pre-structured means or surveys that focus on achieving common datasets on variables that are preselected and a summary generated by the use of descriptive statistics. Qualitative studies entail interpretations whereby there is the presetting of variables to be studied and the horizons of expectations and conclusions derived from the statistical tests results based on a set of assumption (Merriam et al., 2009).

**Research Design**

This qualitative research will utilize the case study design in the collection, synthesis, analysis, and interpretation of data. The case study design involves the researcher engaging in a detailed description of individuals, groups, communities, or institution’s experiences with regard to a particular subject matter. It has commonly been used to study human behavior and social interactions (Harrison, Birks, Franklin and Mills, 2017). The reason for using the qualitative design was that the research is a case study and it involves a deeper dive into the problem through the questionnaires. It also involves studying cases in their real-life contexts with the purpose of creating an understanding of how a problem might influence or be influenced by the context. The case study design may assume multiple techniques of data collection such as questionnaires, structured interviews, direct observation, reports, as well as face-to-face interactions with the subjects (Merriam & Tisdel, 2015). Considering that this study involves investigating the extent of gender discrimination and inequality in the health workforce, the case study design will be the most appropriate to collect data from one of the medical facilities in Tennessee that have been sampled.

The appropriateness of the case study design in this research is based on the fact that the research questions are aligned with the need to understand human behavior, in this case, the gender discrimination and inequalities that are existent in the health workforce and what fuels them. The target population, being the health workforce working in the ten medical facilities in Tennessee, the case study design will provide a framework through which the available participants can be interviewed, whereas those who might be unavailable will be sent questionnaires to fill in. Consequently, and as Yin (2017) suggests, the case study design will provide a framework for data analysis and synthesis for the ultimate purpose of the research which is providing measures that can be taken to bring the desired change, in this case, equality in the healthcare workforce.

**Research Materials, Instrumentation, OR Sources of Data**

* The type of data that will be collected in this case is interviews and observations.
* The main method of data collected will be interviewing the respondents, observations, and questionnaires for the respondents who may not be available.
* The questions that will be standard for all the respondents of the category to

ensure uniformity. The main intended respondents are the human resource workers who are familiar with the facilities practices and policies with regard to human resources.

**Data Collection**

* There are several qualitative methods that may be used by a researcher to conduct a study. The method to use is determined by the situation in which the subject is in. The researcher, therefore, has to analyze the situation and the methods available for use. This is to ensure that the methods that are desirable, efficient, and reliable and cost productive are chosen and applied in the collection of data. In this case, the method that would be required that the method may be applied within the recess time and the data collection is complete. This means that the method should be one that consumes little time and also simple for the research subjects in the health institution to understand. With this case, the following methods would be used.
* The research process will involve the use of interviews; the interviews will be used to collect information from the human resources officers.
* Interviews will be used to collect information regarding the ratio of men to women in the organization, the human resource practices, and policies in hiring, promotion, training, and paying off employees. The questions that would be asked in the interviews will be based on the research questions that have been stated above.
* The data from interviewing will be recorded using audio recorders which will then later be transferred to paper, known as transcription.
* The observation. This method requires the researcher to be personal go to the subject's normal operational area, in this case being the health workers and then get into the subject normal schedule then observe their behaviors. In this case, the researcher goes to the sample health institutions, get into their normal day to day schedule and wait for them during the recess so that he or she may observe the subjects. The researcher will then collect the data from observing the health workers himself and then record the relevant data. The researcher would basically, in this case, acquire a place where he may be able to see the health workers behavior and interaction with each other.
* This, therefore, means that the researcher will select a location which is suitable for observation and also there is no interruption to the researcher and to the health workers (Creswell, J. 2007). The researcher will then records what the students are doing with respect to their ethnic background.
* The researcher will record any other occurrences deems them to be relevant to the research (Lawrence, Louis & Keith 2000). The researcher should carry out all these activities without having attempted to control or manipulate how the health workers work should not be aware of the researcher’s presence or intentions. This will allow the researcher to record the correct observations. This method is, however, subject to observer’s judgment and therefore the researcher may record what he or she feels as appropriate and not the actual details on the ground. The observer may also not record the full details of the subject pupils and the events that occur during the recess with respect to the health workers.
* The second method is focus groups. This method is a type of group interview, with a difference in which the participants interact with each other and not with the interviewer as it is with interviews. The researcher, in this case, will have to select a section of the health workers, taking into consideration that the health workers are of different genders. The workers will then discuss a specific topic, and therefore the interaction between the health workers will enable the researcher to collect data that will emerge. Since these are the participants in the study the researcher will control the group discussion and explain to them the purpose of discussion so that the minimal time is consumed in the activity (Creswell, J. 2007). This will ensure that all the scheduled activities are done within the time allocated for recess for the health workers. The researcher would, therefore, consider the following when creating and running the focus groups; the number of health workers that would be considered in to take part in the research activity. The selection criteria should ensure that all the selected health workers have a characteristic that will be required to make the discussion successful; which in this case is different genders and also the number of focus groups that will be required to have a clear view of the research. This method has some limitations since the data collected may not be the same as the original ones gathered when the pupils are interacting with each other in real life. This, therefore, means the correct data may not be gathered by the researcher. The limitations of the questionnaire are the misinterpretations and unintelligible replies by the respondents.

