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African American Administrators in Community/Migrant Health Centers

AFRICAN AMERICAN ADMINISTRATORS IN COMMUNITY/MIGRANT HEALTH CENTERS

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Abstract: Community and migrant health centers (CHC/MHCs) play a secondary role as avenues for the development of minority and women health care professionals, groups traditionally underrepresented in administrative and managerial positions within the health care system. This paper focuses on the role of CHC/MHCs in eliminating the barriers that typically limit the professional advancement of these groups. In a survey of both rural and urban CHC/MHC administrators, it was found that CHC/MHCs have higher percentages of minorities in top management positions than general management but do not necessarily reflect the minority composition of those being served. Of the CHC/MHC administrators, 20 percent were African American, less than the population served (31 percent) but greater than the percentage of African Americans in the general U.S. population (12 percent). This suggests that CHC/MHCs have partially met the original goal of upward mobility and that there is room for improvement.

Key words: Community/migrant health centers, African American, Hispanic, women, health care administrators

From their inception, community health centers and migrant health centers (CHC/MHCs) were designed to provide an avenue for the development of minority health care professionals. The Community Action Program, established by the Economic Opportunity Act (EOA) of 1964, funded the first CHCs (at the time called Neighborhood Health Centers). This legislation was at the center of the War on Poverty waged by the administration of then President Lyndon B. Johnson. The EOA created and charged the Office of Economic Opportunity (OEO) with eliminating poverty by improving the economic conditions of the poor. In conjunction with this initiative, the OEO also funded

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the development of community-based health centers recognizing that to eliminate poverty, health problems must also be addressed.[1]

CHC/MHCs are managed by 543 not-for-profit corporations in 1,800 sites across the United States. On an annual basis they operate under a combined budget of $1 billion and serve approximately six million people, about 25 percent of the nation's indigent population.[1,2] The patients who use CHC/MHCs are drawn primarily from minority groups—31 percent African American, 28 percent Hispanic, and 5 percent other minorities. CHC/MHCs play a key role in providing primary and some specialty health care (e.g., obstetrics/gynecology, dentistry, pediatrics, podiatry, and optometry) to the nation's poor and underserved. Studies on CHCs show them as having a direct impact on the access and use of health care services by low-income individuals.[3,4] CHCs provide these individuals with a viable financial alternative to using hospital emergency rooms. CHCs have helped to fill the primary health care needs of the poor. Individuals who use CHCs have been shown to have lower rates of hospitalization and hospital admissions than individuals receiving care from private physicians and hospital clinics.[5] Also, CHCs have been able to provide the same level of care as hospital outpatient clinics at half the cost.[5]

In the original design of CHC/MHCs, health policymakers stressed the importance of having individuals from the respective communities involved in the planning and implementation of health services designed to serve them. Each center would provide members of the community with employment, training in job skills, the opportunity to develop stable work histories, and experience in managerial positions.[6] In concept, it was planned that many of the CHCs would have directors and other staff from members of minority ethnic groups and/or women, in other words those who were traditionally barred from administrative and managerial positions in the health care system.

Although employment statistics on minorities in management are difficult to find, evidence continues to point toward disparity in the upward mobility of minority managers in corporate America in general, and in the health care industry in particular.[7] Limited data suggest that minorities continue to encounter a "glass ceiling" in management and remain largely confined to management positions with little authority.[8] In 1979, a survey of 1,708 senior executives showed three to be African American, two to be Asian Americans, and two to be Hispanic.[9] In 1985, the same survey data showed four African Americans, six Asian Americans, three Hispanics, and 29 women.[9] In 1986, in 400 of the 1,000 Fortune companies, less than 9 percent of all managers were minorities, including African Americans, Hispanics, and Asian Americans. An American College of Healthcare Executives (ACHE) survey conducted in 1988 found less than 10 percent of health care administrators in hospitals and other health care settings to be minorities.[7] There is literature suggesting reward differentials for minorities and women. Drazin and Auster found substantial wage differences between men and women in managerial levels.[10] One study

reported women executives earning 42 percent less than their male coun[...]parts.[11] However, the earnings of African American male executives are [...]ported to come closer to the earnings of white male executives.[12] The 1[...] ACHE survey reported African American health care executives as havin[...] median salary that was 21 percent less than white executives.

