

# Gender pay gap in the health and care sector in the WHO European Region

Evidence brief



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## Abstract

The *Framework for action on the health and care workforce in the WHO European Region 2023–2030* calls for concrete action to eliminate gender pay gaps, value unpaid care work and promote gender balance in all decision-making positions across the Region. This evidence brief builds on the 2022 International Labour Organization–WHO gender pay gap report and provides an updated analysis for the Region. The findings confirm that despite being one of the most feminized sectors in the Region, health and care continues to show persistent and substantial gender pay gaps. Much of the gaps remain unexplained by observable factors, indicating that systemic undervaluation and biases are at play. This has consequences that reach far beyond arguments of what is fair or not, with implications for recruitment and retention, career decisions, career progression and leadership of women, and impacts the quality of care that health systems can provide. The findings underscore the need for targeted sector-specific policy interventions to advance gender equality in health and care work and health systems resilience. Closing gender pay gaps in the health and care sector improve not only gender equality outcomes but also wider goals of inclusive economic growth, social protection and sustainable development.

## Keywords

HEALTH WORKFORCE

HEALTH CARE ECONOMICS AND ORGANIZATIONS

GENDER EQUITY – gender equality

LEGISLATION AS TOPIC – health legislation

HUMAN RIGHTS

## Document number

WHO/EURO:2026-13697-53471-83924 (PDF)

WHO/EURO:2026-13697-53471-83923 (print)

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## Acknowledgements

This report was designed and produced as a joint collaboration between WHO headquarters and the WHO Regional Office for Europe.

This report was produced under the leadership of Margrieta Langins (WHO Regional Office for Europe), Michelle McIsaac (WHO headquarters) and Sulakshana Nandi (WHO Regional Office for Europe), who all conceptualized and coordinated the production of this report. Silas Amo-Agyei (University of Manchester, United Kingdom) produced the empirical evidence with input from Michelle McIsaac, and the two drafted the report. Review and feedback was provided by Natasha Azzopardi-Muscat, Melanie Hyde, Stefania Ilinca, Milena Selivanov and Tomas Zapata (WHO Regional Office for Europe).

This report follows the methodology to estimate gender pay gaps that was set out in the sixth edition of the International Labour Organization (ILO) Global Wage Report (*Global Wage Report 2018/19: what lies behind gender pay gaps*), a methodology that was originally developed by Patrick Belser (ILO) and Rosalia Vazquez-Alvarez (ILO), and was employed in the joint ILO–WHO global health and care sector report *The gender pay gap in the health and care sector: a global analysis in the time of COVID-19*.

This evidence brief is based on data from Eurostat. We acknowledge and thank Eurostat for their invaluable contribution in providing data from the European Union Statistics on Income and Living Conditions under contract number RPP 250/2024-EU-SILC. The responsibility for all conclusions drawn from these data lies entirely with the authors.

This document was produced with part funding support from the Universal Health Coverage Partnership, which includes contributions from Belgium, Canada, France, Ireland, Japan, Luxembourg, the United Kingdom, the European Union and WHO.

## Abbreviations

|         |                                                           |
|---------|-----------------------------------------------------------|
| D       | decile                                                    |
| EU-SILC | European Union Statistics on Income and Living Conditions |
| HIC     | high-income country                                       |
| ILO     | International Labour Organization                         |
| LMICs   | low- and middle-income countries                          |
| SDG     | Sustainable Development Goal                              |

## Executive summary

Key facts about the gender pay gap in the WHO European Region are outlined below.

- The health and care sector is the fourth largest source of employment in the WHO European Region and a primary employer of women, who make up nearly 77% of its workforce.
- Health and social care is the largest care economy employer in the WHO European Region, accounting for 53% of care economy jobs compared with 41% globally and surpassing education.
- Employment in the sector is relatively formal and contractual, although part-time work is common in high-income countries, while informal employment remains an issue in some lower-income countries.
- Despite women's high level of representation, gender pay gaps remain significant, with a 28% gap in monthly earnings before adjusting for hours worked.
- After adjusting for hours worked, an average gender pay gap of 19% remains, indicating that differences in working time explain only part of the overall pay disparity.
- Some of this pay gap can be explained by differences in work-related factors such as age, education, sector of employment (public versus private) and employment type (full-time versus part-time). After adjusting for these factors, the average pay gap falls from 19% to 6% for hourly pay.
- The gender pay gap in hourly pay is widest at higher wage levels: from a modest 2% gap at the lowest decile it rises steeply, reaching over 22% at the top of the wage distribution.
- Despite comprising nearly 77% of the workforce, women account for only 55% of top earners.
- Decomposition analyses show that a large share of the gender pay gap remains unexplained by observable characteristics, indicating deeper structural issues, including the undervaluation of feminized occupations, differences in career progression and the potential influence of discriminatory practices and institutional biases.
- Feminized occupations within the health and care sector are systematically paid less than comparable roles in other sectors, regardless of skill level, reflecting structural wage penalties in the sector.

# 1. Introduction

Addressing gender inequality in the world of work is a pressing global priority. Closing gender pay gaps is central to achieving the Sustainable Development Goals (SDGs), particularly SDG 5 on gender equality, SDG 8 on decent work and inclusive economic growth, and SDG 3 on health and well-being. Beyond equity concerns, equal pay is a fundamental economic issue. Reducing pay gaps between women and men promotes labour market participation, enhances productivity and advances sustainable and inclusive economic growth (1).

Yet, the gender pay gap, referred to as the difference in average wages between men and women who are engaged in paid employment, remains one of the most persistent forms of labour market inequality. In the health and care sector this challenge is especially pronounced. Globally, women earn on average 24% less than men, a wider gap than in many other sectors (2). This gap has important economic and social consequences, leading to lower lifetime earnings and pension entitlements, increasing women's risk of poverty, reducing returns to education and undermining sustainable economic growth.

In recent years, political commitment to addressing gender inequalities in the health and care workforce has strengthened. Building on the 2022 International Labour Organization (ILO)–WHO global report *The gender pay gap in the health and care sector: a global analysis in the time of COVID-19* (2), international frameworks and resolutions increasingly recognize the need to address inequalities in pay, working conditions and leadership representation across the health and care workforce. Citing the evidence of the ILO–WHO report, the Political Declaration of the High-level Meeting on Universal Health Coverage adopted by the United Nations General Assembly in 2023 (A/RES/78/4) calls for equal pay for health workers (3). At the Seventy-eighth World Health Assembly in 2025, agenda item 78.16 on accelerating action on the global health and care workforce further urged Member States to address the gender pay gap among health and care workers (4,5), and the 2026 updates to the *WHO global code of practice on the international recruitment of health personnel* that was originally published in 2010 (WHA63.16) (6) – discussed at the Seventy-ninth World Health

Assembly (A79/5 Add.3) (7) – reinforced this agenda, underscoring the need to address gender inequalities, including the pay gap and the underrepresentation of women in senior leadership and decision-making roles. At the regional level, the WHO Regional Committee for Europe in October 2023 unanimously passed the resolution approving the *Framework for action on the health and care workforce in the WHO European Region 2023–2030* (EUR/RC73/R1) (8–10), which calls for concrete action to eliminate gender pay gaps, value unpaid care work and promote gender balance in all decision-making positions across the Region.

In the WHO European Region, the health and social care sector (referred to as the health and care sector throughout this report) plays an important role in employment, particularly for women. It is among the most feminized sectors in the Region. However, a high level of participation by women has not translated to pay equity, reflecting structural inequalities, occupational segregation by gender and inequities in career progression.

This evidence brief builds on the 2022 ILO–WHO report *The gender pay gap in the health and care sector: a global analysis in the time of COVID-19* (2), and provides an updated and Region-specific analysis for the WHO European Region. It draws on harmonized microdata from the 2023 European Union Statistics on Income and Living Conditions (EU-SILC) (11), which cover 32 countries, and complements these with data from the 2022 report to include 43 of the 53 Member States in the Region (the list of 43 Member States is provided in Web Annex A, see Annex 1 for details). It examines raw and factor-weighted gender pay gaps, explores disparities across wage distributions and decomposes wage differentials by job and individual characteristics.

Consistent with the earlier global findings, gender pay gaps in the health and care sector across the WHO European Region are persistent. Much of the gender pay gaps remain unexplained by observable factors, indicating that systemic undervaluation and biases are at play. The findings underscore the need for targeted sector-specific policy interventions to advance gender equality in health and care work and advance universal health coverage.