**Data Analysis Procedures**

* The collected data from the sample will be described and summarized using descriptive statistics, for example, the ratio of male to female employees from various health facilities will be summarized using descriptive statistics.
* The analysis will involve providing explanations of meanings and conclusions that have been consequent of the previous study, which will be included in the research.
* A narrative summary containing explanations of research questions and the exploration of the various thematic issues will be derived across the research questions
* The study will focus on data analysis through non-statistical procedures.

**Ethical Considerations**

Ethical issues such as confidentiality, responsibility, informed consent, honesty and openness in dealing with other researchers and research subjects, physical and psychological protection, and explanations of the objectives of the investigation and ‘de-briefing' subjects afterward should, therefore, be considered. The rights of informants or participants in this study will be protected by all means.

The principle of voluntary participation will be encouraged, and participants will not be coerced into participating in the study. The researcher will first seek consent from the participants of the study before participation after being fully informed about the procedures to be taken in the study. Therefore, In order to get permission to interview the sampled participants, the communication requesting permission to carry out the research in the ten sample facilities will be done through email and phone.

In order to prevent any harassment and non –cooperation of participants the following will be done to protect their identities; the questionnaires would not require the participant's name and the interviewer will not note down or record the participant's name during the interview. Moreover, the anonymity of the participants will be maintained by asking them not to disclose their names in any of the research instruments. The respondents will also assure of non-disclosure of information to third parties. Therefore, the researcher will guarantee the informants’ confidentiality. Those participating in the study will not put in a situation that might result in harm as a result of participation. The collected data will be put in a single safe room after being collected from the participants. The ethical concerns that may pop up include conflict of interest in the human resources employees, confidentiality of the data collected, and the proper interpretation of the collected data.

**Appendix A**

**The 10 Strategic Points**

1. Topic: Gender discrimination and inequalities in the health workforce and measures which should be taken to improve the situation.

2. Literature review:

a. Background of the problem/gap

i. Healthcare leadership needs to change: data show that 56 percent of women leaders in healthcare have experience seeing patients as compared to only 31 percent of men, which translates to a distinct advantage as government regulation increases and more leaders are needed who understand the clinical impact of regulations on the day-to-day running of healthcare organizations (Fischer-Wright, 2016).

ii. Because gender discrimination, whether based in cultural, social, or structural issues, is so entrenched in health worker education and employment systems, gender discrimination and inequality need to be handled by reforms to health profession education (Newman, Ng, Pacque-Margolis, & Frymus (2016).

iii. Some of the most damaging gender inequalities are developed within human resources practices because these practices affect hiring, training, pay, and promotion for women. Not only does institutional discrimination in organizational structures, processes, and practices play a substantial role in creating gender inequalities because they affect HR practices, but they also enable a socializing context in which organizational decision makers can promote hostile and benevolent sexism (Stamarski & Son Hing, 2015).

iv. Since gendered organizations theory predicts that norms and practices founded on stereotyped male and female workers will continue, regardless of how the workforce is composed, the need exists to transform purportedly neutral human resources management practices to address underlying reasons why organizations are gendered (Mastracci & Arreola, 2016).

b. Theoretical foundations (models and theories to be the foundation for study):

 i. Gender at work analytical framework (Rao, Sandler, Keller, & Miller, 2016)

 ii. Theory of gendered organizations (Mastracci & Arreola, 2016)

 iii. Economic models of discrimination (Kim, Lee, & Shin, 2016)

c. Review of literature topics with a key theme for each one:

i.Barriers to women leadership: The health sector faces leadership inequalities whereby the female gender continues to struggle with socially constructed barriers such as the glass-ceiling concept (Chisholm-Burns et al., 2017).