The literature postulates several theories as to why differences exist wi[...] management for women and minorities. There are three major grouping[...] these theories: sexual and racial deficiency theories; sexual and racial bias [...] stereotype theories; and structural, systemic discrimination theories.

Sexual and racial deficiency theories. Early research suggested that [...] person-centered characteristics of women prevented them from assum[...] managerial roles.[13] Later studies have shown mixed results, with the cur[...] trend to be a refutation of sex differences in managerial success.[14,15] A num[...] of studies dispute sexual as well as racial deficiencies. More similarities [...] differences between women and men in management positions were note[...] Howard and Bray in a report of the American Telephone and Telegr[...] Assessment Center management training program.[16] Race differences [...] greater than sex differences. African American managers showed higher [...] more stable performance on interpersonal skill measurements and lo[...] performance on cognitive skill measurements than white managers.[17]

The human capital theory asserts that individuals are rewarded in [...] current jobs based on their past investment in education and job traini[...] According to proponents of this theory, the differences observed for wo[...] and minorities result from their forfeiting an investment in education [...] could yield higher earnings in the long run for lower short-term wage e[...]ings. This theory suggests that women or minorities seeking to correct di[...]ential treatment should invest in acquiring new skills and experiences that [...] qualify them for higher paying positions and policy changes in organizat[...] should be directed toward the educational process rather than the emp[...]ment setting.[19] However, recent studies have shown that education level [...] not fully account for discrepancies in level of pay for women and mino[...] in management.[20,21]

Sexual and racial bias and stereotype theories. Bias on the part o[...] dominant group is often cited as the cause of differential treatment. Even [...] laws in place to prevent discrimination, studies have revealed that a dec[...] to discriminate is driven by whether or not such action is viewed posit[...] or negatively by the relevant parties and by the possibility of being rewa[...] for discriminating.[21,22] These studies suggest that how tolerant the orga[...]tional environment is to discrimination becomes a significant factor i[...] occurrence or nonoccurrence of discriminatory practices. Discrimination [...] occurs as a result of the belief on the part of white males that women [...] minorities are less suited for management. Biases and stereotypes relati[...]

the minority group as a whole are the bases for the selection process as opposed to the individual minority applicant characteristics.[23,24]

Systemic discrimination theories. The dual labor market theory asserts the existence of two sets of jobs, a primary set and a secondary set.[25] Minorities tend to be most frequently identified or categorized with the secondary labor market in lower-level management positions. Movement from the secondary labor market to the primary labor market is not very flexible, and hence minorities find themselves confined to secondary positions.[19] A second structural barrier for minorities in management is their lack of organizational power and growth opportunity. Those few minorities in management are very visible and are often evaluated based on stereotypical guidelines.[26] Minorities also have to deal with biculturism. Multirole African American women, particularly, must seek out coping mechanisms that will help them effectively manage the stress generated from the two very distinct cultural systems operating in the workplace and at home.[19]

Irons and Moore, in their study of the banking industry, reflect the strong influence of structural factors on African Americans in bank management.[2] The most significant problem identified in the study was exclusion from formal and informal networks in the organization. Also cited was racism and the inability to find a mentor. Similar barriers have also been identified in studies of Asian Americans.[19]