## 2. Women and the health and care sector: empowering employment across the WHO European Region

### 2.1. Women's employment and sectoral significance

The health and care sector is the fourth largest sector for employment in the WHO European Region.<sup>1</sup>

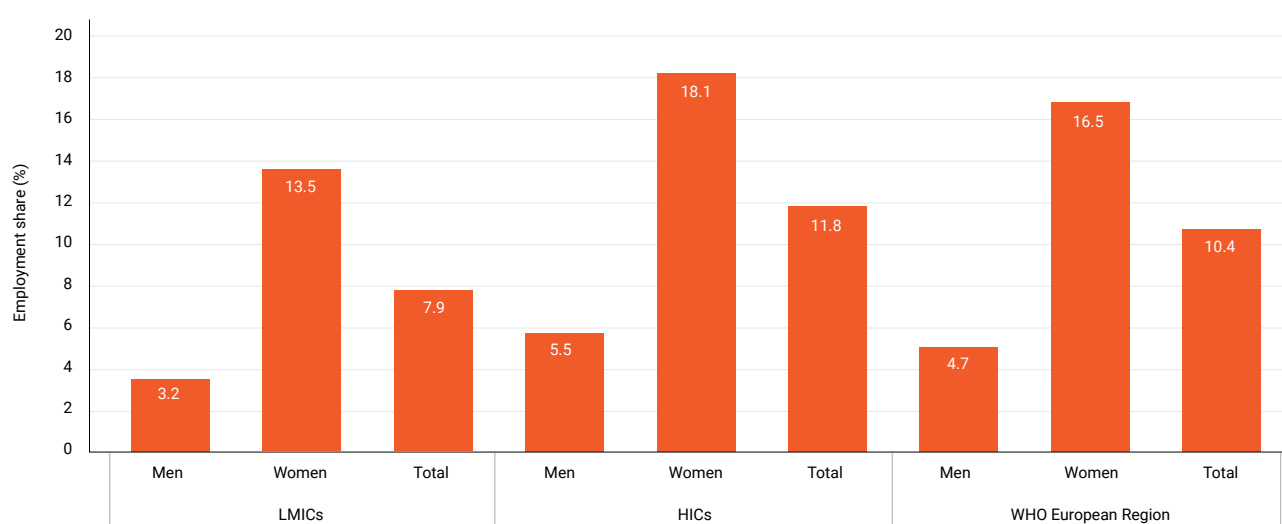
In 2023, health and care accounted for approximately 10% of total employment, an average of 12% in high-income countries (HICs) and 8% in low- and middle-income countries (LMICs) (Fig. 1).

The sector is especially important for women's employment. It represents almost 17% of all women's employment, compared with 5% for men. This share rises to 18% in HICs and falls to just under 14% in LMICs. In several HICs – including Belgium, Denmark and Norway – one in every four employed women works in the health and care sector. In France,

Germany, Ireland, the Netherlands (Kingdom of the) and Switzerland, the share is one in five. In LMICs, women's employment in the sector is lower, about one in seven in the Russian Federation and around one in 10 in Bosnia and Herzegovina, Bulgaria, Kyrgyzstan, Republic of Moldova and Serbia.

Across the Region, women comprise just under 77% of the health and care workforce, compared with 45% in all other sectors combined. Even in Member States where overall female labour force participation is lower – for example, in Tajikistan and Türkiye, where female labour force participation is below 40% – women still represent over 65% of the health and care workforce. In Member States such as Estonia, Lithuania and Poland, women make up nearly 90% of the workforce in the sector, underscoring its critical role in women's labour market integration.

Fig. 1. Proportion of health and care employment as a percentage of total employment, by income group and gender, latest year available



Notes: WHO estimates based on data from EU-SILC and the ILO's ILOSTAT database. Estimates are based on data from 43 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

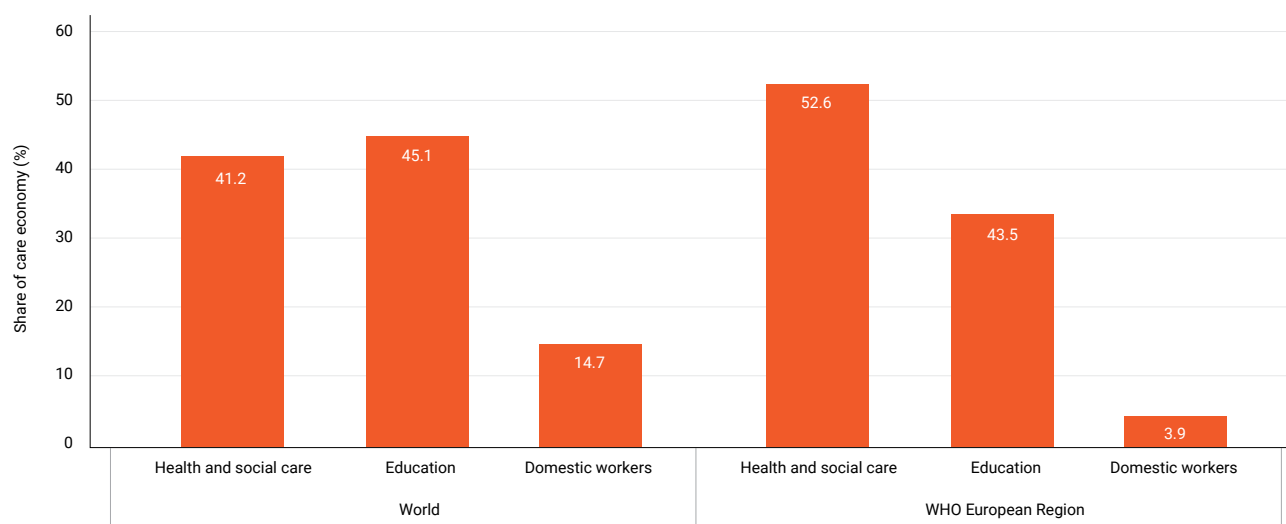
Sources: (2,11,12).

<sup>1</sup> Industrial sector shares of total employment in descending order of employment shares: manufacturing/mining and quarrying/utilities (17.9%); trade (13.4%); finance/real estate (11.6%); health and care (10.4%); transportation and storage/information and communication (9.4%); education (8.4%); public administration, defence and compulsory social security/administrative and support (8.1%); construction (7.0%); agriculture, forestry and fishing (5.1%); other private services (4.7%); and accommodation and food service (3.9%).

The health and care sector constitutes the largest source of employment within the care economy in the Region. While globally, education comprises the largest share of care economy jobs (45%) followed

by health and social care (41%), in the WHO European Region health and care account for 53% of care economy employment, surpassing education (44%) and far exceeding domestic work (4%) (Fig. 2).

Fig. 2. Proportion of care economy jobs that are in the health and care sector compared with those in the education and domestic worker (household activities) sectors, latest year available



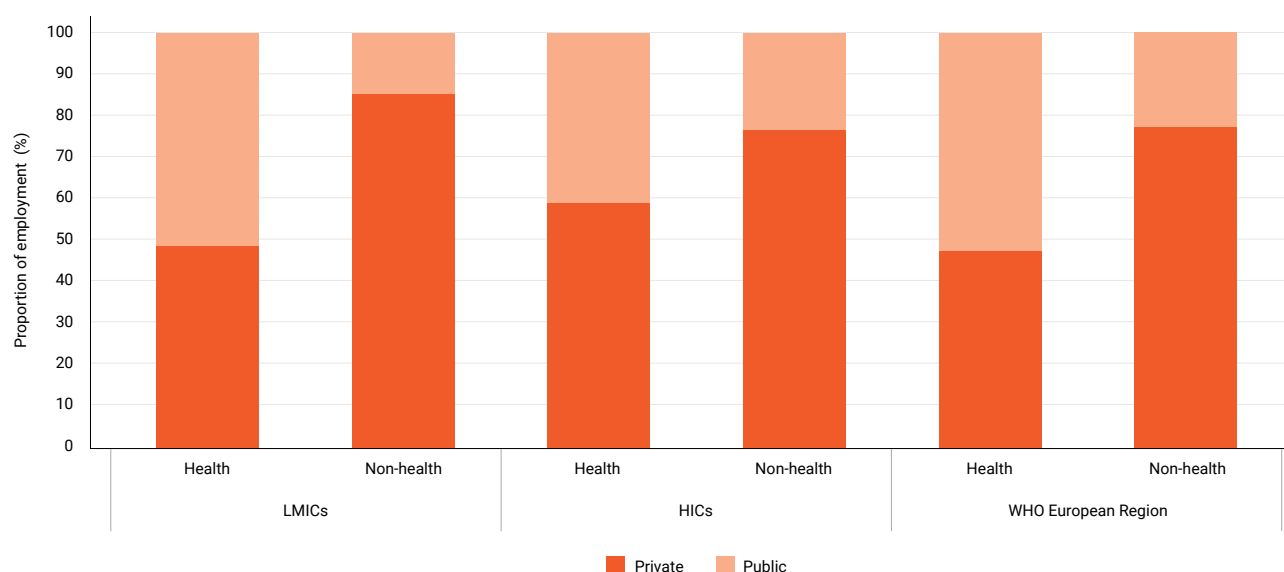
Notes: WHO estimates based on data from the ILO's ILOSTAT database. Estimates are based on data from 132 countries and territories and are weighted by the total number of wage-receiving employees in each.  
Source: (2,12).

