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**A Profile of Women CEO's/Administrators in Community and
Migrant Health Centers**

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in

Community and Migrant Health Centers

by

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ABSTRACT

Most of the current research on women executives has focused on models in which few women achieve the highest position (e.g. hospital CEOs). This article looks at the nation's Community and Migrant Health Centers where substantial numbers of women hold the highest executive position. A national profile of women Community and Migrant Health Centers (C/MHCs) Chief Executive Officers / Administrators is provided in terms of their personal and work characteristics, as well as their values and beliefs regarding successful C/MHC attributes and important managerial practices. The study compares C/MHC Chief Executive Officers / Administrators based on gender. The study found that 41% of the CEO/Administrators were women and that they shared similar values and beliefs about functions/critical managerial factors and managerial characteristics of C/MHCs with their male colleagues. However, the study did find a comparable salary differential of over \$11,000 in favor of male Chief Executive Officers / Administrators. The article reviews the literature of female executives in healthcare and concludes with recommendations for further study using the C/MHCs CEO/Administrators as a model study population.

INTRODUCTION

This study is an analysis based on a 1994 survey of Community and Migrant Health Centers. The purpose of that survey was to profile the CEO/Administrators, which had never been done before. The study found that 41% of the CEO/Administrators were women. This unanticipated finding led to the article that follows. To pursue this line of research a retrospective literature search on women executives in healthcare was undertaken and matched to the findings of the survey. The resulting study is limited by the original survey instrument design; however it is hoped that the limited findings and the literature search provide a basis for more directed research on women CEO/Administrators in Community and Migrant Health Centers.

BACKGROUND

Community and Migrant Health Centers (C/MHCs) are the primary care safety net programs for the poor and underserved populations of the US. They incorporate the concepts of comprehensive and coordinated health services along with continuity of care within a single institutional setting by providing integrated care, including primary and preventive care services. Their central mission is to provide community-oriented primary health care services to improve the health status of medically underserved populations. The center must serve a medically underserved area or population to qualify for grants from the Bureau of Primary Health Care, Health Resources and Services Administration. Evaluative studies have documented the effectiveness of the C/MHC program in alleviating access problems of the rural poor by improving the distribution of health resources (Sardell 1988). By promoting the use of primary care services, C/MHCs reduce hospitalizations, length of stay, and emergency room use among their patients (Stuart and Steinwachs 1993). The federally supported and other community health centers serve over 10 million patients and have a budget of more than a billion dollars from a variety of funding sources. (National Association of Community Health Centers 1998). The role of the C/MHC CEO/Administrator is comparable in complexity and scope to that of a hospital CEO, except in the smaller projects.

C/MHCS have traditionally supported interdisciplinary patient care through the use of nurse practitioners, physician assistants, and nurse midwives (Samuels and Shi 1992; Shi, Samuels, Konrad, Ricketts, Stoskopf and Richter 1993). They have promoted upward mobility in their administrative structure (Samuels, Shi, and Glover 1995). The historical roots of C/MHCS are in the Neighborhood Health Center Movement and have stressed the importance of education and upward mobility (Sardell 1988). That 41% of C/MHC's CEOs are female suggests that the C/MHC movement and its' approach to education, equality and upward mobility may provide a model for equal opportunity in the broader healthcare community.

WOMEN IN HEALTHCARE MANAGEMENT

Women have been entering the work force in increasing numbers over the last fifty years and now comprise 45 percent of the US work force. One third of administrative, executive and management positions are now held by women, but women hold only five to 10 percent of senior executive positions (Bierema 1994). In 1980, 80 percent of those employed in health care were women, but only 4 percent of all hospital chief executive officers (CEOs) were women (Muller and Cocotas 1988; Friedman 1980). Forty-six percent of health care managers at all levels in 1980 were women; five years later that number had increased to 57 percent (Caplan, LeRoy, Rosenthal, and Shyavitz 1988). Rohrer and Dellaportas (1982) reported that 26 percent of all directors of local health departments were female with two thirds of the smallest departments headed by females (usually nurses). Men (physicians) were more often found in charge of larger health departments.