It may be that all three theoretical underpinnings offer explanations of the inability of minorities to successfully move into management at an accelerated pace. However, this paper focused specifically on the structural barriers theory, which, as described earlier, falls within the category of systemic discrimination. In that CHC/MHCs were designed to allow minorities and women an opportunity to fill top management positions, the degree to which this has occurred since their inception should be a measure of their success in eliminating structural barriers. This paper focuses on the role of CHC/MHCs in eliminating the glass ceiling that limits the advancement of women and minorities toward top management positions. CHC/MHC administrators were surveyed regarding their training, experience, values, attitudes, beliefs and perceived problems and opportunities facing the CHC/MHC environment. Significant differences between the characteristics of African American and white administrators are addressed. Findings could be used to structure culturally appropriate training opportunities and identify policy changes that would facilitate management of CHC/MHC programs for minorities and women.

Methods

The survey. Current senior CHC/MHC executives were surveyed to address the research questions. The results of the survey were used to develop profile of the African American CHC/MHC executive and to compare th

factors and characteristics these executives identified as significant to the success of a CHC/MHC administrator with those identified by white CHC/MHC executives. More specifically, significant differences were analyzed relative to the structural barriers theory explanation for the limited number of minorities in positions of power in organizations.

Data. This research is based on data from a 1994 national survey of CHC/MHC administrators conducted by the authors under contract with the National Rural Health Association for the Health Resources and Services Administration, U.S. Public Health Service. The 1993 CHC/MHC directory (published by the U.S. Department of Health and Human Services) was used as the sampling frame. All CHC/MHCs in the United States were included (N = 524). The survey instrument was first mailed to administrators of all the CHC/MHCs in South Carolina as a pretest (N = 14). The questionnaire was modified based on respondents' feedback and sent to administrators of all CHC/MHCs in the United States. Of the 524 mailings, 443 administrators responded for a response rate of 85 percent. An analysis of nonrespondents versus respondents did not yield significant differences in terms of center size or scope of services provided. However, administrators from rural CHC/MHCs were more likely to respond than those from urban CHC/MHCs (91 vs. 75 percent).

Measures. The survey questionnaire was designed based on an extensive review of the literature regarding administrators of health care institutions and a pilot study on South Carolina CHC/MHC administrators. The following five major components regarding administrators' attributes were included: (1) demographic characteristics, (2) work characteristics, (3) values regarding critical factors for CHC/MHC success, (4) beliefs regarding important managerial characteristics for a successful CHC/MHC administrator, and (5) perceived training needs for additional knowledge and skills.

Demographic characteristics consisted of respondents' age (year of birth), sex (male and female); race (white, African American, Hispanic, and other); highest degree attained, including MD, PhD, and other doctoral degrees, Master of Health Administration (MHA), Master of Public Health (MPH), Master of Business Administration (MBA), or other master's degree; bachelor's degree; without bachelor's degree; and year of graduation from the highest educational degree.

Work characteristics included years of current employment as an administrator; average hours worked per week; current annual salary; and monthly distribution of time in various activities with medical staff, other clinical staff and board relations; and outside activities, including reading/professional development, community matters, team building, crisis intervention, entertaining, federal CHC/MHC report activity and other grant activity, professional associations, and other activities outside of work. Respondents were asked to describe the percentage of time per month distributed to each of the

above activities and verify their answers by summing up responses to 100 percent.

Values regarding critical factors for CHC/MHC success were measured with 14 items asking respondents to identify the primary function of CHC/MHC (three items) and the most critical factors to CHC/MHC success (11 items). A five-category agreement Likert-type scale was used to measure responses (5 = *totally agree*, 4 = *somewhat agree*, 3 = *not sure*, 2 = *somewhat disagree*, 1 = *totally disagree*). Beliefs regarding important managerial characteristics for a successful CHC/MHC administrator were based on respondents' assessment of the relative importance of 25 characteristics in identifying a successful CHC/MHC administrator. A 5-point Likert-type rating scale was used for each response (5 = *most important* and 1 = *least important*).