 ii. The functionalist perspective on Gender discrimination: The functionalist perspective on gender equality in the workplace views society as a complex system composed of parts that should work together to achieve solidarity and stability (Boundless Sociology, 2016). This theory then suggests that gender inequalities may be a useful way to increase efficiency and resources by dividing labor along gender lines.

iii. Structural oppression of women: Specifically with respect to socioeconomic factors, structural oppression accounts for men routinely earning more than women for the same work, resulting in the wage gap (Webley, 2016). The emergence of the globalization of capitalism and its methods of production and accumulating wealth based on the exploitation of women workers around the world examines the interplay of these theories.

iv. Leadership: Companies with women CEOs and companies with women on their boards outperform the stock market, and researchers estimate that transitioning from a single-gender office to an office evenly divided between men and women has been associated with a revenue gain of 41 percent (George Washington University, 2016, para. 12). Given the pressure to increase profitability in the healthcare industry, motivation to decrease gender inequality should provide an incentive to eliminate discrimination.

v. Selected evidence of gender discrimination and inequality: In the U.S. labor market, women’s median earnings are less than men’s for almost all occupations, regardless of whether they work in occupations predominantly filled by men, occupations predominantly filled by women, or occupations with a mostly even number of women and men (Institute for Women’s Policy Research, 2017). There is also a wage gap between occupations, with male-dominated occupations paying more than female-dominated occupations requiring similar skills. In 2016, women registered nurses earned on average 90.6 percent as much as their male counterparts.

vi. Inequality at the C-suite level: Gender inequality continues despite the fact that women hold 75 percent of healthcare jobs (Castellucci, 2017, para. 6) and 60 percent of healthcare managers are female (para. 10). Given the number of healthcare organizations who claim to aspire to equal opportunity employment practices, this gender inequality in senior leadership and executive positions may indicate the existence of unintentional bias.

vii. Lack of gender diversity: This inequality is most pronounced in venture capital startups, as summarized in a report by Rock Health in its study of female leadership within the healthcare industry (Brand, 2016). The report highlights the importance of recognizing biases and acknowledging that it is common for men to be “more comfortable” working with other men.

viii. Women Executives in Healthcare: While 2014 and 2015 set records for the highest number of women CEOs leading Fortune 500 companies, this trend did not extend to the healthcare industry. Reviewing the 45 Fortune 500 companies where the average number women executives across all leadership teams remain at approximately 20 percent, and none had 50 percent, or more of their team is made up of women executives (Chinna, 2016, para. 20).

ix. Women in Leadership Positions: Whereas 77 percent of all hospital employees are women; women make up just 27 percent of hospital boards and just 34 percent of leadership teams (Joyce, 2015, para. 2-3). The median salary for male physicians is on average about 20-25 percent higher than for female physicians, and male nurses make about 19 percent more than female nurses (para. 4).

x. Impact on Patient Care: Gender discrimination also impacts patient care because salary disparity motivates people to look elsewhere for jobs, adding to expensive and time-consuming turnover (Joyce, 2016).

xi. Impact on Population Health: A growing number of healthcare organizations recognize that diversity has a positive effect on patient care, particularly population health. Such organizations recommend an inclusion strategy with a commitment to diverse culture, that is, having a leadership team, board of trustees, and frontline workers that reflect the community they serve (Jayanthi, 2016).

xii. Gender Diversity and Teams: The challenge of gender diversity can produce both positive and negative influences on team productivity but can be effectively managed (Vanderbroeck & Wasserfallen, 2017).

xiii. Gender inequality and Economic Cost: Kim et al., (2016) found that if the effects of gender inequality were completely removed from modeling the growth performance of the economy, aggregate income in the Asian economy would be about 6.6 percent higher after one generation and about 14.5 percent higher after two generations than the benchmark economy (p. 6). Per capita income would be 30.6 percent higher and 71.1 percent higher after 2 generations in the hypothetical gender-equality economy (p. 6).

xiv. Wage Gaps: Lower wages paid to women cannot be blamed on women's career choices, given that a substantial number of studies show the when women enter a previously male-dominated occupation the pay drops (Miller, 2016). Conversely, the same studies show that when significant numbers of men enter female-dominated occupations previously, the pay scale rises.

xv. Types of sex and gender discrimination

Women are more likely than men to be affected by gender equality in the workplace because of the stereotype that women are weaker than men and men should, therefore, hold more power over women as well as cultural perspectives on gender inequality (Bungay, 2016).