In the early twentieth century virtually all hospital administrators were women, either nurses or members of Catholic religious orders (Appelbaum 1975; Friedman 1980; Haddock and Aries 1989). By mid-century, hospital administrators were frequently physicians, were almost always promoted from within the institution, and, except for Catholic hospitals, which were headed by religious orders, were always male (Borkowski and Walsh 1992). In 1980, only 74 of the 300 known female hospital CEOs were not members of a religious organization (Caplan,

McGarvey, Rosenthal, and Shyavitz 1984). By 1985, the number of women CEOs (not members of religious orders) rose to 121 of 341 (Haddock and Aries, 1989), and by the early 1990s, there were about 600 female CEOs (Borman and Biordi, 1992).

Until the 1950s there were virtually no formal programs for education in health care administration (Borkowski and Walsh, 1992). In 1973, only 23% of the graduates of health care administration programs were women (Appelbaum 1975), but by 1979 women comprised 40 percent of graduates of programs affiliated with the Association of University Programs in Health Administration (AUPHA). Less than ten years later, 59 percent of health care administration graduates entering the work force were women (Borkowski and Walsh 1992), and by 1993, 61 percent were female (Wiggins 1996). Even so, most top administration positions were filled by men (Borkowski and Walsh 1992), undoubtedly due to the attitudes of the (male) medical staff and hospital management (Appelbaum 1975; Friedman 1980; Dempsey-Polan 1988; Haddock and Aries 1989). Muller and Cocotas (1988) felt that the increased enrollment of women in graduate programs in health care administration was indicative of the opportunities that would be becoming available for women in this field. Citing a study reported in 1985 in the *Harvard Business Review*, they listed health care as one of several areas in business where women seemed to have greater opportunity to move to top positions. Emily Friedman provided an analysis of women in health care administration in the early 1980s. These women had typically worked in another part of health care before working in administration and had obtained graduate education in health administration after beginning to work in that area. As CEOs, women were more likely to be found in public and multi-hospital systems, Catholic hospitals, and rural hospitals, and they earned 18 percent less than their male counterparts.

The type of organization influences career development. Wiggins (1994) identified two styles of organizations: mechanistic and organic. Mechanistic organizations tend to be centralized and to have rigid rules with strict enforcement and sanctions for those who do not conform. These organizations may be less tolerant of the overlapping roles of work and family of many women, but income for women (and for men) tends to be higher in these organizations

than in organic organizations. Organic organizations recognize the unique contribution of each individual and are more likely to be flexible in dealing with changing situations including family roles of employees. Community and Migrant Health Centers, although they function within guidelines set by the Federal government, would be classified as organic. This is attributable to several factors: local control through a consumer dominated governing board, allowance for services offered and organizational structure relevant to local needs, and flexibility in the role of the CEO/Administrator. Weil and Kimball's study reported in 1996 that income was higher for both men and women in mechanistic organizations than in organizations where family needs were supported. Organic organizations, according to Wiggins (1994), recognize the unique contribution of each individual and are more likely to be flexible in dealing with changing situations including family roles of employees. Income and career advancement opportunities are better for men than for women in these organizations. In either case, Borkowski and Walsh (1992) propose that attributes and culture of the organization play a significant role in selecting people for top positions in the organization.

Borkowski and Walsh (1992) note that as we entered the 1990s, the status of women in health care continued to mirror that of women in the rest of industry despite an increasing number of women having completed health care administration graduate education programs. A study published in 1991 by Levey, Cyphert, Levey, Wesbury, Dolan, Weil and Kimball showed that between 1970 and 1985 increasing numbers of women were entering health administration with a Master's degree in health administration (49% to 71%). Studies by the ACHA in 1984, ACHE in 1989, and Weil and Kimball (1996) show that those who have job-specific training receive higher incomes than those who do not. However, Weil and Kimball (1996) found that in 1990 men in health care administration earned about \$16,000 more per year than women and men were more than women likely to have degrees in health administration, public health and business. While there were more women obtaining graduate education in health care administration and initially receiving salaries comparable to those of their male counterparts, this did not continue as their careers progressed. They were the minority in top management

