A Race/Ethnic Comparison of Career Attainments in Healthcare Management
Summary Report—2002

Background

A 1992 joint study by the American College of Healthcare Executives, an international professional society of healthcare executives, and the National Association of Health Services Executives, whose membership is predominantly black, compared the career attainments of their members. The study found that, although blacks and whites had similar educational backgrounds and years of experience in the field, blacks held fewer top management positions, less often worked in hospitals, earned 13 percent less, and were less satisfied in their jobs. A set of specific actions was recommended to leaders in the field, employers of black healthcare executives, and black healthcare executives themselves. The report also concluded that another study should be conducted in three to five years to determine whether career outcomes improved for black healthcare executives compared with their white counterparts.

Following the study's publication, ACHE, the American Hospital Association, and NAHSE sponsored the formation of the Institute for Diversity in Health Management. Later, the Association of Hispanic Healthcare Executives and the Catholic Health Association became sponsors as well. The Institute for Diversity in Health Management is committed to expanding healthcare leadership opportunities for racially/ethnically diverse individuals and increasing the number of these individuals entering and advancing in the field.

In 1997, ACHE, AHHE, and NAHSE, in collaboration with the IFD, conducted a national survey of white, black, Asian, and Hispanic healthcare executives. That research showed that disparities in the proportions of top-level management positions continued to exist between white women and minority women but that there were no significant differences in the proportion of top positions held by male managers in the various race/ethnic groups. Other measures of career attainment continued to show disparities between whites and minorities: whites were more often employed in hospitals and, in general, expressed higher levels of satisfaction with various aspects of their jobs. While the earnings gap grew between white and black women, it narrowed between white and black men. (Other minority executives' earnings fell between the white and black averages.)

The study initiated several suggestions, directed to four different audiences. Practicing healthcare executives were asked to publicize career advancement opportunities such as continuing education, networking events, and job vacancies inside the organization and elsewhere; they were also asked to develop specific criteria for advancement in management that could be used to help identify and promote qualified minorities.

Executive search consultants were counseled to use the resume banks of NAHSE and ACHE when conducting senior-level searches and to urge their clients to consider minority executives for senior-level positions. Professional societies were encouraged to meet annually to discuss progress and issues related to diversity in healthcare management and to conduct a follow-up survey in five years. Finally, minority executives were encouraged to obtain graduate degrees, pursue postgraduate fellowships, and ask practicing executives to serve as their mentors and coaches.

The central objective of this third cross-sectional study is to determine if the race/ethnic disparities in healthcare management careers have narrowed since 1997 based on a similar pool of respondents. In planning this study, leaders of ACHE, AHHE, IFD, and NAHSE invited the collaboration of the Executive Leadership Development Program of the Indian Health Service so that the career attainments of Native American executives could also be assessed.

Methods

A survey instrument was prepared consisting mainly of items from the 1997 instrument, and was administered in 2002. The sample of white healthcare executives, containing equal numbers of men and women, was drawn from among ACHE affiliates. Black executives were sampled from ACHE and NAHSE membership databases. The survey was also administered to all currently employed Hispanic, Asian, and Native American affiliates of ACHE, to the Hispanic members of AHHE, and to a list of Native American executives supplied by ELDP.

The breakdown of responses and response rates to the survey was: blacks - 526 or 33 percent; whites - 779 or 48 percent; Hispanics - 215 or 48 percent; Asians - 118 or 49 percent; and Native Americans - 68 or 44 percent. Not only are there very few Native Americans in this study, but half of them are employed in the federal government's Indian Health Service. Therefore the findings for this group can only be considered suggestive and more definitive findings await a larger sampling frame and more respondents. Aggregating all these groups, the survey was sent to a total of 4,023 individuals. By the end of the study, 1,706 responses were received, of which 1,621 were useable. The overall response rate was 41 percent. (Table 1)

To control for the effects of gender, findings are reported separately for women and men in each of the race/ethnic groups. In this summary, results for the gender groups are aggregated when their differences were unimportant. Overall, it should be noted that especially when findings are disaggregated by both race/ethnicity and gender, that there are few responses (e.g., 27 Native American women, 37 Native American men, 49 Asian women, and 65 Asian men). A non-response analysis based on ACHE data showed respondents were not significantly different from non-respondents in age, field of highest degree, position level attained, or employing organization. However, more non-respondent women had attained a bachelor's degree only.

Major Findings

A note on demographic comparisons (Table 2):
In this sample, whites and Native Americans were older than blacks, Hispanics, and Asians. The implications are that given who answered the questionnaire, whites (and a few Native Americans) will likely have had more experience and therefore will display more favorable career outcomes, including higher-level positions and higher earnings. To help address these differences, some of the outcomes, such as compensation, present data that control for years of experience in healthcare management. Other attributes of the sample that might affect career outcomes and attitudes are that (1) proportionately few black and Asian women were married, and (2) when compared with blacks, whites, and Asians, fewer Hispanics and Native Americans had attained graduate degrees.

Career Outcomes

Position level (Table 3).The proportion of top-level management positions (defined as CEOs, COOs, and senior vice presidents) varies by gender. Among women, a disproportionately large share of whites continue to hold top-level positions (40 percent) when compared with minorities: blacks (26 percent), Hispanics (25 percent), Asians (24 percent), and Native Americans (28 percent). With one exception, a higher proportion of men than women held top-level positions no matter what their race/ethnicity. White men in top positions exceeded minority men by a wide margin. Thus, 62 percent of white men compared with 44 percent of black, 47 percent of Hispanic, 34 percent of Asian, and 46 percent of Native American men held top-level positions.