xvi. Education as a Solution: Women cannot educate themselves out of the wage gap Schieder & Gould, 2016). The wage gap – that is, women being paid 79 cents for every dollar men are paid (p. 2) - is still occurring even though millions of more women have joined the workforce in recent years and women's educational attainment outpaces men's, due to systemic gender discrimination factors that reflect gender bias, including "the culmination of years of education, guidance by mentors, expectations set by parents figures and society, hiring practices of organizations, and widespread norms and expectations about work-family balance held by employers, co-workers, and society" (p. 2)

 xvii. Gender at Work Analytical Framework: Using a gender at work analytical framework argues that transforming the unspoken, informal institutional norms that sustain gender inequality in organizations is pivotal to attaining gender equitable outcomes for everyone (Rao et al., 2016).

xix. Structural Barriers: Structural barriers exist that promote direct and indirect discrimination even in the context of varying concepts of fairness and equality, preventing gender equality. The source of this inequality is differences in power that men and women enjoy, therefore requiring the dismantling of structural and institutional barriers to equality (Webley, 2016).

xx. Proposed Cultural Shift: Proposed solutions include a cultural shift in hospitals that emphasizes the need for fair hiring standards and policies, creating a safe work environment that addresses complaints of sexual harassment, and helping patients and healthcare consumers become more aware of ways they contribute to sexist behaviors and bias toward women (Haskins, 2016).

xxi. Human Resource-Based Solutions: HR-based solutions include increased use of predictive analytics to eliminate gender bias and workforce discrimination (Loehr, 2015). Organizations can use analytics to present data in easy-to-understand graphics and statistical reports for use by leaders making hiring decisions, to revise policies that address pay gap or performance standards, to create initiatives to improve the work experience of those populations most likely to leave; and by creating survey-based algorithms that assesses the match between the applicant and employer and bypasses initial bias in the hiring process.

d. Summary

i. Gap/problem: There is a need to improve gender equality in the health workforce.

ii. Prior studies: previous studies indicate the prevalence of gender inequalities in health education as well as when it comes to employment.

iii. Qualitative study: A wide range of theoretical and empirical studies exist which show factors influencing gender inequality in the health workforce.

iv. Significance: research will help in the identification of factors influencing the prevalence of gender inequalities and what measures should be taken to improve the situation in the health workforce.

3. Problem statement: It is unknown whether there is a unified conceptual understanding to cover the different significant gender inequalities operating in the health workforce and how they impact on health systems.

4. Sample and location: In the state of Tennessee, 10 medical facilities will be sampled for purposes of investigating the ratio between male and female employees working as medical practitioners to explore some of the factors that may be influencing the discrepancies if any.

5. Research questions: R.1: Is there a discrepancy between the ratios of male to female employees in the sampled medical facilities and could gender discrimination be a contributing factor, and how? R.2: What are some of the factors influencing gender inequalities across the health facilities sampled? R.3: Do the gender inequalities begin at the medical schools or are they exclusive in the health workforce sector?

6. Hypothesis/variables or Phenomena:

1. Gender discrimination has continuously been the major contributor to gender inequalities in the health sector.

2. Cultural barriers and the glass ceiling effect have been influencing gender inequalities being faced by women while working in the health sector.

3. Gender inequalities begin at the medical education and then progress to the health workforce.

7. Methodology and design: A qualitative methodology will be used whereby the research design will include conducting interviews with human resource departments across the medical facilities sampled. Through open-ended questions, the interviewees will be encouraged to share on some of the factors that may be influencing the gender inequalities in the health sector.

8. Purpose statement: The purpose of this qualitative research will be to investigate the factors influencing gender inequalities in the health workforce and develop insights on measures that can be taken towards improving gender equality starting from education, to leadership, to the changes needed in the organization of health systems.

9. Data collection

Coupled with information from studies, this research will use interviews to collect essential data for the subsequent analysis whereby the various human resource officers will be asked to share on the needed information. The interviews will be based on the research questions previously developed in relation to the problem statement. Questionnaires will also be used whereby the potential inaccessible interviewees will be asked to share information based on the research questions.

10. Data analysis

a) Descriptive statistics will be used for describing and summarizing the data collected from the sample population, such as on the ratio of male to female employees in the various health facilities.

 b) The analysis will include an explanation of the meanings and conclusions derived from the previous studies, which will be integrated into the research.

 c) A narrative summary will be developed across the research questions explaining and expounding on the various thematic concerns.

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