positions and continued to receive less pay, with a salary gap that approached \$10,000 per year (Borkowski and Walsh 1992; Walsh and Borkowski 1995) at about five to seven years after beginning to work in the field (Wiggins 1996). In other areas of health care, women also lag behind men in advancing into top positions. Walsh and Borkowski (1995) found that men earned more than women at initial employment post-MBA and that the gap widened as they gained experience. In 1996, Weil and Kimball reported that with equal levels of education and experience men earn \$15,000 per year (16%) more than women, but in the group studied in 1990 that had a 20 percent difference in income, there was now a 26% difference in income.

Projections for industry in general show that women will comprise almost half of the US work force by the year 2000, but as of the early 1990s, they comprised only one to two percent of senior or executive management positions and only one third of all the managerial positions (Bierema, 1994).

METHODS

Data

This research is based on data from a 1994 national survey of C/MHC Chief Executive Officers / Administrators conducted by the authors under contract with the National Rural Health Association for the Health Resources and Services Administration, US Public Health Service (Samuels, Shi, and Glover 1995). All C/MHCs in the contiguous United States (n=524) that were Federally Qualified Health Centers (FQHCs) were included. Overall, 85 percent of C/MHC CEO/Administrators (n=443) responded to the survey. Based on Bureau Common Reporting Requirements (BCRR) forms submitted to the Bureau of Health Care Delivery and Assistance as part of the requirement of receiving federal funding, we did not find significant differences between responding and non-responding C/MHCs in terms of center size (either measured by budget, total staff, or medical staff) and scope of services provided.

MEASURES

The survey questionnaire was designed based on an extensive review of the literature regarding CEO/Administrators of health care institutions and a pilot study on South Carolina C/MHC Chief Executive Officers/Administrators. The following five major components regarding Chief Executive Officers/Administrators' attributes were included: (1) demographic characteristics; (2) work characteristics; (3) values regarding critical factors for C/MHC success; (4) beliefs regarding important managerial characteristics for a successful C/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, black, Hispanic, and other), highest educational degree attained (MD, Ph.D. and other doctoral degree, Master of Health Administration-MHA, Master of Public Health-MPH, Master of Business Administration-MBA, other Masters degree, bachelors degree-BA, and without bachelors 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 including medical staff, other clinical staff, board relations, reading/professional development, other grant activity, community matters, team building, crisis intervention, entertaining, federal C/MHC report activity, professional association, and other. 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 the responses to 100 percent.

Values regarding critical factors for C/MHC success were measured with 14 items asking respondents to identify the primary function of C/MHC (3 items) and the most critical factors in C/MHC success (11 items). These factors were obtained through an extensive review of the hospital literature and focus groups with C/MHC CEO/Administrators. A 5-category agreement scale was used to measure responses with 5 indicating "totally agree", 4 "somewhat agree", 3 "not sure", 2 "somewhat disagree", and 1 "totally disagree".

Beliefs regarding important managerial characteristics for a successful C/MHC administrator were based on respondents' assessment of the relative importance of 25 characteristics in identifying a successful C/MHC administrator. A 5-point rating scale was used for each response with 5 indicating "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 these areas using a 7-point scale with 7 as "most needed" and 1 "least needed".

ANALYSIS

Univariate statistics were used to address the study objectives. Sample distributions and means were calculated to draw a profile of C/MHC CEO/Administrators. Bivariate statistics were used to fulfill the second objective of comparing C/MHC women and men CEO/Administrators with different educational preparation in terms of their personal and work characteristics, values and beliefs, as well as their perceived deficiencies. Chi-square statistics were used for categorical variables and analysis of variance for continuous variables. Respondents' rankings of the relative importance of attributes associated with successful C/MHCs and CEO/Administrators were derived from their responses on the rating scales (either 7-point or 5-point scales). Respondents who assigned a higher score to a particular item than another were assumed to rank that item higher. Specifically, two rankings were calculated. The between-group ranking indicates relative ranking among respondents with different education degrees in terms of their perceived importance of a particular item. The within-group ranking indicates how respondents with the same education degrees perceived the relative importance of a particular item.