Training needs for additional knowledge and skills used eight items including communication skills, leadership skills, financial management, human resources management, strategic planning, policy development, formal degree program, and decision-making skills. Respondents were asked to assess those areas using a 7-point Likert-type scale (7 = *most needed* and 1 = *least needed*).

Analysis. Univariate statistics were used to address the first study objective. Sample distributions and means were calculated to draw a profile of African American CHC/MHC administrators in comparison with white administrators. Bivariate statistics were used to fulfill the second objective of comparing African American and white CHC/MHC administrators in terms of their personal and work characteristics, values, and beliefs, as well as their perceived deficiencies. The education categories were recoded from eight to five categories due to sample size consideration and preliminary analysis that indicated similar results. The recoded educational categories were doctoral degree (combining MD, PhD, and other doctoral degrees), management master's degree (combining MHA, MPH, and MBA), other master's degree, bachelor's degree, and no bachelor's degree. Chi-square statistics were used for categorical variables, and analysis of variance (ANOVA) was used for continuous variables.

Results

Demographics. The demographic and some work-related characteristics of CHC/MHC administrators are displayed in Table 1. The mean age of administrators was 47.7 years. They were most likely to be male (59 percent) and white (65 percent). Most of them had advanced degrees: 8 percent had a PhD, 3 percent an MD, 6 percent an MHA, 15 percent an MPH, 6 percent an MBA, and 25 percent an other master's degree. There were more rural centers (63 percent) than urban ones (37 percent). On average, respondents had nine years of experience as administrators, worked 50.5 hours a week, and earned $58,150 in mean salary.

TABLE 1
DEMOGRAPHIC AND JOB-RELATED CHARACTERISTICS OF AFRICAN AMERICAN, WHITE, AND HISPANIC COMMUNITY AND MIGRANT HEALTH CENTER ADMINISTRATORS, 1994

	WHITE		AFRICAN AMERICAN		HISPANIC	
VARIABLE	n	%	n	%	n	%
Sex						
Male	166	66	49	19	37	15
Female	119	70	37	22	15	9
Highest education degree						
High school	20	7	0	0	4	8
Associate	7	2	1	1	2	4
BA	80	29	20	23	18	36
Other master's degree	69	25	28	33	8	16
MBA	18	7	5	6	4	8
MPH	45	16	14	16	1	2
MHA	12	4	4	5	7	14
MD	6	2	2	2	5	10
Other doctoral degree	10	4	9	10	1	2
PhD	10	4	3	4	0	0
Age	47.6		47.7		48.1	
Years of current employment						
Mean	9		8		10	
Standard deviation	0.41		0.74		0.96	
Average hours worked per week						
Mean	50.0		53.0		50.0	
Standard deviation	0.53		0.98		1.25	
Current annual salary						
Mean	$56,468		$64,291		$58,589	
Standard deviation	$1,990.2		$3,616.0		$4,613.0	

The most significant finding of the study was that 20 percent of t[...] CHC/MHC administrators are African American. This percentage is less tha[...] the population served (31 percent) but greater than the percentage of Afric[...] Americans in the general U.S. population (12 percent). The typical Afric[...] American CHC/MHC administrator is more likely to be male (56 percen[...] than female (43 percent) and in an urban locale (67 percent). The Afric[...] American administrators were better educated than white administrato[...] with 76 percent of the African American respondents indicating advanc[...] degrees versus 60 percent of the white administrators. The African Americ[...] administrators' average years of experience was eight, and they worked [...] average 53.3 hours a week with an average mean salary of $64,292. In co[...] parison with white administrators, African American administrators on av[...] age had invested more time in education, spent more time per week at wo[...] and earned more than the white administrators.

Time spent in various activities. When race was compared with the amount of time administrators spent in various activities, significant relationships between race, reading and professional development, and time spent on board relations were found. As shown in Table 2, African American administrators spent 8 percent of their time on reading and professional development compared with 6.4 percent spent by white administrators. A second finding was that African American administrators spent less time on board relations (10.26 percent) than white administrators (10.7 percent).

