
Footnote: A delay in publishing this article has meant that it does not deal with various recent debates within the academy concerned with locating equality within a wider societal context: focusing on familial v individualistic ‘gender contracts’ (Hirdman, 1998; Drew, 1998); the continued existence of gendered careers in what purport to be flatter structures ( O’Connor, 1998); those which have explored the differential impact of ways of reconciling work and family as well as the wider societal factors which affect women’s promotion ((Mahon, 1998; O’Connor and Shortall, 1999; O’Connor, 1999). It is clear that the systematic devaluing of women and their work within a narrow range of occupations; their continued disproportionate responsibility for unpaid work in the household as well as an gendered career structures, cultures etc. all need to be tackled if any real progress is to be made. However it still seems worthwhile to publish this article, since the public discourse at an organisational level is still dominated by concepts of equality which do not even go beyond access and by a naïve idea that arrangements such as flexitime, job sharing are the outer limits of an equality agenda.

Introduction

Over the past ten years sociologists have increasingly recognised the usefulness of highlighting the organisational practises or ‘tactics’ (1) through which horizontal and vertical segregation is perpetuated. Although an exclusive focus on them is insufficient (2) this article is concerned with exploring the ways in which women’s under-representation in management positions is perpetuated by such practises. This article draws on focus group material from a study which was commissioned by the Chief Executive Officer of the Midland and Mid-Western Health Boards, and looks at women’s attitudes to those organisational practises which affect their promotion in these Health Boards (3). Specifically it looks at their concept of an Equal Opportunity Employer; the perceived clarity of criteria as regards promotion; the composition of interview boards; their access to opportunities to achieve visibility and to ‘show form’ within the organisation; their access to various kinds of training; the ways in which combining paid work and family responsibilities was facilitated and their attitudes to the identification of targets and quotas. Prior to looking at this data the concept of equality will be briefly discussed within an organisational context.

The nature of equality

There is a great deal of popular and academic confusion about equality. Popular ideas about gender equality have tended to focus on what has been called ‘equality of formal rights,
opportunities and access’ rather than recognising that it is necessary to enable and encourage formal rights to be exercised (4). Even in the 1977 Employment Equality Act it was noted that it was necessary to engage in positive action in the sense of single sex training. Such action allows an organisation not only ‘to identify and eliminate any discrimination in its employment policies and practices’ but also to begin ‘to put right the effects of past discrimination’ (5).

It is arguable that positive action is typically not seen by Irish women and men as offsetting the implicit positive discrimination in favour of men. In this context it is worth noting that the European Court of Justice (in the Marshall v Land Nordfheim-Westfalen case) concluded that where male and female applicants were equally qualified, a woman should be appointed because of what they called deep seated prejudices against women (6). Indeed it has been noted that: ‘No society in the world treats its women as well as its men’(7). In this context there has been a specific expectation that positive action programmes ‘will feature progressively on the management agenda in Health Boards’ (8). Indeed the Platform for Action at Beijing included a commitment by the Government to promote the equal participation of women in senior management positions (9). Thus the Midland and Mid-Western Health Boards were unusual only in commissioning a study to ‘ascertain the views and advice of women on their perceptions of the barriers to promotion in the Board’s employment and how these can be removed’ (10).

The focus on organisational equality at the level of outcome is concerned with actually affecting ‘results’ i.e. that the target groups ‘must be enabled to succeed at the same rates and in the same contexts as is the case at present for the more privileged groups’ (11). Organisational practises such as the definition of clear criteria for promotion, access to high profile work and the gender balanced composition of interview boards can be seen as relevant to equality at this level. In addition a concern with outcomes typically also directs attention to the use of targets, quotas and contract compliance. Targets (in the sense of non legally binding objectives) have been seen as a useful way of facilitating equality at this level,
particularly if they involve line management in the pursuit of these objectives. Indeed they have been used by FAS for a number of years in the case of the female apprenticeships. A number of companies (such as for example the Electricity Supply Board) have also used such targets at management level. Furthermore the monitoring mechanism in the civil service has been criticised because it ‘does not, in general, include definite targets for hiring or promotion in the US style’ (12).