RESULTS

Personal Characteristics of C/MHC CEO/Administrators

The demographic and some work-related characteristics of C/MHC CEO/Administrators are displayed in Table 1. The mean age of women CEO/Administrators was lower than for men CEO/Administrators. However, women CEO/Administrators had been working in their current position longer than men CEO/Administrators. The most significant finding was that 41% of C/MHCs have women CEO/Administrators. Their reported working hours per week are similar. However, there is a significant difference in annual salary with women CEO/Administrators reporting lower salaries than for men CEO/Administrators. Racial distribution was similar, except for Hispanics. While most women CEO/Administrators had advanced degrees, men CEO/Administrators had a higher rate. The rural/urban distribution for women and men CEO/Administrators was similar.

(Table 1 about here)

Distribution of Activities

Table 2 compares male and female administrators' time distribution of activities. Overall, CEO/Administrators spent the most time on team building, followed by medical staff, professional association, board relations, other clinical staff, efficiency, other grant activity, federal C/MHC report activity, entertaining, reading/professional development, crisis intervention, and community matters. The differences in time distribution of male and female CEO/Administrators were not statistically significant.

(Table 2 about here)

Perceived C/MHC Success Factors

Table 3 displays respondents' rankings on the primary function of C/MHCs and the most critical factors in C/MHC success. Male and female CEO/Administrators were consistent in their rankings on the primary function of C/MHCs: to provide health services to the poor, followed by providing geographic access to services, and becoming self-supporting.

Overall, respondents rated good organizational leadership as the most critical factor in C/MHC success, followed by organization's value to community, efficiency, organizational stability, reputation, effectiveness, community support, physician retention, board support, third-party reimbursement, and grant support. Male and female CEO/Administrators were, for the most part, consistent in their rankings on the most critical factors in C/MHC success. Female CEO/Administrators more highly value "Community support" than their male colleagues.

(Table 3 about here)

Perceived Critical Managerial Characteristics

Table 4 shows the top 25 managerial characteristics perceived to be important for a successful C/MHC administrator. Overall, respondents ranked vision for the future of organization as most important, followed by honesty/integrity, open to new possibilities, understanding external environment, mission oriented, taking responsibility, concern for others, persistent, fairness, knowing where to get information, high energy, people oriented, achievement oriented, business oriented, and creativity. The two factors considered least important were understanding organization's history and being competitive. Male and female CEO/Administrators were, for the most part, consistent in their rankings on the most critical managerial characteristics in C/MHC success. Female CEO/Administrators more highly value "Takes responsibility, don't blame others" and "Know where to get information" than their male colleagues.

(Table 4 about here)

Perceived Additional Training Needs

Overall, respondents expressed greatest training needs in strategic planning, followed by financial management, leadership skills, human resources management, communication skills, policy development, decision-making skills, and formal degree program. Female CEO/Administrators were less likely to express the need for training in "Decision making skills" than their male colleagues.

(Table 5 about here)

Salary by Educational Level.

Overall, women CEO/Administrators earned less than their male counterparts with like educational preparation. In two educational categories, Associate Degree and MD degree, women CEO/Administrators were paid more; however the numbers of CEO/Administrators in these categories were very small and could have been the effect of the influence of unusual levels of compensation. In the two educational categories High School and Bachelors the standard deviation for salaries for males is high or exceeds the mean. High standard deviation reflects significant differences. In this case, administrators with high school or bachelors education vary significantly in terms of their salary. This is because other factors, such as years of work experience and rural/urban location, also contribute to salary level.

(Table 6 about here)

Salary by Educational Level by Year of Degree.

Adjusting for the length of time since the highest formal degree was earned shows that overall women CEO/Administrators with a degree 10 years old or less earned less than their male counterparts. In two subcategories this was not the case. Women with a bachelors level degree 10 years old or less had a higher mean salary than their male counterparts. Women with a doctoral level degree 10 years old or less had a higher mean salary than their male counterparts. The number of female MDs included in this category may explain this. In the educational category BA the standard deviation for salaries for males exceeds the mean. High standard deviation reflects significant differences. In this case, administrators a bachelors education vary significantly in terms of their salary. This is because other factors, such as years of work experience and rural/urban location, also contribute to salary level.

