Career Attainment among Healthcare Executives: Is the Gender Gap Narrowing?

Joan Julia Branin, Director, Center for Health & Aging, Chair, Masters in Health Administration, University of La Verne

Abstract

Health care occupations are expected to be among the fastest growing professions in the next ten years. With such incredible growth expected in employment and wages, and with women's participation in the industry remaining strong, are women in the health care industry, particularly those in health care administration, experiencing a narrowing of the gender gap? This paper briefly reviews various theories of career success as they relate to the gender gap in executive level positions in healthcare administration and synthesizes the findings of a longitudinal study of the career attainment and attitudes of male and female healthcare executives. For the first time in almost two decades, a positive trend has been seen in the career attainment of women in health care administration. A 2006 ACHE study found an increase in the proportion of women relative to men who achieve CEO status. Women and men have similar levels of experience and education and experience similar levels of satisfaction with their positions. These findings suggest an increased commitment by healthcare organizations to integrate more women into leadership positions and to make the organizational culture more family friendly. However despite having attained equal levels of education and experience, a gender gap in salary levels still exists. Although women have made progress in attaining executive level positions, organizational structural factors rather than human capital factors contribute to the gender gap within healthcare executive management.

Career Attainment among Healthcare Executives: Is the Gender Gap Narrowing?

Health care occupations are expected to be among the fastest growing professions in the next ten years growing by 30.3% and adding 4.3 million jobs between 2004 and 2014. With such incredible growth expected in employment and wages, are women in the healthcare industry, particularly those in executive levels of healthcare administration, experiencing a narrowing of the gender gap?

Women have made some progress in entering the managerial ranks of U.S. healthcare in recent years but not at the highest levels. For example, in one of the healthcare management's largest professional societies, the proportion of women managers increased from 13 percent in 1983 to 36% in 2001 (Weil and Mathis 2001). Although women compose 78 percent of the healthcare industry's workforce and are the largest consumers of healthcare, they remain underrepresented in the top echelons of management and executive leadership positions (Lantz 2008).

Strong leadership and increased diversity are prominent issues in today's health services workforce; however, surprisingly little progress has been made to close the gender gap in healthcare leadership especially among the nation's top hospitals. A recent 2005 study of the Solucient 100 top hospitals, considered to be the highest quality and leading institutions in the

United States, revealed that of the 474 chief administrators only 24 % were women. In addition, nearly one third of these hospitals employed no female chief administrators, and another one third employed one female chief administrator. Female chief administrators were more likely to be a CIO (chief information officer) or CHR (chief human resources officer) rather than CEO, COO, CFO or CMO (chief medical officer).

At first glance, a woman's prospects for a career in healthcare administration appear encouraging. More than half of the recent graduates of health administration master's programs are women. Initially, most post-master's salaries are comparable with those of male graduates. Unfortunately, opportunities for promotion and financial benefits seem to decrease for women and expand for men as their respective careers advance (Walsh and Borkowski 1995).

This paper briefly reviews various theories of career success as they relate to the gender cap in executive level positions in healthcare administration and synthesizes the findings of a longitudinal study of the career attainment and attitudes of male and female healthcare executives. It argues that although women have made progress in attaining executive level positions, organizational structural factors rather than human capital factors contribute to the gender gap within healthcare executive management.

Theories of Salary and Career Mobility Disparities

Differences in salary and career mobility have been addressed repeatedly in the professional literature as separate and distinct factors. Economic, organizational, and psychological theories as well as human capital and organizational theories have been developed to explain these issues and why they are treated as separate problems.

Economic theorists suggest that wage and career opportunity differentials may be attributable to interrupted employment cycles. Periods of employment inactivity due to child rearing, responsibility for aging family members, or involuntary unemployment inevitably affect career mobility and future earnings. Increased family obligations may preclude women from accessing opportunities in the organizational structure. Frequently, these increased demands necessitate interruptions in the employment cycle with a concomitant loss or obsolescence of skills, higher absenteeism, and restrictions in number of hours worked. Salary differentials and advancement, therefore, are perceived as a market response to a transient work history (Corcoran and Duncan 1979).