## 2.2. Employment arrangements: working time and contract security

In LMICs across the Region, paid health and care work is predominantly full-time (96%), slightly above other sectors (94%) (Fig. 3). However, in HICs full-time work accounts for 74% of health and care employment, compared with 85% in other sectors. This reflects greater use of part-time work, often associated with efforts to accommodate work–life balance or, alternatively, staffing constraints.

Contractual stability for paid work is generally higher in the health and care sector overall: 80% of workers hold permanent contracts compared with 68% in other sectors, with broadly consistent patterns across income. This aggregate finding likely reflects the sector's reliance on stable, trained personnel to ensure quality and continuity of care. However, this average may mask important variation across occupations. In long-term care in particular, precarious employment and part-time work are well documented (13).

**Fig. 3. Proportions of workers in public versus private sector employment in health and care work compared with in other economic sectors, latest year available**



Notes: Health: health and care sector; non-health: other economic sectors. WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 43 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

Sources: (2,11,12).

### 2.3. Public and private employment composition: who employs health and care workers?

Distinguishing between public and private sector employment is important, because working conditions, benefits and job security often differ across these settings. Health and care employment across the WHO European Region is much more likely to be in the public sector than employment in other sectors. Regionally, 43% of health and care workers are working in the public sector, nearly double the 22% in non-health sectors (see Fig. 3).

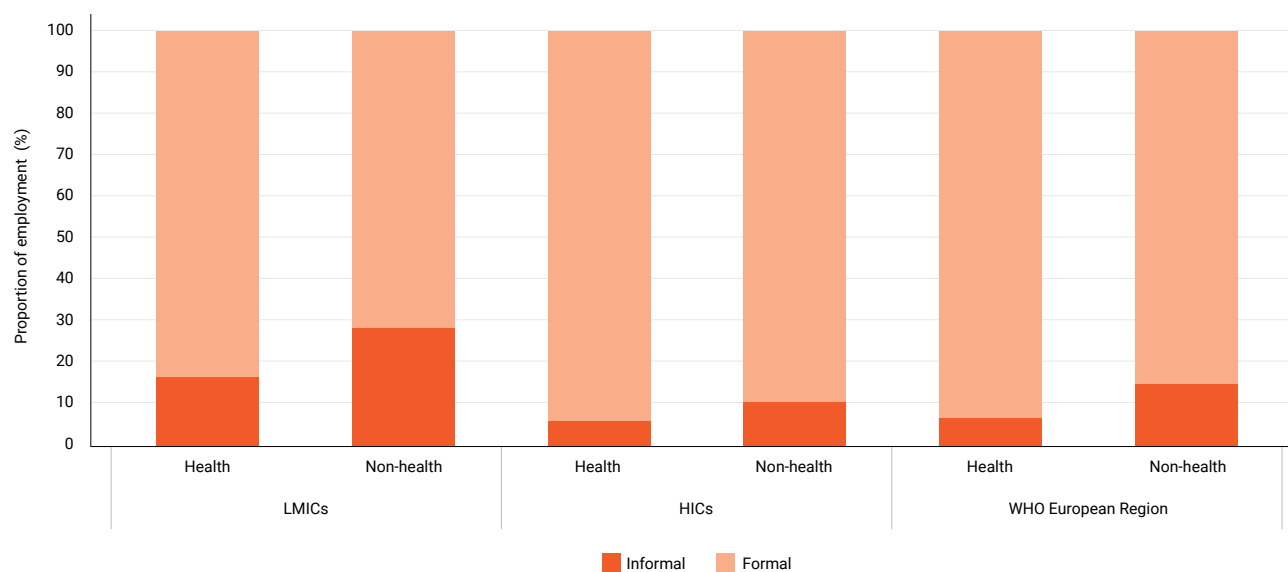
In LMICs, the public sector accounts for 51% of health and care employment, versus 15% in other sectors. This reflects a model where governments are primary providers of health and social services. In HICs, private provision is more prevalent (59%), although public employment remains significant (41%) compared with other WHO regions, pointing to mixed delivery systems.

### 2.4. Informal employment

Levels of informal employment, working arrangements that are in practice or by law not subject to national labour legislation, income taxation or entitlement to social protection or other employment guarantees – for example, advance notice of dismissal, severance pay or paid annual or sick leave (14) – are lower in the health and care sector (6%) than in other sectors (13%) across the Region (Fig. 4). However, disparities persist between income groups.

In LMICs, the proportion of informal employment in the sector is 15%, compared with 5% in HICs. Nevertheless, this remains far below informality rates in other sectors (29% in LMICs). In HICs, the proportion of health and care employment across the Region is overwhelmingly formal (95%), compared with 89% in non-health sectors.

Fig. 4. Proportions of workers employed formally and informally in health and care work compared with in other economic sectors, latest year available



Notes: Health: health and care sector; non-health: other economic sectors. WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 43 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).  
Sources: (2,11,12).

### 3. Revealing the gender pay gap in the health and care sector in the WHO European Region

Interpreting gender pay gaps in this section: a positive gender pay gap means that men earn more than women and a negative gender pay gap means that women earn more than men.

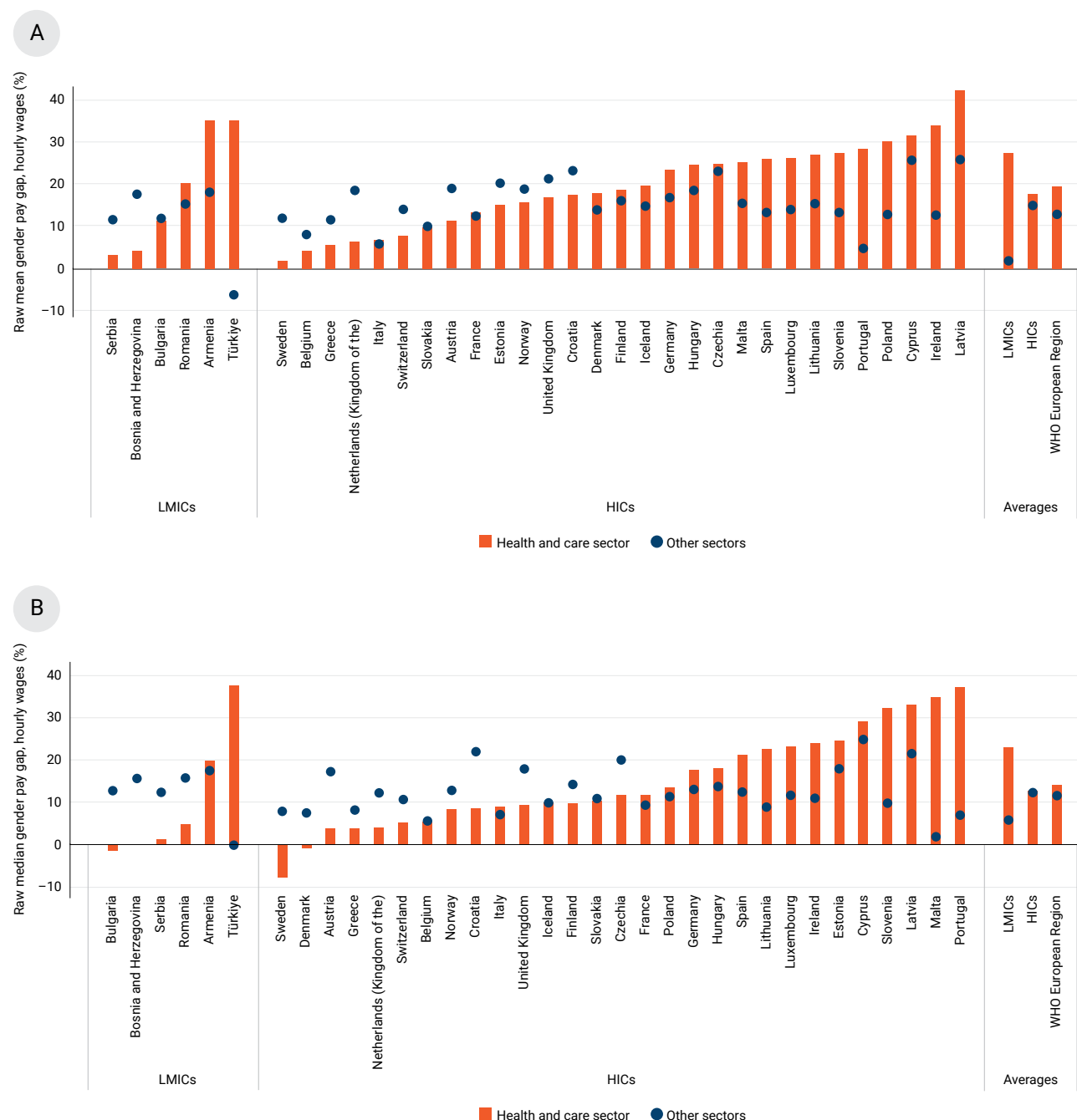
#### 3.1. Raw gender pay disparities in hourly and monthly earnings

Significant gender pay gaps persist in the health and care sector across the WHO European Region. Fig. 5 and Fig. 6 present estimates for both hourly and

monthly earnings, highlighting important differences in the magnitude and drivers of disparities.