(Table 7 about here)

SUMMARY AND DISCUSSION

The current study has provided a profile of female C/MHC CEO/Administrators. The most important finding is that 41% of all C/MHC CEO/Administrators are female. This is much higher than the estimate of 5-10% of senior executive positions held by women nationally (Bierema 1994). It is also greater than the 4% of hospital CEO positions held by women nationally (Muller and Cocotas 1988; Friedman, 1980). It is also greater than the 26% of local health departments directed by women (Rohrer and Dellaportas 1982). Even allowing for the time differentials in the studies, C/MHCs clearly have an outstanding record in providing career mobility for women CEO/Administrators. In comparing these findings with a profile of women CEOs in hospitals (Friedman, 1980), they are similar in that C/MHCs may be considered public in nature and that female CEOs tend to be in public hospital systems. They differ in that female CEOs tend to be in rural hospitals, while C/MHC CEO/CEO/Administrators have about the same rural/urban distribution as their male peers. This finding can have several explanations. Organizational culture is a major determinate in career mobility. C/MHCs, with their historic commitment to equal opportunity, training, and career development, offer an environment in which women could expect career advancement opportunities. In addition, the patient population of C/MHCs is primarily women and children. The insights offered by this population make C/MHCs more sensitive to women's issues. C/MHCs are committed to providing equal access to care and are less business oriented than their private counterparts. Taken as a whole C/MHCs should be attractive career options for women and their advancement to senior management positions expected. On the other hand, C/MHCs are similar to long term care institutions in that they lack the prestige of more main stream institutions such as hospitals. This would imply that feminization of CMHC's may be a function of this lower status.

Their racial composition is similar to their male colleagues, except for Hispanics (women 8%, men 14%). They have been in their current positions about the same length as men and report working about the same number of hours per week. As a group they have slightly lower educational levels and earn lower salaries. In terms of specific training for healthcare

administration women CEO/Administrators had a about the same percentage of MPH degrees (women 16%, men 14%), but less MHA degrees (women 3%, men 8%). These small numbers make it difficult to compare with studies of hospital CEOs (Applebaum 1975; Friedman 1980; Dempsey-Polan 1988; Hadock and Aries 1989) that suggest even with large numbers of female graduates trained in healthcare administration the CEO positions go predominately to men. Women are also paid less when adjusting for educational levels. In this respect C/MHCs mirror the broader society. The average salary of females is \$11,459. less than their male counterparts. This is comparable to the findings of other studies of male/female salary differences (Borkowski and Walsh 1992; Wiggins 1996; Weil and Kimbell 1996). However, the wide range of salaries for C/MHC CEO/Administrators suggests that considering other factors such as work experience and rural/urban location may narrow that gap. Their perception of the primary functions of C/MHCs is also comparable to male CEO/Administrators. In examining their perceptions of critical factors in C/MHC success, no significant difference were noted. In reviewing their distribution of work time by management activities they are comparable to their male counterparts. One would expect that female administrators to spend more time handling person-related activities (e.g., team building, medical staff, board relations, other clinical staff, entertaining) than their male counter-parts. The fact that no significant differences are observed between male and female administrators on these matters indicates male and female administrators share the same concerns, perform similar roles, and attach similar importance. Part of the shared activities may reflect requirements by funding agencies (e.g., Board relations, other grant activity). The lack of gender differences in managerial activities also may also reflect good communication among C/MHC administrators.

In examining managerial characteristics valued by C/MHC CEO/Administrators there were two significant differences. Women CEO/Administrators ranked "Takes responsibility, don't blame others", "Knows where to get information" and "High energy, physical and mental stamina" as more important than male CEO/Administrators. Female CEO/Administrators were

less likely to express the need for training in "Decision-making skills" than their male colleagues.