In contrast, psychological theories suggest that career advancement and subsequent earnings are affected by the psychological attributes of the individual. Consequently, the ability to be a team player or to network effectively with others are cited as key ingredients for success within the organization (Terborg 1977). Men and women may consider different factors to be more important to career success than do men. Morrison, White, and VanVelsor (1997) found that women felt that a desire to succeed or willingness to work was critical to organizational success while men considered these attributes as instrumental to career advancement.

Several studies have suggested that career aspiration level may affect career advancement. Haddock and Aires (1980) found that men aspire to higher positions than women aspire to, while Harlan and Weiss (1982) argue that aspiration levels are not necessarily lower, but different for men and women. Walsh and Borkowski (1995) found that although men had higher career aspirations than women, actual expectations of career attainment were virtually identical for men and women. Fahey, Myrtle, and Schlosser (1998) also found that more women than men claimed to have fulfilled their career aspirations.

Finally, organizational theories emphasize the structural and behavioral dimensions within the organization that can affect mobility. This approach suggests that the centrality of a person's position to those in influence or the ability to acquire appointment to key organizational committees contributes to advancement. Organizational variables may profoundly influence the ability of women to succeed within the organization. Pazy (1987) found that while women were more likely to use formal organizational career management systems than men for career advancement, access to informal networks and mentors may be more crucial for career advancement. Women and men were found to develop separate networks, with men forming the dominant organizational coalition. Only those women whose immediate workgroups included both men and women were well-integrated into the male networks. This integration was crucial since advancement is related to centrality of position and degree of integration into the male-dominated network (Brass 1985). More importantly, the male network may provide access to mentors within the organization.

Two generic theories of career success have dominated the generic management literature and have been applied to healthcare management. The first theory, the “human capital” theory of career success, hypothesizes that individuals have time, effort, and individual assets, or human capital such as education, experience, skills, and personal characteristics, which we bring to the

job. It is the amount and effectiveness of the human capital that one has and expends on the job that is the main determinant of career success. The human capital approach argues that woman either have less human capital than men (i.e., less experience, less skills) or use some of their human capital on home and family issues therefore, having less to expend at work.

The second theory, "organizational structure," hypothesizes that there are barriers within the organization that work either for or against career success. Organizational structures, systems, processes, and policies directly or indirectly help or hamper career success. Many of these barriers are explicit barriers, such as discrimination and unfair hiring practices, have been acknowledge and outlawed. Many of the less explicit, more transparent and implicit barriers, such as the glass ceiling and old boys' club, which bar women and minorities from the highest level of management in organizations, may still exist.

While each of these theories may contribute to explanations of gender differences in business management, few studies have investigated the specific extent to which these distinctions currently exist in healthcare administration.

Method

In 1990 the American College of Healthcare Executives (ACHE) conducted a pivotal study comparing the career attainments and attitudes of male and female healthcare executives. This study has since been undertaken every 5 years (1990, 1995, 2000, and 2006) using a sample of member affiliates who have been in the field between 5 to 19 years. The 2006 study surveyed 1,597 affiliates; 837 responded for an overall response rate of 52 percent. (For more details of these studies, refer to Weil and Zimmerman 2007). The results presented and discussed are based on the findings of this longitudinal study of male and female healthcare executives.

Results and Discussion

For the first time in almost two decades, a positive trend has been seen in the career attainment of women in healthcare administration. According to the 2006 study, about 12% of women, compared to 19% of men, had achieved CEO positions. Although significantly more men than women hold CEO positions, there has been an increase in the proportion of women relative to men who achieve CEO status. In contrast to the three previous studies, where women achieved

CEO positions at about 40% of the male rate; in 2006, they achieved CEO positions at 63% of the male rate (a narrowing of the gender gap!)

In contrast to the 2000 study, women appear to have moved up the organizational hierarchy within their current firms at nearly the same rate as men. About 20 percent of both men and women who began as COOs/ senior vice presidents / associate administrators were CEO positions in 2006.

Women tend to be are more involved than men in specialized management positions including nursing services (12% vs. 2%); planning, marketing and quality assurance (18% vs. 11%); and continuum of care such as ambulatory, home, and long-term (4% vs. 2%). By contrast, a higher proportion of men than women are in general management positions (57% vs. 44%).