The comparison of hourly pay (Fig. 5) shows what women and men earn per hour for similar amounts of work, regardless of whether they work full-time or part-time. On average, women in the sector earn 19% less per hour than men (or 14% less at the median, which is less affected by very high or very low salaries). The raw gap is larger than in other sectors, where women's mean hourly pay is 13% lower than that of men (or 11% lower at the median).

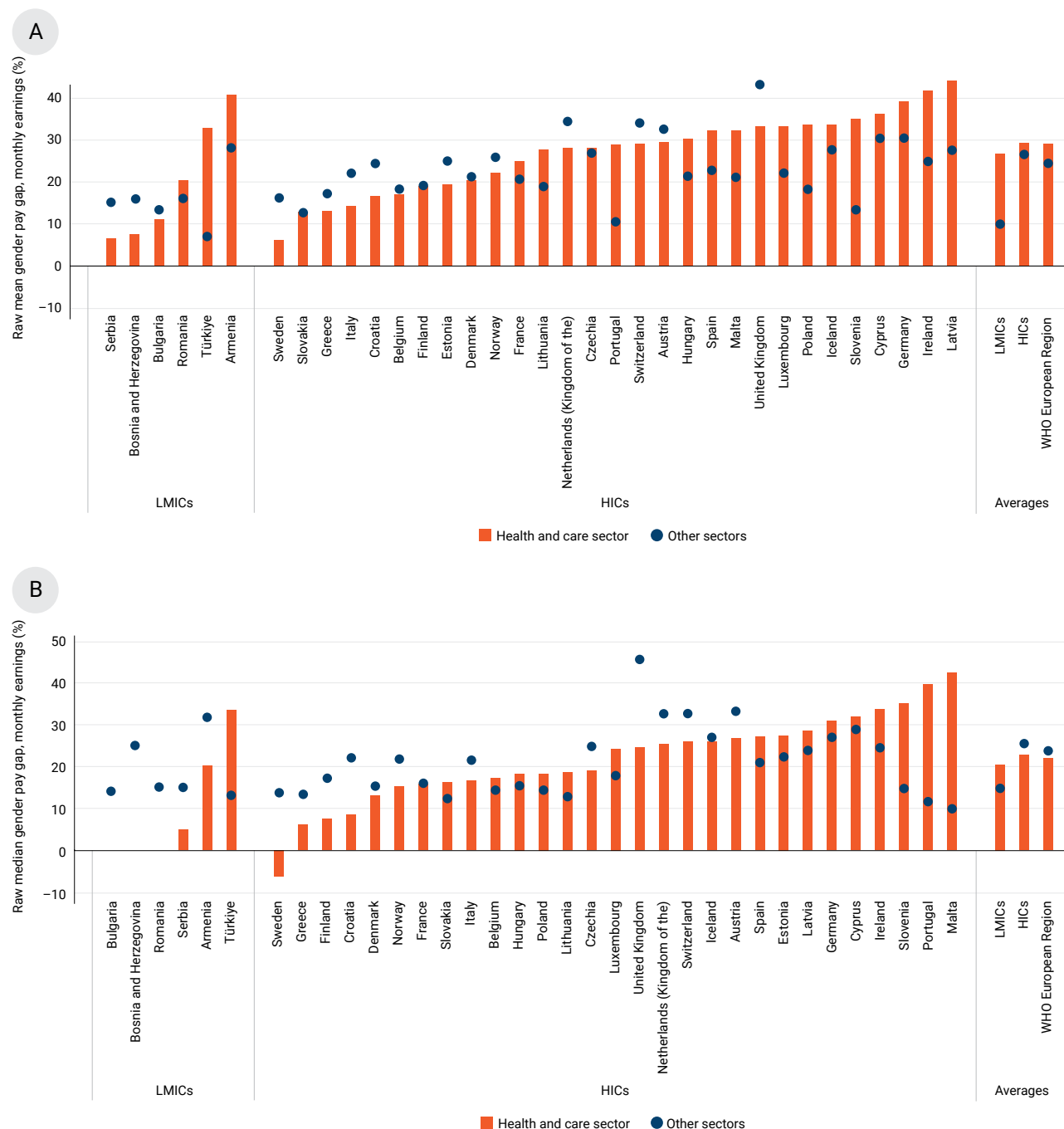
Fig. 5. Raw mean (A) and median (B) gender pay gaps in the health and care workforce versus other economic sectors in WHO European Region Member States using hourly wages, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. Positive estimates indicate higher wages for men, while negative estimates indicate higher wages for women. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

Sources: (2,11,12).

Fig. 6. Raw mean (A) and median (B) gender pay gaps in the health and care workforce versus other economic sectors in WHO European Region Member States using monthly earnings, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. Positive estimates indicate higher earnings for men, while negative estimates indicate higher earnings for women.

Sources: (2,11,12).

Monthly earnings, by contrast, reflect not only wage rates but also differences in working time and continuity of employment (see Fig. 6). As a result, they provide a broader measure of income inequality between women and men. Monthly estimates show even wider gender pay gaps, with a mean gap of 28% in the health and care sector compared with 24% in other sectors. The gap between the health and care sector and other sectors is wider in LMICs (26% versus 10%, respectively) than in HICs (29% versus 27%, respectively). Median monthly earnings reveal slightly lower but still substantial disparities: 22% in health and care versus 23% in other sectors.

The raw monthly and hourly gender pay gaps presented here provide a critical benchmark for international comparisons and SDG indicator 8.5 (2,15). However, they do not control for differences in worker or job characteristics. Section 3.2. presents factor-adjusted estimates to better isolate the roles of structural and potentially discriminatory forces in shaping pay disparities.

## 3.2. Beyond raw disparities: factor-weighted gender pay gaps

While the previous section presented raw gender pay gaps, which provide important overall measures of wage differences between women and men in the health and care sector, they do not account for differences in workers' characteristics or job attributes.