The findings of this study are mixed on one hand C/MHCs have a clear record of achievement in providing access to top management for women. On the other hand they appear to have the same salary differential discrimination. Within the limitations of the study they do not appear, as managers, to function differently or hold different values than their male colleagues. The study does demonstrate an opportunity for further research on female CEO/Administrators. Studies designed specifically for this purpose could examine their career progression, the availability of mentors, the influence of family, and their personal goals and identification of barriers and facilitators in reaching them. There should also be further studies that examine the differences between C/MHCs and other health services delivery systems in terms of organizational goals, values, structures, and status, This would set the stage for more definitive studies that could compare women's career potential within the context of differing organizational cultures. The authors hope that identification of the success story in Community and Migrant Health Centers will encourage researchers in women's issues to direct their future studies to this little studied program that is the major "safety net" healthcare provider for the nation's unserved and underserved populations.

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Table 1. Demographic and Job Related Characteristics of Male/Female Community and Migrant Health Center (CHC/MHC) CEO/Administrators, 1994

Variables	Male		Female	
	Mean (Standard Deviation)		Mean(Standard Deviation)	
<i>Age (mean)</i>	48.6 (.49)		46.8 (.58)	
<i>Years of Current Employment</i>	8.7 (.43)		9.3 (.51)	
<i>Average Hours Worked per Week</i>	51.5 (.56)		49.6 (.68)	
<i>Current Annual Salary</i>	\$62,891. (\$2,069.)		\$51,432. (\$2,468.)	
	N	(%)	N	(%)
<i>Respondents</i>	261	(59%)	179	(41%)
<i>Race</i>				
White	166	(64%)	119	(67%)
African-American	49	(19%)	37	(21%)
Hispanic	37	(14%)	15	(8%)
Other	6	(3%)	7	(4%)
<i>Highest Education Degree</i>				
Less than BA	13	(5%)	22	(8%)
BA	65	(25%)	56	(33%)
Other Masters Degree	75	(29%)	34	(20%)
MBA	18	(7%)	9	(5%)
MPH	36	(14%)	28	(16%)
MHA	20	(8%)	5	(3%)
MD	12	(5%)	2	(1%)
Ph.D.	20	(8%)	13	(8%)
<i>Location</i>				
Rural	161	(62%)	116	(65%)
Urban	100	(33%)	63	(35%)

Table 2. Distribution of Time by Male and Female Community and Migrant Health Center (CHC/MHC) CEO/Administrators, 1994

Variables	Male	Female	P-value
Team building			
-Mean %	13.4	13.4	.9953
-Standard deviation	.6	.8	
Medical staff			
-Mean %	12.7	11.1	.0777
-Standard deviation	.6	.7	
Board relations			
-Mean %	11.0	10.8	.7021
-Standard deviation	.4	.5	
Community matters			
-Mean %	10.2	10.8	.4367
-Standard deviation	.5	.6	
Other grant activity			
-Mean %	9.8	9.3	.6135
-Standard deviation	.6	.7	
Federal CHC report activity			
-Mean %	8.5	9.2	.4223
-Standard deviation	.5	.6	
Crisis intervention			
-Mean %	8.1	9.3	.2307
-Standard deviation	.6	.7	
Other clinical staff			
-Mean %	7.4	8.3	.1775
-Standard deviation	.4	.5	
Reading/professional development			
-Mean %	6.5	6.7	.8658
-Standard deviation	.4	.5	
Professional association			
-Mean %	4.1	4.2	.7040
-Standard deviation	.2	.3	
Entertaining			
-Mean %	1.3	1.2	.4422
-Standard deviation	.1	.2	

Table 3 Ranking the Values and Beliefs by Male and Female
Community and Migrant Health Center (CHC/MHC) CEO/Administrators,
1994

Variables	Male	Female
The primary function of a CHC/MHC is to:		
Provide geographic access to services	1	1
Provide health services to the poor	2	2
Become self-supporting (without grant)	3	3
The most critical factors in CHC/MHC success is:		
Good organizational leadership	1	1
Organization's value to community	2	2
Efficiency	3	7
Effectiveness	4	5
Organizational stability	5	3
Organization's reputation	6	4
Physician retention	7	8
*Community support	8	6
Board support	9	9
Third-party reimbursement	10	10
Grant support	11	11