Current area of responsibility (Table 4). Corresponding to their higher positions, white women and white men are more likely than their minority counterparts to serve in general management positions. Conversely, minorities more often supervise single business disciplines such as finance or human relations, or manage sectors such as ambulatory care or associations.

Employing organization (Table 5). About 60 percent of all minority respondents report being employed by hospitals, compared with about 75 percent of whites. Those that work in hospitals show differences by race/ethnicity. Whites, for example, manage hospitals that on average have between 200 and 300 beds. But minorities are often found in larger hospitals, a characteristic of many hospitals under government ownership. (Native Americans report managing very small hospitals—under 75 beds.) Blacks, whites, Hispanics, and Asian women most typically work in not-for-profit secular settings; Asian men (and Native American men and women because of the unique sampling procedure) most typically are employed in governmental settings.

Mentoring (Table 6). Approximately 60 percent of black and white women serve as mentors, compared with less than 50 percent of Hispanic women and even fewer Asian and Native American women. But among men, more blacks—over 70 percent—take on

this role than whites (57 percent), Hispanics (58 percent), Asians (48 percent), or Native Americans (51 percent).

Compensation (Table 7). Respondents reported their median salary plus bonus for the year 2001. Among women, whites earned the highest compensation—$104,000. The next highest salary was earned by blacks—$79,800. Even though these are the actual median salary and bonus data reported, strictly speaking, we are not comparing like groups. Since whites in the sample were older, they also accrued more experience and therefore could be expected to earn more. To achieve a better indicator of income disparity, we tried to determine what the salary and bonus outcomes would be for all of the groups if they had the same experience and education that whites had. The data show that indeed, minority women would have earned higher compensation than they report but they would continue to earn less than white women do. Thus, even if minority women had achieved the same levels of experience and education that white women achieve, their incomes would be lower. Of the three minority groups considered, Hispanic women appear to be more highly remunerated than blacks. (There were too few Asian and Native American respondents to determine income controlled for education and experience.)

Among men, whites again earned the highest compensation—$118,800—followed by Hispanics at $103,700. What would happen if the minority groups achieved the same education and experience levels of the white men? Here the picture is different from the women respondents. The data show that with education and experience levels identical to whites, black and Hispanic men's salaries and bonuses would have approximated that of their white counterparts. (There were too few Asian and Native American respondents to determine income controlled for education and experience.)

This initial attempt to consider the experience of whites relative to minorities' compensation has shown that unexplained income disparities continue to exist among women but less so among men.

Job satisfaction (Table 8). Black women expressed less satisfaction than whites with their pay and fringe benefits, job security, the respect they received from their supervisor, and the sanctions and treatment received when they made a mistake. Black women, along with Asian women, were also less satisfied than white women with the respect they received from subordinates. However, there were no important differences among the race/ethnic groups relative to their satisfaction with their autonomy: Hispanic, Asian, and Native American women's satisfaction generally fell between the satisfaction levels of blacks and whites.

Men showed a mixed picture with respect to job satisfaction. Black men were less satisfied than whites with pay and the respect they got from supervisors. In addition, black men, along with Native Americans, were less satisfied than other groups with their treatment when they made a mistake. However, all of the responding groups expressed high levels of satisfaction with their autonomy and to a lesser extent, the security of their positions.

Job commitment (Table 9). Based on a previously validated scale, the data show that overall, fewer blacks feel emotionally attached to their organization, feel like the organization's problems are their own, or feel that their organization has great personal meaning for them. Black females and Asian males were least likely to feel like "part of the family" at their organizations or to enjoy discussing their organization with outsiders; they were also least likely to state that they would be happy to spend the remainder of their career at their current organization. In contrast, whites expressed the highest levels of job commitment along these measures. With the above noted exceptions, Hispanic, Asian, and Native American respondents fell between those ratings given by whites and blacks.

Education and Early Career Experiences

Note: The tables referenced in this and subsequent sections of the Executive Summary are located in the full report, available online in the Publications area of ***ache.org****.*

Nearly all respondents in all groups, except for Native Americans, have a graduate degree. With the exception of Hispanic women and Native Americans, the majority of all respondent groups that took graduate degrees did so in healthcare management (Table 13).

A higher proportion of all the groups took internships than took residencies or fellowships. While about a third of all the men had an internship, the women varied in having such experience. Half or more of the men taking a residency were subsequently hired by that organization, but greater variation was observed among the women. Black and Asian women were more likely than any other group to have taken a fellowship (Table 14).

A majority of all groups report having had a mentor and most of those who did not said they wished they had had one. About half of the blacks and Hispanics identified whites as their main mentor; even larger proportions of Asians said their main mentor was white. Fully 95 percent of whites identified whites as their main mentor (Table 15).

Compared with whites, more minorities launched their careers in government; whites more often began in organizations under not-for-profit church auspices (Table 16). Except for Native American women, on average, women have worked for about three organizations in their careers and have held an average of four positions in healthcare management. White women, who are older and more experienced than their minority counterparts, typically have held five managerial positions. On average, men in the study worked for four organizations and held five to six positions in healthcare management. However, black and Native American men worked for an average of three organizations and held an average of four positions (Table 17).