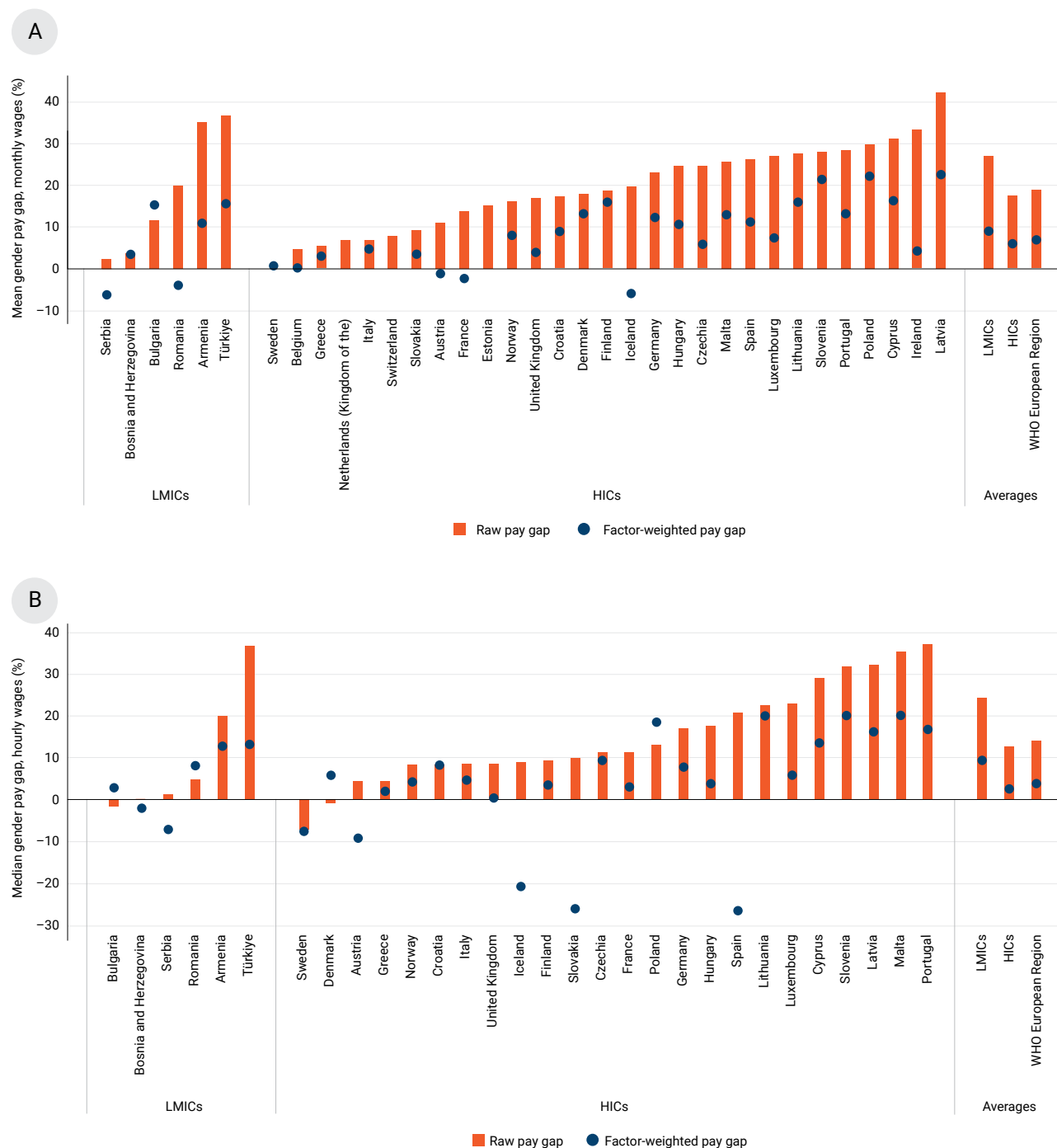
To better assess whether women and men with comparable characteristics receive similar pay, this section presents gender pay gaps that adjust for four observable factors: age, education, sector of employment (public versus private) and employment type (full-time versus part-time). This is referred to as the factor-weighted gender pay gap. Some of the difference in hourly pay between women and men

can be explained by these factors: differences in age and/or experience, level of education reached, working in the public versus the private sector and full- or part-time working. After taking these differences into account, the mean gender pay gap for hourly wages across the Region falls from 19% to 6% (or from 14% to 3% using the median) (Fig. 7). These factors therefore explain part (but not all) of the gender pay gap. A gap remains even after adjustment and it is wider in LMICs, where women still earn around 10% less per hour than men (9% at the median).

Monthly earnings reveal a similar pattern. After adjusting for observable characteristics, the mean gender pay gap falls from 28% to 10%, while the median gap declines from 22% to 2% (Fig. 8). The large differences between the mean and median measures are themselves revealing. As Section 4 shows, gender pay gaps in the health and care sector are concentrated at the upper end of the earnings distribution, where women remain underrepresented among the highest earners and overrepresented in the lower level of earnings. Because the median reflects only the gap for the worker in the middle of the distribution, it largely overlooks these disparities at the top. In contrast, the mean provides a more informative measure of gender pay gaps for the sector. It shows that even after accounting for age, education, sector and employment type, women still earn on average around 10% less than men per month.

As demonstrated here and in recent research on gender pay gaps among nurses (16), pay gaps that are not factor-weighted provide only a partial picture. Differences in age, education, sector of employment and working time explain some of the observed disparity, but not all of it. The proportion of the gap that remains after accounting for these factors points to other underlying drivers of inequality, which are explored through the decomposition analysis that follows.

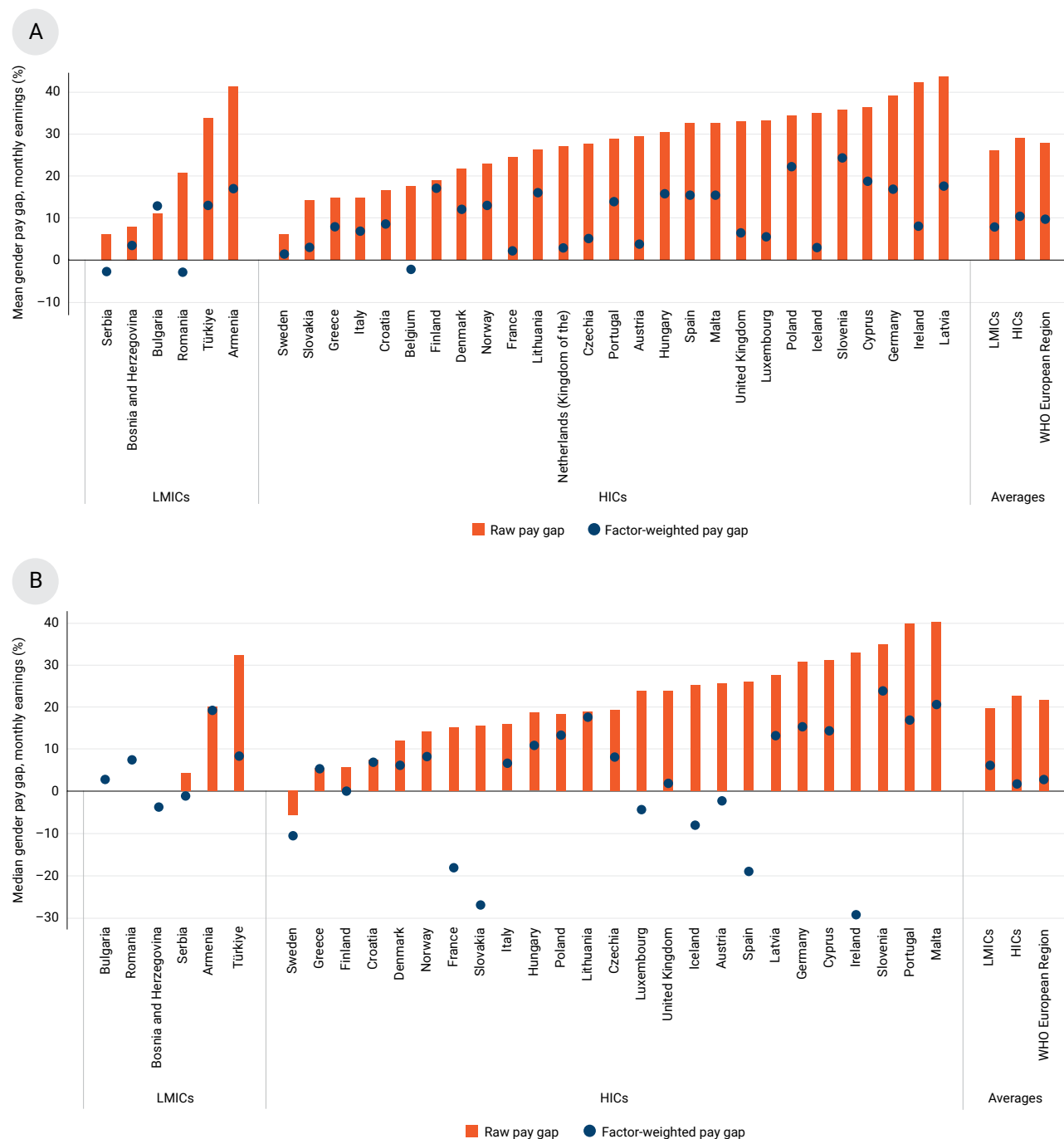
Fig. 7. Mean (A) and median (B) raw and factor-weighted gender pay gaps in the health and care workforce in WHO European Region Member States using hourly wages, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. Positive estimates indicate higher wages for men, while negative estimates indicate higher wages for women. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

Sources: (2,11,12).

Fig. 8. Mean (A) and median (B) raw and factor-weighted gender pay gaps in the health and care workforce in WHO European Region Member States using monthly earnings, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 33 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. Positive estimates indicate higher earnings for men, while negative estimates indicate higher earnings for women. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).  
Sources: (2,11,12).