* P<.01

Table 4. Ranking of 25 Managerial Characteristics by Male and Female
Community and Migrant Health Center (CHC/MHC) CEO/Administrators,
1994

Variables	Male	Female
Honesty/Integrity	1	1
A vision for the future of the organization	2	2
Open to new possibilities	3	3
Concern for others	4	7
Understands external environment	5	9
Mission oriented	6	6
Fairness	7	8
*Take responsibility, don't blame others	8	4
Persistent	9	10
*Knows where to get information	10	5
Creativity	11	14
Network building skills	12	15
Business oriented	13	13
Achievement oriented	14	17
*People oriented	15	12
*High energy, physical and mental stamina	16	11
Patience	17	16
Being an implementer	18	18
Entrepreneurial skills	19	25
Good sense of timing	20	19
Analytical	21	21
Good at synthesizing	22	22
Appears calm and in charge	23	20
*Understanding of organization's history	24	24
Competitive	25	25

* P<.05

Table 5. Relative Need for Additional Knowledge and Skills by Male and Female Community and Migrant Health Center (CHC/MHC) CEO/Administrators, 1994

Variables	Male	Female
Strategic planning	1	1
Leadership skills	2	3
Financial management	3	2
Human resources management	4	5
*Decision making skills	5	7
Communication skills	6	6
Policy development	7	4
Formal degree program	8	8

* P<.05

Table 6. Salary by Educational Level by Male and Female
Community and Migrant Health Center (CHC/MHC) CEO/Administrators,
1994

Variables	Male Mean (Standard Deviation)	Female Mean(Standard Deviation)
High School	\$41,550. (\$40,733.)	\$36,100. (\$12,368.)
Associate Degree	\$44,288. (\$9,009.)	\$49,905. (\$17,506.)
Bachelors Degree	\$65,144. (\$67,424.)	\$49,905. (\$17,506.)
Other Masters Degree	\$59,057. (\$16,263)	\$58,423. (\$14,455.)
M.B.A.	\$65,283. (\$18,021.)	\$52,968. (\$22,485.)
M.P.H.	\$66,408. (31,076.)	\$55,719. (\$18,996.)
M.H.A.	\$60,350. (\$17,202.)	\$54,200. (\$15,611.)
M.D.	\$75,090. (\$35,093.)	\$85,000. (\$14,142.)
Other Doctoral	\$73,136. (\$31,204.)	\$64,316. (\$17,207.)
Ph.D.	\$71,688. (\$15,576.)	\$51,112. (\$26,620.)

Table 7. Salary by Educational Level by Year of Degree by Male and Female
Community and Migrant Health Center (CHC/MHC) CEO/Administrators,
1994

	Highest Degree	Year of Degree	Salary Mean(Standard Deviation)
Female	Less than BA	< 10Years	\$28,500. (\$3,536.)
Male	Less than BA	< 10Years	\$41,622. (\$33,992.)
Female	Less than BA	≥ 10Years	\$36,951. (\$11,419.)
Male	Less than BA	≥ 10Years	\$41,622. (\$33,992.)
Female	BA	< 10Years	\$43,046. (\$13,586.)
Male	BA	< 10Years	\$36,717. (\$7,899.)
Female	BA	≥ 10Years	\$50,844. (\$18,034.)
Male	BA	≥ 10Years	\$68,666.(\$70,748.)
Female	Masters	< 10Years	\$48,833. (\$17,429.)
Male	Masters	< 10Years	\$57,554. (\$14,193.)
Female	Masters	≥ 10Years	\$59,717. (\$16,308.)
Male	Masters	≥ 10Years	\$62,878. (\$22,149.)
Female	Doctoral	< 10Years	\$67,913. (\$13,916.)
Male	Doctoral	< 10Years	\$54,000. (\$14,787.)
Female	Doctoral	≥ 10Years	\$59,344. (\$26,278.)
Male	Doctoral	≥ 10Years	\$78,424. (\$29,291.)