When compared with other women, more blacks said they were willing to relocate to a different city for an attractive career opportunity. Black and Hispanic men were also more willing to relocate to another city for their career advancement than other groups.

But less than a third of all women and less than half of all men said they would relocate for a career opportunity in a rural or semi-rural location.

A majority of blacks, a third of Hispanics and Asians, and a fifth of Native Americans claim that their careers were negatively affected by racial/ethnic discrimination. Except for Native American men, each race/ethnic minority group is less satisfied with its career progression than whites. (Table 19). According to one respondent:

> *I have noted numerous African American women who have become self-employed after numerous lateral moves in healthcare management. Many of us found our career tracks interrupted by childbearing, and were not able to regain status or similar opportunities as our white male counterparts of similar educational backgrounds and experience. I also see fewer minority executives in senior-level positions across the country than I did 10 years ago. Executives no longer seem to appoint people to positions based on their talent and potential, but on their prior experience and comfort with someone's "precise" prior experience. In order for minorities in healthcare to advance, because we are few, executives will need to place (hire) for talent, not just on precise replication of experience.*

Current Organization

The work environment continues to represent a fertile place for possible explanations for the lower career attainments of minorities in healthcare management. More white healthcare executives than minorities took high-level first positions in the organizations for which they currently work. Moreover, we saw that whites were promoted to higher-level positions to a greater extent than their minority counterparts. Importantly, all of the race/ethnic groups learned about the availability of their current positions in very similar ways—notably, through their professional networks and via promotions (Table 20). Here is how one respondent characterized the importance of a personal network:

> *Personal networking contributes to many, many job placements. If minorities are not visible because they're in public hospitals, long-term care, etc., and if they're not known through LOCAL programming (and to a much lesser extent, national programming) of professional organizations, hospital or health system executives don't think of them or even know to include them as candidates for management positions.*

Despite their differences in having achieved higher-level positions, minorities and whites are about equally optimistic (or pessimistic) about the likelihood of their being promoted in the coming year (Table 22) .

Minorities and whites work in predominantly white organizations serving white populations. In addition, the direct reports of these managers are disproportionately white as well. Finally, a majority of minority managers (except Native Americans)

report to a white supervisor (Table 23). Despite these findings, one black respondent commented:

> *Many hospitals may serve 50 percent African American people and have an even larger proportion of African American employees, and yet have no representation at the senior managerial level. Then, when the hospital loses money year after year, the question of what to do continues to go unanswered. Many hospitals fail to attach themselves to the communities they serve or who is serving them!*

On the whole, the policies of respondents' employing organizations were quite similar for all groups, but more whites reported that their organizations offer job sharing opportunities than did minorities. Black males continue to report that their organizations more often fill upper-level management slots from the outside (Table 24). As one respondent suggests, more organizations should develop its executives internally:

> *I believe some white executives and board members view a black person in a senior position in much the same way as those within the NFL view a black quarterback or head coach. Due to ignorance, I believe those in decision-making positions believe a black person cannot lead a healthcare organization. Across the board in healthcare there is not a lot of succession planning. Organizations are starting to realize they need to develop their own leaders. When organizations develop their own leaders they need to include and select minority candidates. By developing minority candidates for the future, healthcare may see an even racial balance in executive leadership.*

Individual efforts within the organization showed that white women worked longer hours than black women at work but black women reported working more hours outside the office (Table 25). White managers continue to be more involved in recruiting physicians and administrators than minorities (Table 26). Overall, minorities and whites socialize with other managers to a roughly similar extent—including going to lunch, going out after work, having dinner, or attending cultural or sporting events (Table 27). One respondent commented:

> *I think minorities who prove themselves to be capable and socialize with the majority race are recognized by the organization. In our health system, there are blacks who hold senior VP positions. There are also minority managers who are well respected by their peers or supervisors.*

Another respondent wrote:

> *I think there is a general misperception that if you are not white and have an accent, you are not bright and competent enough to be promoted. I have attained a CEO position because I worked much longer hours and harder (took on more assignments) just to prove my competence. Even then, there were always others who doubted whether*

> *or not I was adequate! I have seen other less competent whites move ahead much faster than me, and I realized retrospectively that they were promoted because they were in the social network.*
>
> *Minorities tend to be excluded from the inside events and parties, so they can never penetrate the mental prejudices. "Inside" organizational information is not shared freely, as if minorities would not be smart enough to comprehend.*

Finally, a black women conscious of the differences in class often evidenced between racial/ethnic groups wrote:

> *As an African American female having to come up through the ranks, it's difficult to assimilate into the executive healthcare community when you are playing "catch up." As positions become available, minorities are often left out from the professional network because they aren't readily available in the finest neighborhoods, not seen at the theatre, can't afford tickets to sporting events, etc. The average white person is totally clueless as to how past circumstances of African Americans still affect the present and the future.*