## 4. Drivers of the gender pay gap in the health and care sector

### 4.1. Pay gaps across the hourly wage distribution

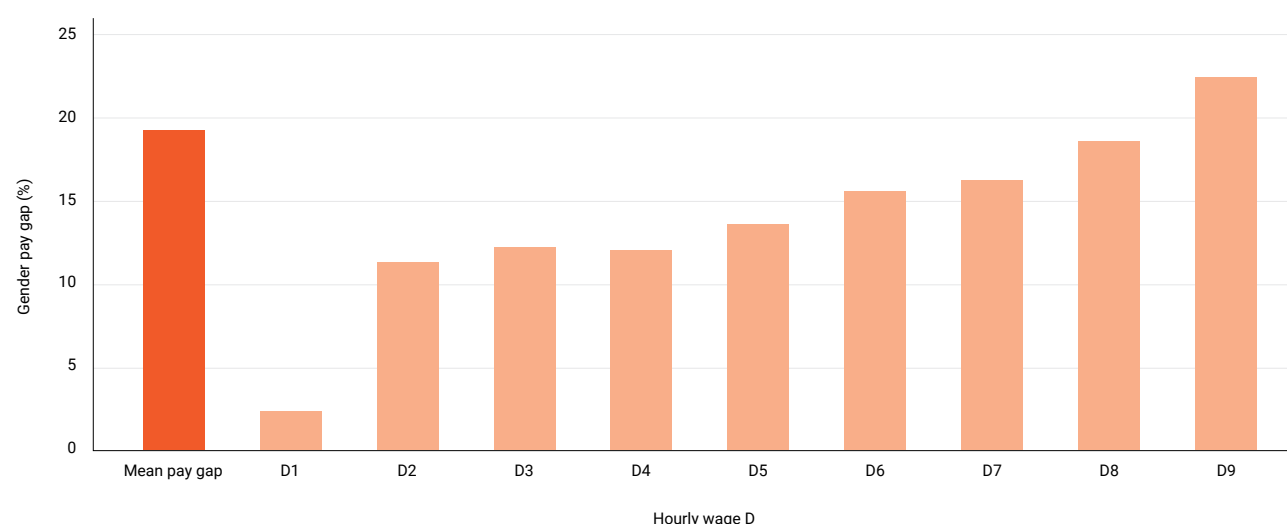
Gender pay gaps are not uniform across the hourly wage distribution. To show this, Fig. 9 reports the pay gap at nine points along the wage scale, known as deciles (Ds). These are the nine cutoffs that divide all wages into 10 equally-sized groups, running from the lowest-paid tenth of workers up to the highest-paid tenth. The first (D1) sits near the bottom of the scale and the ninth (D9) near the top, marking the threshold above which the best-paid tenth of workers fall.

The gap widens steadily as wages rise: from a modest 2% at D1, it reaches almost 23% at D9.

The gradient is steeper in LMICs than in HICs, but the direction is the same in both.

A gap that widens towards the top of the distribution is not particular to the health and care sector. It is found across most sectors of the economy. At the lower end, statutory minimum wages compress pay for both women and men, narrowing gender pay gaps, as reflected in the smaller gap observed in D1. What these results add is evidence that the health and care sector, despite being highly feminized, follows the same pattern rather than being shielded from it. The rest of this section examines what lies behind the widening at the top: first the composition of who occupies the best-paid roles, then a formal decomposition of the gap.

Fig. 9. Gender pay gaps by D across the hourly wage distribution in the health and care sector, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and weighted by the total number of wage-receiving employees in each Member State. Positive estimates indicate higher wages for men, while negative estimates indicate higher wages for women. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

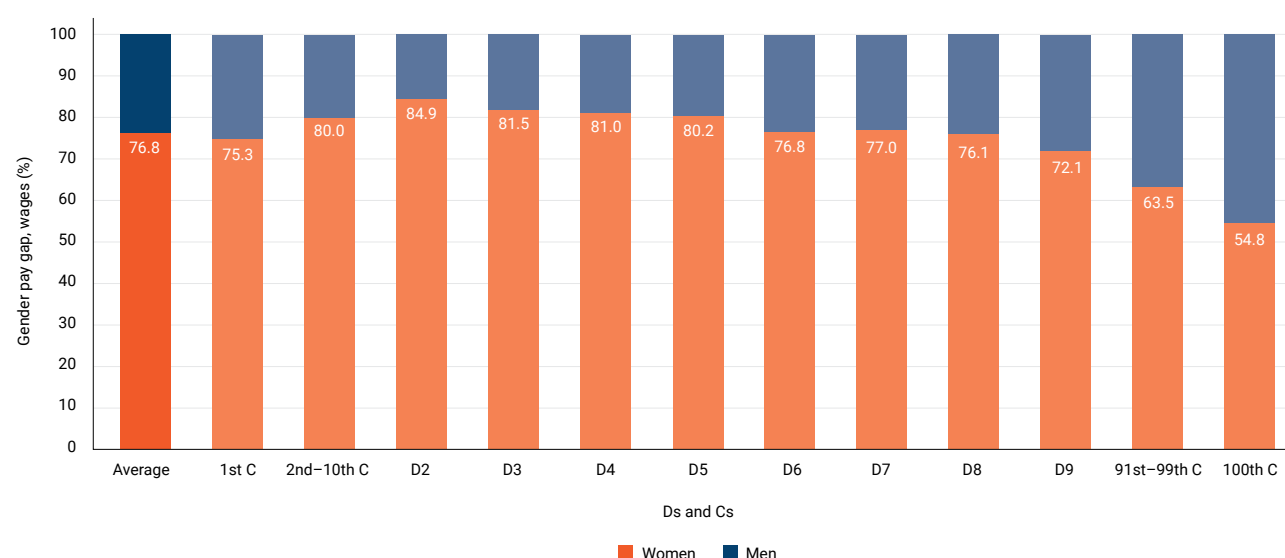
Sources: (2,11,12).

## 4.2. Gender composition across the wage ladder

Because the gap is widest at the top of the distribution, understanding it means looking at who holds the highest-paid roles. Fig. 10 shows the proportions of women and men across the hourly wage distribution. Although women make up nearly 77% of the health and care workforce, they hold only 55% of the highest-paying positions.

This signals vertical occupational segregation: women are concentrated in the lower and middle regions of the wage structure and thin out towards the top. Limited progression into the highest-paid roles can reflect a mix of unequal promotion pathways, the uneven distribution of caregiving responsibilities and gendered assumptions about leadership, which together restrict women's upwards mobility and sustain the gap at the top.

Fig. 10. Proportions of women and men by top and bottom Ds, intervening Ds and average across the hourly wage distribution in the health and care sector, latest year available



Notes: C: centile. WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and are weighted by the total number of wage-receiving employees in each Member State. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

Sources: (2,11,12).

## 5. Decomposing the gender pay gap in the health and care sector

### 5.1. What can we explain?

Workforce composition explains part of the gap, but how much? To separate the part attributable to observable differences between women and men from the part that is not, Fig. 11 decomposes the gender pay gap at each point of the wage distribution into “explained” and “unexplained” components across the wage distribution<sup>2</sup>. However, the available data do not enable us to understand fully how this pay gap varies between professions, race, age, ethnicity and other characteristics, and further data are needed. See Web Annex B for the characteristics included and Web Annex C for the methodology used for the decomposition (see Annex 1 for details).

At the lower end of the distribution (D1), observable factors account for most of the gap: the explained component is almost 8% against a total gap of around 10%. Across the rest of the distribution, the balance reverses and the unexplained component dominates, growing wider as wages rise, until it

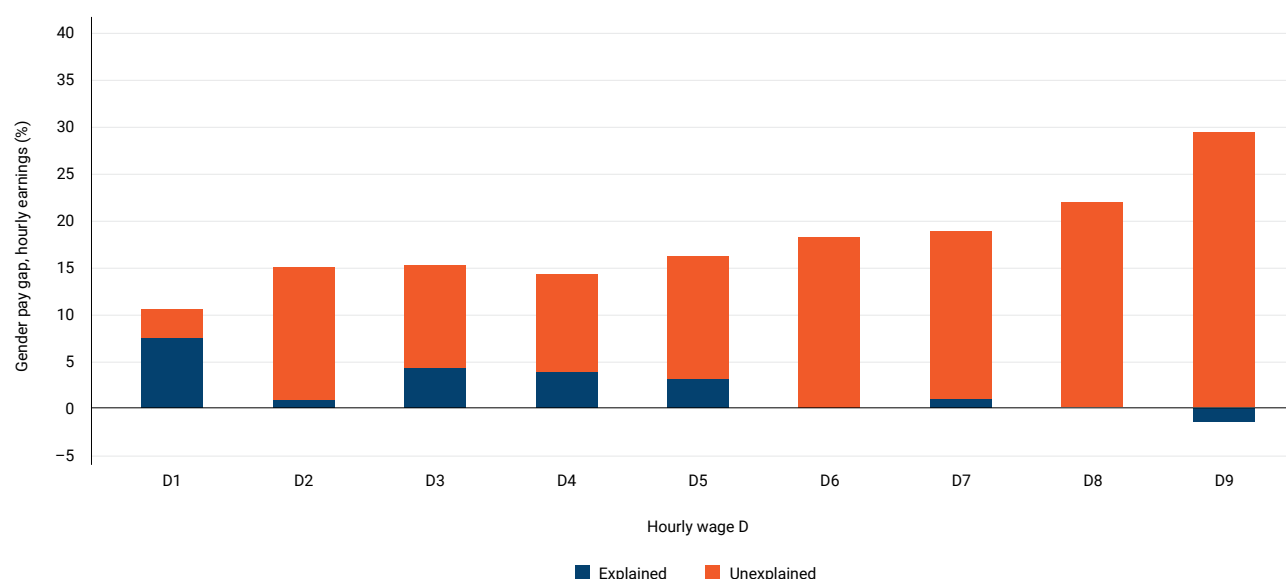
reaches close to 30% near the top of the distribution (D9). There, the explained component is just over – 1% meaning that, on their measured characteristics alone, women would be predicted to earn slightly higher wages than men, yet their actual pay is lower. Almost the entire gap at the top of the distribution is therefore left unexplained by differences in age, education, occupation, sector and working time.