Women and men expressed similar high levels of satisfaction with their positions (86%). More specifically, men and women expressed similar levels of satisfaction with job security, job opportunities in their organization, recognition and rewards, and balance between work and personal/family commitment. They were similar in their satisfaction with the support they received from their supervisors. Both men and women expressed similar levels of commitment to their organizations and slight chances that they will leave their organizations voluntarily within the next year.

About three quarters of women and men were satisfied with their compensation, while 80 percent of both groups were satisfied with their overall advancement within their organization. Somewhat fewer were satisfied with the availability of mentors and coaches.

However, women were less satisfied than men with the support they received from male co-workers. Women were also less satisfied than men with their compensation compared with others in their organization at the same level, their overall advancement in the organization, and the availability of mentors and coaches. In previous years, women expressed less satisfaction with their advancement in the organization, their compensation compared with others in their organization at their level, and availability of mentors/coaches than their male counterparts.

While prior studies showed that more men than women majored in healthcare management, today about half of each group majored in healthcare management. However, more women than men had had previous experience as clinicians (56% vs. 12%). For the first time, women and men have spent similar number of years in management positions after receiving a

master's degree (12.9 years for men vs. 12.3 years for women). More men than women took their first position at the vice president or assistant administrator level.

However, a gender gap in salary levels still exists. Controlling for education and years of experience, female healthcare executives earn an average of 18 percent less than their male counterparts. This gender wage gap was comparable to prior studies in 1990, 1995, and 2000 when women with similar characteristics earned 18, 17, and 19 percent less respectively than men did. In 2005, women on average earned $107,800 and men earned on average $131,000, a difference of $23,200 or 18 percent. Despite this persistence of a wage gap, women in healthcare administration are in a better relative position than women in general business who in 2005 earned 27 percent less than men.

Women earned significantly more if they had more male mentors, a spouse willing to relocate for their career advancement or an employer whose policies accommodated families such as flexible time, and if they themselves socialized informally with other healthcare executives.

Even though women have attained equal levels of education and work experience, there are significant differences in salary attainment and, to a lesser degree, career attainment. What are the reasons for these gender disparities?

Differences in Types of Education and Work Experience

More men than women had specialized training in health administration (e.g., MHA degree). Women more often had clinical degrees (e.g., MSN). Men were also more likely to have completed a residency in healthcare management as part of their graduate degree requirement.

Men have spent a greater number of years in management positions since receiving their master's degree. Why? Men were more likely than women to begin their careers in general management, financial services management, ancillary services, or clinical services. Women were more likely to begin in nursing or planning and marketing and may not necessarily start their careers with aspirations toward management positions.

Differences in Response to Work/Family Balance

Overall, fewer female than male healthcare executives are married, which suggests that women more often have to choose between having a career or a family. Women with families typically

serve as the primary caregiver for children (or elderly adults) and they tend to carry a greater share of family responsibilities. Family responsibilities are four times more likely to fall on women than men. Thirty-nine percent of women vs. eight percent of men felt family/home obligations fell disproportionately on them. However, short career interruptions of three or four months did not markedly diminish women's salaries when compared with women with uninterrupted careers.

Married men were more likely to have a spouse willing to relocation for their spouse's career advancement than married women. Sixty-seven percent of the married men's spouse was willing to relocate to help them obtain a better position; only 41% of the married women said their spouses were willing to do so.

Although there were few differences in the flexibility that workplaces offered men and women, the study found two areas where women's employing organizations were more flexible than men's: (1) leaves and sabbaticals and (2) telecommuting/working from home.

Perceived Workplace Inequities

More than 40% of women and 25% of the men cited the following reasons for the disparities in women's career attainment: failure of senior leadership to assume accountability for women's advancement, lack of professional or executive development opportunities for women, and lack of opportunities for visibility within the organization.

More female healthcare executives than males see women's advancements stymied because of stereotyping of women's leadership attributes as nurturing while men's leadership attributes as assertive, competitive risk takers who benefit more from advancement opportunities; perceptions about women's roles and abilities; and exclusion of women from informal networks of communication.