Primary function of CHC/MHC. Regardless of race, there was consensus on the primary functions of CHC/MHCs to provide health service to the poor and to provide geographical access to service (see Table 3). There was a significant difference relative to the function of becoming self-supporting (independent of grant support), with African American administrators more inclined to consider a move toward reduced grant funding as an important function (mean rank 3.14). Hispanic administrators also assigned a higher importance to this function (mean rank 2.9) than did white administrators (mean rank 2.7).

Race and perceived CHC/MHC success factors. Both white administrators and African American administrators indicated that good organizational leadership was the most important factor in the success of a CHC/MHC (see Table 3). However, African American administrators rated board support higher than did their white counterparts.

Race and perceived managerial characteristics. Although honesty/integrity was rated the most significant workplace value for white and Hispanic managers, African American managers ranked vision for the future to be most important. There are other significant differences on a number of characteristics by race. The results of the ANOVA for job characteristics reflect significant differences, as shown in Table 4.

Significant racial differences were found on the following 11 managerial characteristics: appears to be calm and in charge, knows where to get information, patience, understanding of organization's history, network building skills, being analytical, being an implementer, competitive, fairness, achievement oriented, and business oriented. African American administrators rated all 11 higher than did white administrators, indicating that African American administrators equate characteristics that will increase their power base (knows where to get information, understanding of organization's history, network building skills, competitive, achievement oriented), characteristics that refute racial management deficiencies (being an implementer, business oriented), and characteristics that offset stereotypical biases (appears to be calm and in charge, patience, being analytical, and fairness) as most important to success as a CHC/MHC administrator.

TABLE 2
DISTRIBUTION OF TIME BY AFRICAN AMERICAN, WHITE, AND HISPANIC COMMUNITY AND MIGRANT HEALTH CENTER ADMINISTRATORS, 1994

VARIABLE	WHITE	AFRICAN AMERICAN	HISPANI
Team building			
Mean percentage	13	14	12
Standard error	0.6	1.1	1.42
Medical staff			
Mean percentage	12	11	13
Standard error	0.54	0.99	1.28
Professional association			
Mean percentage	4	3	4
Standard error	0.24	0.43	0.56
Board relations			
Mean percentage	11	10	12*
Standard error	0.39	0.71	0.91
Other clinical staff			
Mean percentage	8	7	7
Standard error	0.42	0.76	0.98
Other grant activity			
Mean percentage	9	11	8
Standard error	0.58	1.06	1.37
Federal community health center report activity			
Mean percentage	9	9	8
Standard error	0.5	0.92	1.19
Entertaining			
Mean percentage	1	1	2
Standard error	0.13	0.24	0.31
Reading/professional development			
Mean percentage	6	8	6
Standard error	0.36	0.66	0.85
Crisis intervention			
Mean percentage	9	8	9
Standard error	0.58	1.05	1.36
Community matters			
Mean percentage	10	11	10
Standard error	0.45	0.83	1.07

*Significant at < 0.05 level.

Training needs. White and Hispanic administrators agreed that strateg planning training was the number one priority; however, African Americ administrators ranked leadership and financial management training as th highest priority (see Table 5). African American administrators also rated bo policy development and formal degree programs higher than did wh respondents.

TABLE 3

RANKING THE VALUES AND BELIEFS OF AFRICAN AMERICAN, WHITE, AND HISPANIC COMMUNITY AND MIGRANT HEALTH CENTER (CHC/MHC) ADMINISTRATORS, 1994