These results follow the same pattern documented across the wider labour market: heightened structural inequality that intensifies at higher wage and seniority levels. The unexplained portion is consistent with the systemic undervaluation of feminized work and with gender biases in how pay is set, both of which tend to bite hardest in the senior, better-paid roles where women are least represented. It does not read as direct proof of discrimination, since it also absorbs other characteristics that the data do not capture; however, it does show that observable differences in workers and jobs leave most of the top-end gap unaccounted for.

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<sup>2</sup> See Web Annex C for details of the labour market attributes and characteristics responsible for the observable differences (see Annex 1 for details).

Fig. 11. Decomposition of the gender pay gap for hourly earnings in the health and care sector into explained and unexplained parts, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and are weighted by the total number of wage-receiving employees in each Member State. The bars show the components of the gap rather than the gap itself. A negative explained component means women's observable characteristics would, on their own, predict higher pay than men's at that D; the gap still favours men because of the larger unexplained component. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

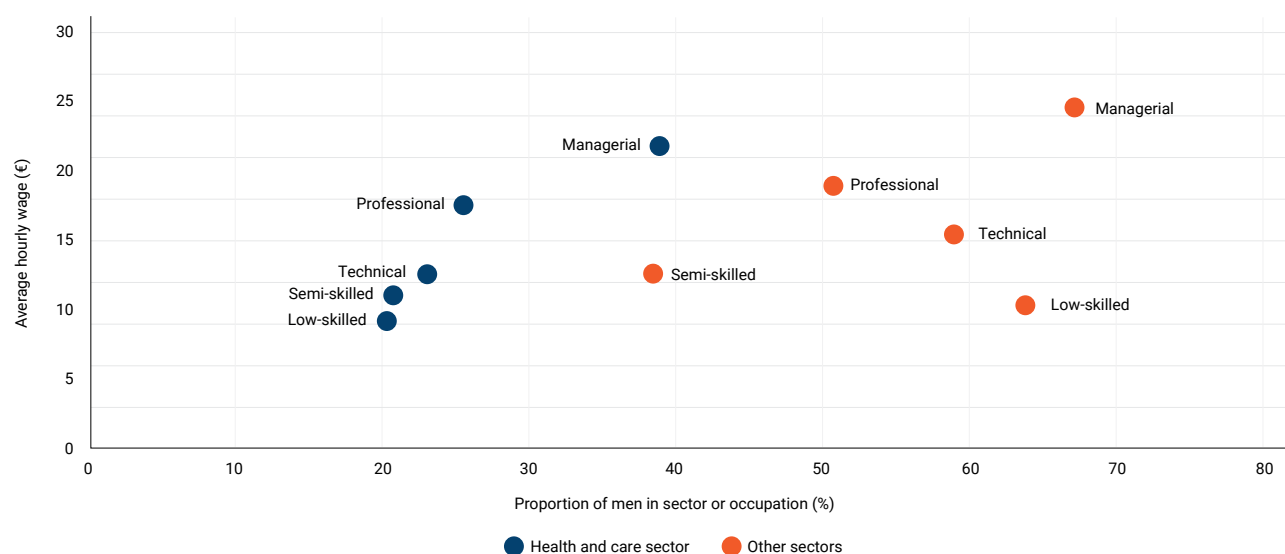
Sources: (2,11,12).

## 5.2. Unpacking the unexplained: undervaluation and occupational feminization

One concrete driver of this unexplained gap is the way feminized work is valued. Fig. 12 examines the relationship between wage levels, occupational skill and the gender composition of roles. It shows that the more feminized the occupational category, the

lower its pay. Managerial roles in health and care, which employ a higher proportion of women than other sectors, pay less on average their counterparts (€22.00 versus €24.70 per hour, respectively). The same holds in occupations in the professional and technical categories: where the proportion of women is greater pay is systematically lower, regardless of the qualifications and responsibilities that the work demands.

Fig. 12. Average hourly wages by degree of feminization, sector type and occupation, latest year available



Notes: WHO estimates based on data from EU-SILC (2023) and ILOSTAT (2022). Estimates are based on data from 35 Member States in the WHO European Region and are weighted by the total number of wage-receiving employees in each Member State. The latest year available for each Member State is outlined in Web Annex A (see Annex 1 for details).

Sources: (2,11,12).

## 6. The way forward: reducing gender pay inequalities in the health and care sector

This regional analysis extends the findings of the 2022 ILO–WHO report *The gender pay gap in the health and care sector: a global analysis in the time of COVID-19 (19–24)* with new evidence from Member States in the WHO European Region. It presents data for 43 out of the Region's 53 Member States because data were not available for the remaining 10 Member States. Data gaps also precluded analysis based on profession, age, race, ethnicity and other characteristics.

The analysis confirms that despite being one of the most highly feminized sectors, health and care continues to show persistent and substantial gender pay gaps. The findings show that while part of the gender pay gaps can be explained by differences in work hours, age, education, employment type or sector of work, a significant unexplained pay gap remains, especially among top earners. This points to deeper structural factors, such as the undervaluation of care work, occupational segregation and potential discrimination in pay-setting practices (1,2,17–19). It has consequences that reach far beyond arguments of what is fair or not, with implications for recruitment and retention, career decisions, career progression and leadership of women (19–24).

This ultimately impacts on the quality of care that health systems can provide. Closing gender pay gaps is therefore both an equity imperative and an investment in a stronger and more sustainable health workforce. Closing the gender pay gap would also yield economic and other benefits far beyond the sector because health and care is such a large employer of women across the Region, by strengthening labour force participation and retention, and by improving the attractiveness of health and care careers.

Delivering these gains will require targeted action to address the structural and institutional factors that perpetuate the undervaluation of health and care work and contribute to unequal pay. Priorities will differ across Member States and contexts, and specific policy dialogue is needed to tailor the

response to each health system. Measures that are commonly warranted for addressing both the explicit and the unexplained pay gaps include those listed below (1,2,17).

- **Fill the gender gap in data:** Strengthen health and care workforce statistics to include disaggregated data (based on race, sex, age, ethnicity and professions) on health and care work across all settings, and in all occupations, to support more disaggregated analysis and unpacking of the unexplained pay gaps. Identify evidence gaps and invest in research.
- **Ensure wage transparency:** Introduce mandatory gender pay reporting, especially for senior occupational levels guided by the current analysis. Transparency in pay structures is essential to identify hidden disparities, guide corrective measures and enable equitable wage negotiations.
- **Strengthen wage equity and its governance:** Adopt or reinforce equal pay and non-discrimination legislation. Bolster institutional mechanisms for monitoring and enforcement. Implement/strengthen wage policies and gender-responsive wage setting mechanisms. Encourage strong social dialogue and inclusive bargaining frameworks.
- **Facilitate leadership and representation of women in decision-making by removing structural barriers to career progression:** Promote gender-transformative leadership pipelines by investing in mentorship, management training and family-friendly workplace policies. These measures are essential to reduce occupational segregation and address the glass ceiling in senior roles.
- **Eliminate gender segregation (both horizontal and vertical segregation) in the health and care sector:** Invest in ensuring the decency of labour conditions in health and care jobs.