Differences were found in experiences with discrimination. Forty-three percent of women, compared to three percent of men, stated that they failed to receive fair compensation because of their gender. Twenty percent of women, compared to seven percent of men, said they failed to receive promotions because of their gender. Twenty-three percent of women, compared to six percent of men, reported that they had experienced sexual harassment in the workplace.
The clear contrast in gender groups shows that even in 2006, nearly one-fifth of women continue to feel their careers are being stymied by gender discrimination.

Differences in Career Aspirations

While male and female business executive differ significantly in their aspirations to higher level positions (60% of business men vs. 44% of business women), male and female healthcare executives had similar aspirations to higher-level positions—about 60% said they planned to achieve higher positions, most within five years. However, more male healthcare executives aspired to a CEO level position (70% men vs. 40% women). Compared to women, twice as many men in 1990, 1995, 2000 and 2006 desire to be CEOs in 5, 10, or 15 years. Also, a higher proportion of men stated they were willing to move to advance their careers.

Conclusions and Recommendations

There are several conclusions to be drawn from this review and these studies. First, while the gender gap in career attainment in the healthcare administration field has not disappeared, it seems to be narrowing. Since the initial study in 1990 comparing the career attainment of men and women healthcare executives, there have been positive changes in the proportion of women achieving CEO positions of the male rate. In contrast, women appear to have moved up the organizational hierarchy with their organization at nearly the same rate as that of men. Overall, except for offering career development programs and preferences for filling senior level positions with internal candidates, few healthcare organizations have established practices and programs intended to advance the careers of women in healthcare management.

Second, the widening wage gap is often attributed to human capital issues such as education and experience. Both the ACHE longitudinal study and other studies do not support this conclusion. Controlling for education and years of experience, Wiggins (1996) found that the income gap between female and male healthcare managers widens as their careers progress. Females and males started their careers at equal incomes, but within seven to eight years women earned approximately $10,000 less than men. Similarly, Weil and Kimball (1996) found that opportunities for promotion and financial benefits seem to decrease for women and expand for men as their career progress. Significant differences in the compensation levels of public and private hospital CEOs were found by Santerre and Thomas (1993). These differences were based on hospital and human capital characteristics, not ownership. One of the human characteristics that predicted higher compensation was gender: female CEOs earned less than male CEOs. The authors concluded that hospital ownership did not have an independent effect

on CEO compensation levels, but that human capital measures such as education, experience, and gender are important determinants of executive pay.

Third, organizational structural barriers also contribute to the underrepresentation of women and the salary differences of men and women in healthcare administration. Gender differences in mentoring and leadership development training are key barriers to career advancement. Healthcare executives report not investing enough in mentoring and leadership development and that this lack of attention is even more pronounced for women and minorities (ACHE 2006). More importantly, women have less interaction with other executives within the organization. Executives provide visibility within the organization, they can assign projects than can advance one's career, and they have access to informal networks that provide timely information.

Fourth, for both women and men a combination of human capital and organizational structure may be predictors of career attainment and income. Wiggins (1996) found that for men and women there were three significant, but different, predictors of income. For men, the three significant predictors were: meeting with colleagues from outside one's home organization, working in a privately owned organization, and meeting with external colleagues at a location other than one's own organization. For women, holding a line position, working in an organization that strongly enforced personnel policies, and being of younger age were the three significant predictors of income.

Recommendations

Access to middle management positions is crucial to those who wish to advance in the field of healthcare administration. Traditionally, these positions have provided a mechanism to cultivate relationships with organizational executives as well as an opportunity to learn about the internal dynamics of the organization. Since these informal structures influence promotional opportunities and future compensation, it is critical for women to gain increased access to these positions in the early phases of their career.

One approach to increasing this access is using career development programs that facilitate interaction between female managers and organizational executives. Similar training programs, which emphasize rotation among key executives, have been implemented successfully in the private sector. These programs provide employees with a comprehensive organizational

perspective and enable them to interact routinely with a variety of administrators within the organization. At the same time, this type of program allows executives to generate a viable roster of prospective candidates to consider for promotion as opportunities occur within their institutions.