Blacks and whites are at opposite poles when considering their organizations' fairness in areas such as compensation—66 percent of blacks believe their organization is fair, compared with 83 percent of whites; promotion—65 percent of blacks vs. 85 percent of whites; and recognition—69 percent of blacks vs. 85 percent of whites (Table 28). Blacks feel their organizations are not treating them as fairly as whites, for example, more blacks than whites feel that minorities need to be more qualified than whites to obtain positions and that race relations need to be improved (Table 29). About a third of blacks and less than 5 percent of whites believed they experienced racial/ethnic discriminatory acts in the past five years—acts such as not being hired or being evaluated with inappropriate standards. Moreover, nearly half of black women (and a third of black men) said they failed to be promoted or receive fair compensation because of their race/ethnicity in the past five years. In these comparisons, Hispanics, Asians, and Native Americans fell between whites and blacks both in objective and most subjective measures (Table 30). Following is how one respondent perceives the inequities in promotions to arise:

> *When many of these positions become vacant, they are filled with individuals who are either familiar with the peer group of similarly employed people or have similar interests to them. While a minority candidate might be equally qualified as a white candidate, because individuals influencing candidate selection may feel that they have little in common with the minority candidate, they may feel ill-positioned to assess the candidate and therefore choose the familiar (one).*

One black healthcare executive said that minorities need a high emotional quotient and must be more visible in order to advance:

> *White and black professionals in healthcare do not often socialize in the same arenas, thus giving white up-and-coming professionals an*

advantage because most senior leaders in healthcare are white and many socialize in these same settings. When whites and blacks do socialize together, often the conversations are superficial. Black professionals have to make a special effort to endear themselves to white senior leaders so white leaders can get to know that (black professional) person on a more in-depth level, which leads to opportunities to show one's skill and talent in healthcare administration.

Often white up-and-coming professionals are afforded greater (because of relationships) access to visible projects than up-and-coming black professionals. Thus, senior leaders more often see the ability of the white healthcare professional than the black healthcare professional. Lastly, stereotypes of black healthcare professionals cloud our performance. We have to be 10 times better to get any recognition.

Career Expectations

More black and Asian women intend to leave their employers in the coming year than other groups (Table 31). More men than women had a definite career plan and more blacks and Hispanics expressed an interest in working in non-hospital settings than whites did (Tables 32, 33). Significantly fewer black and Asian men expressed a desire to be a CEO than white men (Table 34). While all groups would initially turn to their personal network if they were planning a job change, the second most popular source of assistance for blacks and whites of both genders, as well as Hispanic men, was executive search firms. Hispanic women and Asians of both genders list electronic job listings as their second most preferred source of assistance (Table 35).

General Attitudes and Policies Promoting Equity

Minority respondents feel that minorities garner greater support from their subordinates than do whites; whites disagree. On the other hand, most respondents do not feel that supervisors give more support to minority managers. But minorities say that their evaluations are less thorough and careful than whites'. In evaluating their colleagues, minorities feel that whites fail to share growth and career-related information with them. Moreover, minorities stated that the quality of all their collegial interactions—with both other minorities as well as whites—could be improved. Blacks especially felt that white managers have greater opportunities to advance than minorities. Nevertheless, despite these expressions of need for improved relationships, about 90 percent of each race/ethnic group would recommend the field to a young person today (Table 36).

Overall, respondents agreed that managers should, as part of their role responsibilities, influence their staff's views on racial/ethnic relations. The majority also believe it is the manager's role to speak out and take a public position on equal employment opportunities. However, about half of the white respondents were either neutral or opposed to efforts to increase the percentage of race/ethnic minorities in senior

healthcare management positions. Most supportive were blacks—nearly all endorsed the idea; more than 80 percent of all the remaining race/ethnic groups (excluding Asian men) also supported such efforts (Table 37). One black male respondent noted:

> *Just as we are mounting a campaign against racial and ethnic disparities in the delivery of healthcare so too must a battle be waged to ensure opportunities exist for minorities to advance to senior-level positions in healthcare management. The issue is commitment to the profession as evidenced first by minorities seeking to enter it, then by senior leadership (some of the best and most highly trained minds in the country) doing everything they can to facilitate knowledge sharing, mentoring, and appropriate/timely promotion of those who demonstrate the capacity and skill for advancement—at the same time as or ahead of their peers.*

A majority of respondents did not think that white executives expose themselves to risks in promoting diversity initiatives. However, about a third of black respondents did think so, as did the following white healthcare manager:

> *Senior executives are evaluated based on their effectiveness, rather than whether they are very liked by their staff and peers, or whether they have a diversified staff. I believe senior executives are risk averse when it comes to promotions since they perceive that they're taking a chance on minority candidates. A wrong decision would impact their own performance. Overcoming this risk aversion comes from having well-prepared candidates from management programs, who are given opportunities within the organization to demonstrate competence, business acumen, and decision-making skills. Subsequent promotions are based on performance only.*

Nearly all respondents agreed that the morale of minority staff would be enhanced by building a diverse management team in healthcare organizations. Thus, the main stumbling block to advancing the equity of career attainment appears not in helping minorities gain a foothold onto the healthcare management career ladder. Instead, it rests on providing special efforts to advance minorities into senior-level positions (Table 37). One white respondent stated:

> *My experience with any group is they can achieve whatever heights they desire if they pursue education, have the right work ethic, and have the initiative necessary to excel and achieve their goal. Whether man/woman, white/black, etc., if the individual prefers to achieve goals based on race, sex, or ethnic group, then they will never be as successful as the person who is driven based on individual merit!*

Another white male wrote:

> *It is important to focus on talent and ability to add value to the organization rather than other unimportant/irrelevant attributes such as race or sex. The question presupposes that a quota system is in place. Quotas are not compatible with a focus on talent and ability. I will not hire or promote anyone because they are a minority; nor will I fail to do because they are a minority...talent is the sole criterion. Focusing elsewhere does a disservice to the position.*

Yet another white male wrote:

> *There are, and will always be, inequalities for minorities. There are also inequalities to otherwise qualified individuals who are not minorities by organizations that promote diversity. I personally try to hire the person best prepared to do the job. Sometimes, that means a minority gets the job—most times it doesn't. Thus, the onus is on the preparation, not the recruitment. Bring me a star and perhaps they'll have a place to shine!*

On the other hand, a black male wrote:

> *The position I hold today is a direct result of the organization's interest and commitment to bringing in a black senior executive. It makes good business sense for the organization to do so, as the community we serve is largely black and Hispanic. Only when organizations are able to look past the differences we share, and recognize that it's good business to do so, will we begin to see more minorities in the senior ranks*.

Governmental action, in the view of most minority respondents, is needed to create incentives for the healthcare field to engage in equal employment efforts. Most whites disagreed, while Asians were ambivalent as a group. One Native American male wrote a qualified testimonial on the effectiveness of governmental action:

> *In my organization (Indian Health Service) there are many minorities in high level positions because of the Indian Preference Law. I feel certain this wouldn't have happened without the law and rules in place. I think my agency, and the federal government in general, has made good progress in the EEO process, however I still see many people who lodge complaints with the EEO.*

Blacks, Hispanics, and a plurality of Asians support the notion of government and private sources providing more financial support for minority students who wish to become healthcare managers. Less than a third of the whites support the idea and about 40 percent oppose it (Table 37).

Respondents were asked to write about any best practices they knew that promote diversity in healthcare management. The most cited best practice concerned diversity planning and training initiatives. Another practice receiving many mentions was for the

organization to be committed to diversity, such as when the CEO promotes diversity and sets goals to diversify the management team. Others suggested establishing mentoring arrangements and using the resources of organizations like the Institute for Diversity, the National Association of Health Service Executives, and ACHE (Table 38).

Other less-cited practices included offering and supporting minority scholarships, internships, and fellowships; having senior management and board recognize diversity issues; providing diversity education; placing minorities in healthcare executive positions; networking; and advocating the benefits of a diverse staff (Table 38). Some individuals cited practices like pursuing Continuous Quality Improvement or other global improvements as ways to integrate and promote diversity. For example, one Native American respondent stated:

> *... there are a lot of good things happening in our organization. We have a tremendous number of dedicated individuals that are here because of their commitment to provide quality care to our patients. We try to involve employees at all levels of the organization, seeking their input on teams, and workgroups to implement new ideas for patient care.*

To the question of whether or not there are inequities in minorities' attaining senior-level executive positions today, nearly all the blacks and more than three out of four Hispanic, Asian, and Native American executives agreed that inequities exist. However, fewer whites concurred—60 percent felt there are inequities in minorities' attaining senior-level executive positions (Table 39).

Respondents identified the following top factors accounting for these inequities: (1) the "good ole boy" white network, (2) racism, (3) cultural differences, (4) lack of education, (5) lack of mentors, and (6) lack of organizational initiatives such as equal employment opportunity policies. Factors cited varied by respondents' race/ethnicity. For example, black women more than other groups cited racism or prejudice. Whites—both men and women—cited an insufficient number of applicants and few minority executives in the pipeline. Hispanic and Asian men disproportionately cited the fact that minorities lacked certain attributes such as assertiveness or willingness to accept responsibility for senior-level positions. Asian women cited cultural differences that impeded minorities from advancing (Table 39). One Asian respondent commented:

> *There are definite inequities, differences in culture, i.e., Asians tend to view verbal people as shallow; in Western culture, being articulate is an asset. Those who are articulate in Western culture get ahead easier and faster. There are differences in management styles—in Asian culture, relationships are of utmost importance; Western culture views the task as important—people are secondary to tasks, projects, etc.*