Promote training and equal opportunity for upward mobility for women health and care workers. Institute policies to attract more men into middle occupational categories in the health and care sector. Promote access to gender-equitable higher education. Raise awareness and invest in science, technology, engineering and mathematics careers for young girls and women. Legislate for gender-equitable maternity, paternity and family leave, and flexible working arrangements: flexible work hours, carer and family leave, carer pensions, flexitime and teleworking. Standardize working conditions between women and men with respect to working contracts and promote collective pay agreements.

- **Promote diversity and inclusion in the workplace:** Diversity, equity and inclusion

organizational strategies for staff recruitment, retention and development. Diversity in management and gender-equal leadership. Accountability for leadership.

- **Address gender norms and stereotypes:** Support efforts, including education and awareness-raising, to address the social and cultural factors that contribute to occupational segregation and influence career choices and wage outcomes.
- **Revalue health and care work:** Institutionalize job evaluation mechanisms that recognize the true economic and societal value of health and care occupations. Adjust pay structures to better reflect skills, responsibilities and contributions to population well-being.

## 7. Conclusion

Closing gender pay gaps in the health and care sector calls for sustained action across several fronts, in line with the existing global and regional commitments already in place. By tackling both the observable drivers of pay gaps and the structural factors, Member States across the WHO European Region can make measurable progress on improved workforce motivation and retention in keeping with the *Framework for action on the health and care workforce in the WHO European Region 2023–2030*

(EUR/RC73/R1) that was published in 2023 (8,9), and towards stronger health systems.

Targeted actions within the health and care workforce are essential if commitments made through international frameworks, including the SDGs and the resolutions on the health and care workforce, are to be delivered. Advancing pay equity in this sector will serve not improve only gender equality outcomes, but also wider goals of inclusive economic growth, social protection and sustainable development.

## 8. References<sup>3</sup>

1. Towards pay equity: a comprehensive response to the gender pay gap. Geneva: International Labour Organization; 2026 (<https://doi.org/10.54394/UJMT6226>). Licence: CC BY 4.0.
2. World Health Organization and International Labour Organization. The gender pay gap in the health and care sector: a global analysis in the time of COVID-19. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/358057>). Licence: CC BY-NC-SA 3.0 IGO.
3. Seventy-eighth United Nations General Assembly 2023, 5 October 2023: Political declaration of the high-level meeting on universal health coverage. New York: United Nations; 2023 (A/RES/78/4; <https://docs.un.org/en/A/RES/78/4>).
4. Seventy-eighth World Health Assembly: Geneva, agenda item 78.16, 19–27 May 2025: resolutions and decisions, annexes. Geneva: World Health Organization; 2025 (WHO878.16; <https://iris.who.int/handle/10665/385724>).
5. Seventy-eighth World Health Assembly: Geneva, agenda item 13.7, 27 May 2025. Accelerating action on the global health and care workforce by 2030. Geneva: World Health Organization; 2025 (WHO878.16; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA78/A78\\_R16-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R16-en.pdf)).
6. Sixty-third World Health Assembly, Geneva, agenda item 11.5, 21 May 2010: WHO global code of practice on the international recruitment of health personnel. Geneva: World Health Organization; 2010 (WHA63.16; <https://iris.who.int/handle/10665/3090>).
7. Seventy-ninth World Health Assembly: Geneva, agenda item 12.8, 18–23 May 2026: draft resolution WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva: World Health Organization; 2026 (A79/5 Add.3; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA79/A79\\_5Add3-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA79/A79_5Add3-en.pdf)).
8. Seventy-third Regional Committee for Europe: Astana, 24–26 October 2023: framework for action on the health and care workforce in the WHO European Region 2023–2030. Copenhagen: WHO Regional Office for Europe; 2023 (EUR/RC73/8; <https://iris.who.int/handle/10665/372563>).
9. Seventy-third Regional Committee for Europe: Astana, 24–26 October 2023: framework for action on the health and care workforce in the WHO European Region 2023–2030, resolution. Copenhagen: WHO Regional Office for Europe; 2023 (EUR/RC73/R1; <https://iris.who.int/handle/10665/373730>).
10. Azzopardi-Muscat N, Zapata T, Kluge H. Moving from health workforce crisis to health workforce success: the time to act is now. *Lancet Reg Health Eur.* 2023;35:100765 (<https://doi.org/10.1016/j.lanepe.2023.100765>).
11. Eurostat. EU Statistics on Income and Living Conditions microdata, release 2 in 2023, data 2004–2022 version 1 [database]. Luxembourg: Eurostat; 2023.
12. ILOSTAT database description. ILO modelled estimates (ILOEST database) [online database]. Geneva: International Labour Organization; 2026 (<https://ilostat.ilo.org/methods/concepts-and-definitions/ilo-modelled-estimates/>).

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<sup>3</sup> All references were accessed on 30 July 2026.

- 13.** European Labour Authority. The long-term care sector: labour mobility and enforcement challenges, ELA Strategic Analysis. Luxembourg: Publications Office of the European Union; 2026 (<https://www.ela.europa.eu/sites/default/files/2026-04/ela-report-labour-mobility-long-term-care.pdf>).
- 14.** Guidelines concerning a statistical definition of informal employment. Geneva: International Labour Organization; 2003 (<https://www.ilo.org/resource/guidelines-concerning-statistical-definition-informal-employment-0>).
- 15.** Global wage report 2018/19: what lies behind gender pay gaps. Geneva: International Labour Organization; 2018 (<https://www.ilo.org/publications/global-wage-report-201819-what-lies-behind-gender-pay-gaps>).
- 16.** Amo-Agyei S, McIsaac M. Gender pay gaps in nursing and midwifery: evidence from cross-country comparative analysis. *Int J Nurs Stud.* 2026;182:105608 (<https://doi.org/10.1016/j.ijnurstu.2026.105608>).
- 17.** Fair share for health and care: gender and the undervaluation of health and care work. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/376191>). Licence: CC BY-NC-SA 3.0 IGO.
- 18.** Dill JS, Frogner BK. The gender wage gap among health care workers across educational and occupational groups. *Health Aff Sch.* 2023;2(1):qxad090 (<https://doi.org/10.1093/haschl/qxad090>).
- 19.** Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. Human Resources for Health Observer Series No. 24. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/311322>). Licence: CC BY-NC-SA 3.0 IGO.
- 20.** Jefferson L, Golder S, Essex H, Dale V, Bloor K. Exploring gender differences in uptake of GP partnership roles: a qualitative mixed-methods study. *Br J Gen Pract.* 2023;73(732):e545–e555 (<https://doi.org/10.3399/BJGP.2022.0544>).
- 21.** European Commission: Directorate-General for Employment, Social Affairs and Inclusion, Bettio F, Verashchagina A. Gender segregation in the labour market – root causes, implications and policy responses in the EU. Luxembourg: Publications Office of the European Union; 2009 (<https://data.europa.eu/doi/10.2767/1063>).
- 22.** Rudman JS, Farcas A, Salazar GA, Hoff JJ, Crowe RP, Whitten-Chung K et al. Diversity, equity, and inclusion in the united states emergency medical services workforce: a scoping review. *Prehosp Emerg Care.* 2023;27(4):385–397 (<https://doi.org/10.1080/10903127.2022.2130485>).
- 23.** Knaul FM, Arreola-Ornelas H, Essue BM, Nargund RS, García P, Gómez USA et al. The feminization of medicine in Latin America: 'more-the-merrier' will not beget gender equity or strengthen health systems. *Lancet Reg Health – Am.* 2022;8:100201 (<https://doi.org/10.1016/j.lana.2022.100201>).
- 24.** Pincha Baduge MSS, Garth B, Boyd L, Ward K, Joseph K, Proimos J et al. Barriers to advancing women nurses in healthcare leadership: a systematic review and meta-synthesis. *EClinicalMedicine.* 2023;67:102354 (<https://doi.org/10.1016/j.eclinm.2023.102354>).

## Annex 1. List of Web Annexes

Gender pay gap in the health and care sector in the WHO European Region: evidence brief: web annex A - national data sources. Copenhagen: WHO Regional Office for Europe; 2026 (<https://iris.who.int/handle/10665/387468>).

Gender pay gap in the health and care sector in the WHO European Region: evidence brief: web annex B - labour market attributes and characteristics for the decomposition of the gender pay gap. Copenhagen: WHO Regional Office for Europe; 2026 (<https://iris.who.int/handle/10665/387469>).

Gender pay gap in the health and care sector in the WHO European Region: evidence brief: web annex C - methodology for decomposing the gender pay gap in the health and care sector. Copenhagen: WHO Regional Office for Europe; 2026 (<https://iris.who.int/handle/10665/387470>).

## The WHO Regional Office for Europe

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#### Document number:

WHO/EURO:2026-13697-53471-83924 (PDF)  
WHO/EURO:2026-13697-53471-83923 (print)