VARIABLE	AFRICAN AMERICAN	WHITE	HISPANIC
The primary function of a CHC/MHC is to			
Provide geographic access to services			
Mean	4.42	4.64	4.42
Standard error	0.10	0.05	0.12
Rank	1	1	2
Provide health services to the poor			
Mean	4.24	4.37	4.44
Standard error	0.11	0.06	0.14
Rank	2	2	1
Become self-supporting (without grant)			
Mean	3.14*	2.71	2.92
Standard error	0.14	0.08	0.18
Rank	3	3	3
The most critical factors in CHC/MHC success is			
Good organizational leadership			
Mean	4.52	4.62	4.67
Standard error	0.10	0.05	0.12
Rank	1	1	1
Organization's value to community			
Mean	4.46	4.59	4.44
Standard error	0.09	0.05	0.12
Rank	2	2	5
Efficiency			
Mean	4.34	4.47	4.54
Standard error	0.10	0.05	0.12
Rank	8	6	3
Organizational stability			
Mean	4.42	4.49	4.57
Standard error	0.10	0.05	0.12
Rank	1	4	3
Organization's reputation			
Mean	4.39	4.48	4.44
Standard error	0.09	0.05	0.12
Rank	4	5	5
Effectiveness			
Mean	4.38	4.48	4.44
Standard error	0.10	0.05	0.12
Rank	5	5	5
Community support			
Mean	4.36	4.36	4.36
Standard error	0.10	0.05	0.13
Rank	7	8	6
Physician retention			
Mean	4.37	4.38	4.26

TABLE 3 Continued

VARIABLE	AFRICAN AMERICAN	WHITE	HISPANIC
The most critical factors in CHC/MHC success is			
Board support			
Mean	4.38	4.23	4.46
Standard error	0.10	0.06	0.13
Rank	5	9	4
Third-party reimbursement			
Mean	4.25	4.22	4.31
Standard error	0.10	0.05	0.13
Rank	9	10	7
Grant support			
Mean	3.96	4.03	4.10
Standard error	0.11	0.06	0.14
Rank	10	11	9

*Significant at < 0.05 level.

Discussion

When compared with the number of minorities in management in gener CHC/MHCs show much higher percentages of minorities in top manageme positions. However, the percentage does not reflect the minority compositi of those being served by CHC/MHCs. This suggests that CHC/MHCs ha partially met the original goal of upward mobility and there is room for furth improvement. The results of this survey refute the reward differentials by ra however, additional study is warranted to determine the exact relationsh between pay and education level and whether the relationship suggests th minorities must obtain higher degrees to receive higher pay.

African American administrators rated all 25 managerial characterist higher than did white administrators. CHC/MHC minority administrato attributed managerial success to more personal characteristics and values th did white administrators. Of the 11 characteristics that showed statistica significant differences, African American administrators were higher on 8 them and rated 1 equal in importance with Hispanic administrators. Specu tion can be made on some of the race differences found based on the th theoretical approaches used to explain discrimination against minorities management positions. The majority of the characteristics rated significan higher by African American administrators relate to the systemic discrimi tion theory. Higher ratings on knowing where to get information and netwo building in addition to understanding the organizational history, being implementer, and having a high need for achievement all suggest that min ity administrators perceive that systemic barriers are very real in their orga zational structures and indicate their belief that these characteristics will all them to surmount systemic barriers to upward mobility and success.

TABLE 4
EDUCATION DEGREES AND IMPORTANCE OF 15 MANAGERIAL CHARACTERISTICS BY AFRICAN AMERICAN, WHITE, AND HISPANIC COMMUNITY AND MIGRANT HEALTH CENTER ADMINISTRATORS, 1994