Summary

- Whites exceed minorities in having attained senior-level positions in healthcare organizations. Among women, 26% of blacks, 40% of whites, 25% of Hispanics, 24% of Asians, and 28% of Native Americans are CEOs, COOs, or senior vice presidents. Among men, 44% of blacks, 62% of whites, 47% of Hispanics, 34% of Asians, and 46% of Native Americans hold senior-level positions.
- More whites than minorities work in hospital settings. Among women, 53% of blacks, 72% of whites, 58% of Hispanics, 67% of Asians, and 63% of Native Americans are employed in a system or freestanding hospital. Among men, 59% of blacks, 75% of whites, 62% of Hispanics, 63% of Asians, and 58% of Native Americans are so employed.
- Despite their lower positions, more blacks serve as mentors than any other racial/ethnic group. About two-thirds of blacks—compared with less than 60% of whites and even lower proportions of other race/ethnic groups—currently serve as mentors.
- Controlling for education and years of experience, white women earned more than women of other racial/ethnic groups in 2001. Even if minority women had achieved the same levels of experience and education that white women achieve, their incomes would continue to be lower. Of the three minority groups considered, Hispanic women appear to be more highly remunerated than blacks and Asians.
- With education and experience levels identical to whites, black and Hispanic men's salaries and bonuses in 2001 would have approximated that of their white counterparts. Because there were so few Asians with high levels of experience, it is difficult to estimate what salaries highly experienced Asians actually would have.
- Blacks expressed less satisfaction than whites with (1) their pay and fringe benefits in view of their contribution to their organizations; (2) the degree of respect and fair treatment they received from their supervisors; and (3) the sanctions and treatment they received when they made a mistake. In nearly all measures of job satisfaction, the other race/ethnic groups fell between the extremes set by blacks and whites. On the other hand, most racial/ethnic groups are equally satisfied with the amount of independent thought and action they exercise in their jobs.
- On several dimensions, such as whether or not their organization has great personal meaning for them, blacks express the lowest level of commitment to their organizations and whites express highest levels. In most cases, Hispanic, Asian, and Native American respondents fell between the extremes set by blacks and whites.
- A majority of all race/ethnic groups have obtained a graduate degree. However, there are variations: Among women, 91% of blacks, 93% of whites, 85% of Hispanics, 96% of Asians, and 54% of Native Americans had graduate degrees. Among men, 91% of blacks, 93% of whites, 91% of Hispanics, 100% of Asians, and 78% of Native Americans had graduate degrees.

- There were also variations in the proportion of respondents who majored in healthcare management in their graduate studies. Among women, 60% of blacks, 55% of whites, 41% of Hispanics, 63% of Asians, and 33% of Native Americans majored in health administration. Among men, 53% of blacks, 61% of whites, 60% of Hispanics, 60% of Asians, and 42% of Native Americans majored in health administration.
- While a majority of all respondent groups began their careers in not-for-profit settings, more minorities than whites launched their careers in government agencies.
- About a third of blacks and less than 5% of whites believed they experienced racial/ethnic discriminatory acts in the past five years—acts such as not being hired or being evaluated with inappropriate standards. (Hispanics, Asians, and Native Americans reflected intermediate values between these extremes.)
- Approximately 85% of whites claim that race relations within their organizations are good—compared with 47% of blacks, 64% of Hispanics, 65% of Asians, and 57% of Native Americans.
- Looking five years into the future, only about 15% of women in each racial/ethnic group aspire to become a CEO. In contrast, many more white men (45%) had such aspirations than men who are black (26%), Asian (23%), or Hispanic (33%).
- About half of the white respondents were either neutral or opposed to efforts to increase the percentage of race/ethnic minorities in senior healthcare management positions. However, nearly all blacks (97%) endorsed the idea, as did more than 80% of all the remaining race/ethnic groups (excluding Asian men—two-thirds of whom supported such efforts).

TABLE 1

POPULATION, SAMPLE, AND RESPONSE RATES

	Black	White	Hispanic	Asian	Native American
Population	2,033[1]	13,601	449[2]	240	153[3]
Sample	1,573	1,608	449	240	153
Responses	526	779	215	118	68
Response Rate (%)	33.4	48.4	47.9	49.2	44.4
Analyzed[4]	497	742	204	114	64
Males (#)	222	359	125	65	37
(%)	44.7	48.4	61.3	57.0	57.8
Female (#)	275	383	79	49	27
(%)	55.3	51.6	38.7	43.0	42.2

[1]Composed of 696 ACHE affiliates, 539 of whom were sampled and 282 of whom responded and 1,337 NAHSE members, 1,034 of whom were sampled and 244 of whom responded.

[2]Composed of 281 ACHE affiliates, 159 of whom responded and 168 AHHE members, 56 of whom responded.

[3]Composed of 51 ACHE affiliates, 29 of whom responded and 102 EDLP members 39 of whom responded.

[4]Responses were analyzed if they were from employed healthcare executives who gave their gender.

TABLE 2

DEMOGRAPHIC INFORMATION[1]

	Female					Male				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
Age										
median	45	48	43	37	49	46	50	45	43	48
Marital status										
Married	53%	72%	61%	49%	59%***	81%	89%	84%	75%	92**
Single	47	28	39	51	41	19	11	16	25	8
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(275)	(383)	(79)	(49)	(27)	(221)	(358)	(124)	(65)	(37)
Highest educational level completed										
Some college	1%	0%	1%	0%	15%***	1%	0%	1%	0%	6%***
College graduate	8	6	14	4	31	8	7	8	0	17
Masters degree	82	86	78	85	42	82	87	78	8	67
Doctoral/Professional degree	9	8	6	10	12	9	7	13	12	11
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(273)	(382)	(78)	(48)	(26)	(220)	(354)	(120)	(64)	(36)

**Chi-square significant p<.01

***Chi-square significant p<.001

[1]Responses may not total to 100 due to rounding.

TABLE 3

POSITION BY RACE/ETHNICITY[1]

	Females					Males				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
CEO	11	13	9	9	12***	19	37	23	11	32***
COO/Senior Vice President	15 (26)	27 (40)	16 (25)	15 (24)	16 (28)	25 (44)	25 (62)	24 (47)	23 (34)	14 (46)
Vice President	19	28	24	17	8	24	19	23	20	16
Department Head	39	19	32	34	44	22	10	20	31	30
Department Staff/Other	17	14	20	26	20	11	9	10	15	8
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(266)	(381)	(76)	(47)	(25)	(216)	(355)	(123)	(65)	(37)

***Chi-square significant p<.001

[1]Responses may not total to 100 due to rounding.