Seminars and educational programs also can furnish an opportunity for both male and female administrators to develop informal relationships with their colleagues. These programs encourage networking and provide informal information about the organization.

These strategies can contribute to the professional advancement and development of healthcare administrators and narrow the gender and leadership gap in executive healthcare administration in the 21st century.

References

American College of Healthcare Executives. 2002. A race/ethnic comparison of career attainments in healthcare management. [Online information; www.ache.org/pubs/research/rstudy/execsum.cfm.

Borkowski, Susan C. and Ann Walsh. 1992. Executives in healthcare administration: Where do women stand? *Healthcare Financial Management* 46, No. 7: 47-55.

Brass, Daniel. J. 1995. Men's and women's networks: A study of interaction patterns and influence in an organization, *Academy of Management Journal* 28, No. 2: 327-343.

Corcoran, Mary and Greg J. Duncan. 1979. Work history, labor force attachment, and earnings differences between the races and sexes. *Journal of Human Resources* 14, No. 1: 3-20.

Dreachslin, Janice L. 2007. The role of leadership in creating a diversity-sensitive organization. *Journal of Healthcare Management* 52, No. 3: 151-155.

Dreachslin, Janice L. and Ellen Foster Curtis. 2004. Study of factors affecting the career advancement of women and racially/ethnically diverse individuals in healthcare management. *The Journal of Health Administration Education* 21, No. 4: 441-484.

Dreachslin, Janice L., Gloria E. Jimpson, and Elaine Sprainer. 2001. Race, ethnicity, and careers in healthcare management. *Journal of Healthcare Management* 46, No. 6: 397-409.

Dunham N. and I. Yhouse 2007. Census of Women Chief Administrators of the Solucient 100 Top Hospitals. Unpublished paper, University of Michigan, Ann Arbor.

Fahey, Daniel F., Robert C. Myrtle, and Jack R. Schlosser. 1998. Critical success factors in the development of healthcare management careers. *Journal of Healthcare Management* 43, No. 4: 307-320.

Haddock, Cynthia Carter and Nancy Aries. 1980. Career development of health care administration: A preliminary consideration. *Health Care Management Review* 14, No. 31; 33-40.

Lantz, Paula M. 2008. Gender and leadership in healthcare administration: 21st century progress and challenges. *Journal of Healthcare Management* 53, No. 5:

Pazy, A. 1987. Sex differences in responsiveness to organizational career management. *Human Resource Management* 26, No. 2: 243-256.

Santerre, Rexford E. and Janet M. Thomas 1993. The determinants of hospital CEO compensation. *Health Care Management Review* 18, No. 3: 31-39.

Terborg, J. R. 1977. Women in management: A research review," *Journal of Applied Psychology* 62, No. 6: 647-664.

Walsh, Anne and Susan C. Borkowski. 1995. Gender differences in factors affecting health care administration career development. *Hospital & Health Services Administration* 40, No. 2: 263-278.

Weil, Peter, A., Haddock, Cynthia Carter, and Diane Barowsky. 1996. Exploring the gender gap in healthcare management. *Health Executive* 11, No. 6: 18-21.
Weil, Peter A. and P. Kimball. 1996. Gender and compensation in health care management. *Health Care Management Review* 21, No. 3: 19-33.
Weil, Peter, A. and Mary C. Mathis. 2003. Narrowing the gender gap in healthcare management. *Health Executive*, November-December: 12-17.
Weil, Peter, A. and Mary C. Mathis. 2001. To shatter the glass ceiling in healthcare management: Who supports affirmative action and why? *Health Services Management Research* 16, No. 4: 224-233.
Weil, Peter, A. and Mary Zimmerman. 2007. Narrowing the gender gap in healthcare management. *Health Executive*, May-June: 23-30.
Wiggins, Carla 1996. Counting gender: Does gender count? *Journal of Health Administration Education* 14, No. 4: 379-388.
Wiggins, Carla and Sarah Y. Bowman. 2000. Career success and life satisfaction for female and male healthcare managers. *Hospital topics: Research and perspectives in healthcare* 78, No. 3: 5-10.

Published by the Forum on Public Policy