VARIABLE	WHITE	AFRICAN AMERICAN	HISPANIC
Appears to be calm and in charge			
Mean	4.02	4.26	4.33*
Standard error	0.05	0.09	0.12
Rank	22	17	12
Knows where to get information			
Mean	4.47	4.69*	4.54
Standard error	0.04	0.07	0.09
Rank	7	5	5
High energy, physical and mental stamina			
Mean	4.36	4.53	4.42
Standard error	0.04	0.08	0.1
Rank	13	11	9
Patience			
Mean	4.27	4.47	4.35
Standard error	0.04	0.08	0.10
Rank	16	12	11
Good sense of timing			
Mean	4.16	4.34	4.35
Standard error	0.04	0.08	0.10
Rank	18	14	11
Understanding of organization's history			
Mean	3.73	4.05	4.15*
Standard error	0.05	0.09	0.12
Rank	24	18	15
A vision for the future of the organization			
Mean	4.79	4.91	4.71
Standard error	0.03	0.05	0.07
Rank	2	1	2
Open to new possibilities			
Mean	4.68	4.70	4.65
Standard error	0.03	0.06	0.08
Rank	3	4	3
Mission oriented			
Mean	4.52	4.65	4.57
Standard error	0.04	0.07	0.09
Rank	5	6	4
Creativity			
Mean	4.41	4.55	4.46
Standard error	0.04	0.08	0.10
Rank	9	10	7
Entrepreneurial skills			
Mean	4.11	4.28	4.28
Standard error	0.04	0.08	0.11
Rank	19	16	13

TABLE 4 Continued

VARIABLE	WHITE	AFRICAN AMERICAN	HISPANIC
Network building skills			
Mean	4.35	4.59*	4.46
Standard error	0.04	0.07	0.07
Rank	14	8	7
Being analytical			
Mean	4.04	4.39*	4.38*
Standard error	0.04	0.08	0.10
Rank	21	13	10
Good at synthesizing			
Mean	4.09	4.26	4.11
Standard error	0.05	0.09	0.11
Rank	20	16	16
Being an implementer			
Mean	4.20	4.48*	4.25
Standard error	0.04	0.08	0.10
Rank	17	12	14
People oriented			
Mean	4.37	4.56	4.42
Standard error	0.04	0.08	0.10
Rank	10	9	9
Persistent			
Mean	4.44	4.56	4.48
Standard error	0.04	0.07	0.09
Rank	8	9	6
Take responsibility, do not blame other			
Mean	4.51	4.65	4.57
Standard error	0.04	0.07	0.10
Rank	6	6	4
Competitive			
Mean	3.85	4.30	4.44*
Standard error	0.05	0.10	0.13
Rank	23	15	8
Understands external environment			
Mean	4.53	4.63	4.48
Standard error	0.04	0.07	0.10
Rank	5	7	6
Fairness			
Mean	4.44	4.74*	4.57
Standard error	0.04	0.07	0.09
Rank	8	3	4
Achievement oriented			
Mean	4.28	4.53*	4.44
Standard error	0.04	0.05	0.10
Rank	15	11	8
Honesty/integrity			
Mean	4.82	4.87	4.75
Standard error	0.03	0.05	0.06
Rank	1	2	2

TABLE 4 Continued

VARIABLE	WHITE	AFRICAN AMERICAN	HISPA
Concern for others			
Mean	4.58	4.65	4.48
Standard error	0.04	0.07	0.09
Rank	4	6	6
Business oriented			
Mean	4.38	4.63*	4.46
Standard error	0.04	0.08	0.09
Rank	11	7	7

*Significant at < 0.05 level.

Of lesser importance, but also significant, were characteristics identifie refute the stereotypical biases that are often consciously or unconscio arguments against minorities and women as effective managers. Afr American administrators indicated the importance of appearing calm an charge, showing patience, having analytical ability, and being fair.

The least supported theory was the racial deficiency theory. Havi business orientation was rated significantly higher by African American ministrators, suggesting that they believe such an orientation is necessa refute the notion of perceived deficiency in their management potential the other hand, Hispanic administrators responding to training needs r the need for a formal degree significantly higher; Hispanic administra however, ranked lowest in current degree level attained.

The managerial characteristics identified by African American CHC/M administrators as important to success as administrators can be linked t three of the theoretical approaches that explain the lack of advancemen minorities in top management positions. However, African American ad istrators appear to identify more characteristics that match elements o systemic discrimination theory. Recognition that these characteristics ar portant in successful management positions is in itself a self-imposed m nism for minorities to focus on these characteristics and to overcome ba to success.