TABLE 4

CURRENT AREA OF RESPONSIBILITY[1]

	Females					Males				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
General Management	36	45	37	33	32**	47	69	44	45	51***
Single Business Discipline (Finance, Human Resources)	17	16	20	21	16	19	10	19	11	11
Clinical/Ancillary	17	23	17	17	36	11	10	18	25	20
Sector Management (Ambulatory, Association)	30	16	26	29	16	23	12	18	19	17
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(269)	(377)	(76)	(48)	(25)	(212)	(354)	(120)	(64)	(35)

** Chi-square significant p<.01

*** Chi-square significant p<.001

[1] Responses may not total to 100 due to rounding.

TABLE 5

EMPLOYING ORGANIZATION[1]

Setting	Females					Males				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
System Hospital	31	38	36	43	50***	36	41	37	47	44***
	} 53	} 72	} 58	} 67	} 63	} 59	} 75	} 62	} 63	} 58
Freestanding Hospital	22	34	22	24	13	23	34	25	16	14
Other Provider	15	11	19	9	17	13	9	18	15	14
Public health agencies/ military (nonhospital)	12	4	8	9	17	12	3	9	10	19
Non-provider (e.g., consulting; education)	20	14	15	15	4	15	13	11	13	8
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(260)	(376)	(78)	(46)	(24)	(217)	(352)	(122)	(62)	(36)
Number of beds										
Median	450	292	435	364	35	399	226	233	334	72
Ownership										
Not-for-profit church	18	22	13	11	4***	14	15	15	13	11***
Not-for-profit secular	45	43	52	47	15	41	47	36	25	14
Investor-owned	3	10	6	6	0	6	9	11	8	3
For-profit--other	9	10	16	9	0	10	7	11	13	5
Government	21	12	12	26	81	27	18	24	38	65
Self-employed	5	2	1	2	0	3	4	2	5	3
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(265)	(378)	(77)	(47)	(27)	(218)	(354)	(123)	(64)	(37)

***Chi-square significant p<.001

[1]Responses may not total to 100 due to rounding.

TABLE 6

ROLE AS MENTOR

	Females					Males				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
Serve as mentor(%)	63	58	47	37	37***	71	57	58	48	51**
n	(271)	(376)	(79)	(49)	(27)	(222)	(351)	(125)	(65)	(37)

** Chi-square significant p<.01

*** Chi-square significant p<.001

TABLE 7A

SALARY + BONUS
FEMALES

	1992		1997				2002				
	Black	White	Black	White	Hispanic	Asian	Black	White	Hispanic	Asian	Native American
Median	52,500	55,600	61,000	72,900	59,600	57,500	79,800	104,000	80,500	71,300	61,100
n	(163)	(272)	(204)	(192)	(81)	(37)	(271)	(374)	(78)	(48)	(27)
Less than $30	7%	4%	2%	3%	2%	0%*	1%	0%	3%	0%	0%***
30-45	28	23	22	14	22	16	8	3	8	10	19
45-60	31	33	25	18	26	41	15	6	17	21	30
60-75	17	17	21	18	20	22	20	14	18	25	26
75-90	7	9	12	18	12	3	18	16	14	17	11
90-105	6	5	8	12	11	8	11	12	15	17	0
105-120	2	3	5	6	4	11	6	12	5	4	7
120-135	0	3	4	3	0	0	4	6	1	2	0
135-150	0	2	+	2	1	0	4	7	4	0	4
150-165	0	1	+	1	0	0	3	4	8	0	4
165-180	1	0	0	3	1	0	2	5	5	0	0
180-200	1	1	0	1	0	0	3	3	0	2	0
200-225	0	0	0	0	0	0	2	5	0	0	0
225-250	1	0	+	1	0	0	1	2	1	2	0
250-300	0	0	0	2	0	0	1	1	0	0	0
300-350							1	1	1	0	0
350-400							0	1	0	0	0
400-450							1	0	0	0	0
450-500							0	0	0	0	0
More than $500							0	1	0	0	0
	100%	100%	100%	100%	100%[1]	100%[1]	100%	100%	100%	100%	100%
n	(163)	(272)	(204)	(192)	(81)	(37)	(271)	(374)	(78)	(48)	(27)
Mean	58,178	63,066	66,814	80,469	64,963	64,324[ade]	95,653	120,682	91,846	77,792	68,593[adegh]
n	(163)	(272)	(204)	(192)	(81)	(37)	(271)	(374)	(78)	(48)	(27)

[a] t test is significantly different at p<.05 between Blacks and Whites
[d] " " " " Whites and Hispanics
[e] " " " " Whites and Asians
[g] " " " " Blacks and Native Americans
[h] " " " " Whites and Native Americans

+ Less than 0.5%
[1]Responses may not total to 100 due to rounding.
*Chi-square significant p<.05
*** Chi-square significant p<.001

TABLE 7B

SALARY + BONUS
MALES

	1992		1997				2002				
	Black	White	Black	White	Hispanic	Asian	Black	White	Hispanic	Asian	Native American
Median	66,800	80,400	72,300	82,300	73,000	78,800	98,800	121,400	103,700	86,600	84,800
n	(159)	(237)	(171)	(190)	(143)	(71)	(217)	(350)	(123)	(63)	(37)
Less than $30	4%	1%**	1%	2%	2%	1%	1%	0%	1%	0%	0%**
30-45	13	5	11	8	10	8	1	1	1	8	5
45-60	24	19	23	14	17	15	10	5	7	8	8
60-75	20	19	18	19	24	20	16	6	11	21	14
75-90	11	17	13	16	8	20	15	15	16	17	35
90-105	8	12	9	9	10	10	13	9	15	11	19
105-120	8	5	5	9	9	3	7	13	16	3	11
120-135	3	6	5	3	5	4	9	9	6	2	5
135-150	1	4	5	4	5	3	7	6	7	10	0
150-165	4	2	2	4	3	4	4	4	3	5	3
165-180	1	3	1	2	1	1	4	6	1	3	0
180-200	0	1	1	2	0	1	1	4	5	2	0
200-225	1	2	1	2	2	3	2	4	2	8	0
225-250	1	1	1	2	1	1	2	4	3	2	0
250-300	1	3	4	5	2	4	2	5	0	0	0
300-350							1	3	2	0	0
350-400							2	1	1	2	0
400-450							1	1	1	0	0
450-500							0	0	0	0	0
More than $500							1	2	3	0	0
	100%	100%[1]	100%	100%	100%[1]	100%	100%	100%	100%	100%	100%
n	(159)	(237)	(171)	(190)	(143)	(71)	(217)	(350)	(123)	(63)	(37)
Mean	77,755	94,515[a]	88,421	99,916	88,867	95,690[a]	124,493	152,531	130,821	107,730	85,783[adehi]
n	(159)	(237)	(171)	(190)	(143)	(71)	(217)	(350)	(123)	(63)	(37)

[a] t test is significantly different at p<.05 between Blacks and Whites
[d] " " " " Whites and Hispanics
[e] " " " " Whites and Asians
[g] " " " " Blacks and Native Americans
[h] " " " " Whites and Native Americans
[i] " " " " Hispanics and Native Americans

*Chi-square significant p<.05
*** Chi-square significant p<.001
[1]Responses may not total to 100 due to rounding.

TABLE 8

JOB SATISFACTION
(percent satisfied or very satisfied)

	Females					Males				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
Pay and fringe benefits	42	67	59	57	56***	48	68	60	62	67***
n	(256)	(370)	(76)	(46)	(27)`	(211)	(339)	(118)	(60)	(36)
Security	60	79	68	72	70***	69	76	71	75	69
n	(257)	(370)	(76)	(46)	(26)	(211)	(339)	(118)	(60)	(36)
Sanctions and treatment received when mistake made	53	76	65	57	65***	58	73	66	60	51***
n	(255)	(368)	(36)	(46)	(26)	(210)	(338)	(116)	(60)	(35)
Supervisor's respect	65	79	74	67	70**	71	83	77	73	69*
n	(255)	(368)	(76)	(46)	(27)	(206)	(336)	(118)	(59)	(36)
Subordinates' respect	77	89	84	69	76***	82	92	91	84	69***
n	(244)	(357)	(70)	(39)	(25)	(206)	(335)	(115)	(56)	(35)
Autonomy	79	86	78	80	78	83	89	86	90	89
n	(257)	(370)	(76)	(46)	(27)	(212)	(338)	(117)	(60)	(35)

*Chi-square significant p<.05

**Chi-square significant p<.01

***Chi-square significant p<.001

TABLE 9

JOB COMMITMENT
(percent agree)

	Females					Males				
	Black	White	Hispanic	Asian	Native American	Black	White	Hispanic	Asian	Native American
A strong feeling of belonging to organization	58%	82%	71%	70%	74%***	72%	85%	79%	72%	76%**
n	(257)	(370)	(77)	(46)	(27)	(212)	(341)	(118)	(61)	(33)
Feels emotionally attached	61	81	77	67	78***	69	87	72	70	74***
n	(257)	(371)	(77)	(46)	(27)	(213)	(341)	(117)	(61)	(34)
Organization has great personal meaning for respondent	60	79	69	67	81***	70	83	74	72	88**
n	(257)	(370)	(77)	(46)	(26)	(213)	(341)	(118)	(61)	(34)
Feels like "part of the family" at organization	51	79	65	67	63***	62	85	74	61	76***
n	(257)	(371)	(77)	(46)	(27)	(213)	(341)	(118)	(61)	(34)
Happy to spend remainder of career at organization	43	72	58	46	67***	59	74	58	57	71***
n	(256)	(370)	(77)	(46)	(27)	(213)	(341)	(118)	(61)	(34)
Enjoy discussing organization with outsiders	70	85	74	76	81***	84	90	80	75	91**
n	(257)	(371)	(76)	(46)	(27)	(213)	(341)	(118)	(61)	(34)
Feels organizations problems are his/her own	51	76	64	57	69***	62	81	76	75	74***
n	(257)	(370)	(76)	(46)	(26)	(213)	(241)	(118)	(61)	(34)
Could easily become as attached to another organization as this one	21	27	26	27	35	20	26	14	11	26*
n	(256)	(371)	(77)	(45)	(26)	(213)	(341)	(118)	(61)	(34)

*Chi-square significant p<.05
**Chi-square significant p<.01
***Chi-square significant p<.001