In reasserting their original commitment to using CHCs as vehicl provide minorities with opportunities in management positions, policy ers can use the results of this study to design training programs to ensur African American administrators of CHC/MHCs receive career and awareness training, mentoring, and leadership development in additi skill-building training.

Conclusion

The nation's CHC/MHCs are the major safety net health care provid the nation's poor and minorities who live in medically underserved rura

TABLE 5

EDUCATION DEGREES AND RELATIVE NEED FOR ADDITIONAL KNOWLEDGE AND SKILLS BY AFRICAN AMERICAN, WHITE, AND HISPANIC COMMUNITY AND MIGRANT HEALTH CENTER ADMINISTRATORS, 1994

VARIABLE	WHITE	AFRICAN AMERICAN	HISPANIC
Communication skills			
Mean	5.04	5.32	5.88
Standard error	0.13	0.23	0.30
Rank	6	5	2
Leadership skills			
Mean	5.36	5.70	5.48
Standard error	0.09	0.18	0.23
Rank	2	1	6
Financial management			
Mean	5.36	5.70	5.69
Standard error	0.09	0.16	0.20
Rank	2	1	3
Human resources management			
Mean	5.31	5.43	5.47
Standard error	0.08	0.15	0.20
Rank	3	3	7
Strategic planning			
Mean	5.76	5.03	6.03
Standard error	0.14	0.25	0.32
Rank	1	6	1
Policy development			
Mean	5.07	5.47	5.63
Standard error	0.09	0.16	0.42
Rank	5	3	4
Formal degree program			
Mean	3.67	4.35	5.38
Standard error	0.13	0.22	0.33
Rank	7	7	8
Decision-making skills			
Mean	5.14	5.36	5.52
Standard error	0.11	0.20	0.25
Rank	4	4	5

inner-city areas. In a time of major revolution in the provision and financing of health care, there is great concern over the viability of CHC/MHCs. Can they survive in the competitive and highly sophisticated world of managed care? Do their administrators have the management skills to lead their institutions to survival while maintaining the central mission of service to the poor and minorities? The findings of this study suggest that the answer to both questions is yes. The study found high levels of education and minority leadership among the nation's CHC/MHCs. The study also found a high level

of commitment to the provision of geographic access and providing health services to the poor, as well as an appreciation for the need for leadership and administrative characteristics in making CHC/MHCs successful.

In looking at CHC/MHC administrators' perceived training needs, this study found subtle differences between African American, Hispanic, and white administrators. This presents a major opportunity to tailor management training to meet specific needs of minority managers. In addition, the findings on managerial characteristics will be useful in developing training programs for minority managers. These insights should be valuable to academic institutions as well as the federal managers of CHC/MHC funding.

The study also confirms the viability of the model devised by the founders of the Neighborhood Health Center movement. The model had multiple goals: delivering health services on a geographical basis, community governance of health services, community development, research, and professional upward mobility. It is interesting to note that most of these elements are included in today's managed care model. It will be of further research interest to follow the careers of CHC/MHC administrators and staff trained in this model as managed care coverage increases. What will be the role in managed care within and outside of CHC/MHCs? A reasonable hypothesis is that many of them will be recruited by managed care organizations seeking to serve minority and poor populations.

The most important finding of this study is that one of the Great Society programs not only succeeded but in many ways is a model for all primary and preventive health care. It has also demonstrated the power of equal opportunity in the success of women and minorities in obtaining the most senior position in individual CHC/MHCs. It is our hope that the leadership in both public and private health care will benefit from the positive experience of the CHC/MHC administrators and modify their recruitment, training, and retention programs to apply these findings throughout the entire U.S. health care system. This can result only in a better system responsive to the needs of our diverse society.

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