It has long been noted that contract compliance is another way of achieving organisational equality at the level of outcome (13). It has been used in Sweden with companies who are receiving regional aid being required to employ ‘at least 40 per cent of both sexes at all levels of the promotional ladder’ (14). However despite the fact that it is legal under EU law; has been used in Northern Ireland; and has been shown to be particularly successful in opening up managerial and professional jobs to women (15) no attempt has been made to introduce it in Ireland. An EU requirement to gender audit structural funds has also effectively been ignored (16). Typically the state structures in Irish society have not even begun to contemplate putting in place procedures to offset:

‘the effects of apparently neutral, but effectively discriminatory processes which have built up in the system as a result of a history of inequality’ Callan & Wren (17)

The European Union has suggested that equality at the level of outcome is not simply an organisational issue and that work and family must be reconciled (18). However in so far as it is women who overwhelmingly avail of job sharing, flexitime etc.(19) and in so far as the use of them is seen by organisations as reflecting a lack of commitment, then clearly such arrangements do not facilitate equality at the level of outcome. It is recognised that there are other fundamental limitations to an organisational equality agenda. This arises from the fact that it ignores the wage differentials which have been shown to exist and which are partly based on the differential valuing of male and female skills (which in turn reflect power differentials). Indeed this was recognised in the EU Code of Practice on the abolition of the implicit gender bias in job classification schema (20). This is not even seen as an issue by the
Irish state, although for the past twenty years, a variety of bodies including the United Nations, the International Labour Organisation; the Organisation for Economic Co-operation and Development as well as the EU have been referring to the need for change in the traditional role of men as a way of achieving equality (21). Indeed questions have been raised as to whether we should be more concerned with men and women having the same responsibilities (for example, as regards unpaid work) rather than being concerned with equal rights (22).

**Methodology and Description of the Sample**

In consultation with senior Health Board Management it was decided to focus on three sectors which provided very different contexts as regards women’s employment viz. Administration, Nursing and other Professions Allied to Medicine (the latter being referred to as Paramedics by the Health Boards). These sectors provided 68 per cent of the female employment in the Midland and Mid-Western Health Boards. More specifically then, women made up 81% of those employed at the lower grades in the Administrative hierarchy (Grade 11 or 111), but they constituted only 21 per cent of those at senior level (even when senior was defined to include community welfare officers and Grade V1). In Nursing, women constituted 85 per cent of those at the lower levels (i.e. permanent staff nurse) and 71 per cent of those at senior level (i.e. assistant matron and above). In the case of the other Professions Allied to Medicine, women made up 76 per cent of those at the basic grade and 75 per cent of those at senior level, although the pattern varied between different disciplines (23). There were no women at management team level in these Health Boards.

Equivalencies were established between the three career hierarchies on the basis of pay (24). In view of this and since the focus of the project was on identifying those factors which inhibited women’s movement into senior management positions at Health Board level, a decision was made to exclude those who were at the lower income levels. Using a stratified random sample, roughly one in three of those at middle and senior level in each of these sectors in the two Health Boards was selected (N=222). A small number (n = 9) were on
maternity leave, sick leave or unpaid leave. The overall response rate amongst the effective sample (N=213) was 76 per cent. As is clear from the table below, variation in the response rate between sectors was greater than variation within them, and overall can be seen as very satisfactory.

**Table 1** Response rate in the sample by sector of employment and level of employment

<table>
<thead>
<tr>
<th>Level</th>
<th>Administration</th>
<th>Nursing</th>
<th>Other Professions allied to medicine</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior</td>
<td>86% (12/14)</td>
<td>75% (15/20)</td>
<td>66% (19/29)</td>
<td>73% (46/73)</td>
</tr>
<tr>
<td>Middle</td>
<td>100% (17/17)</td>
<td>72% (55/76)</td>
<td>77% (44/57)</td>
<td>77% (116/150)</td>
</tr>
<tr>
<td>Total</td>
<td>94% (29/31)</td>
<td>73% (70/96)</td>
<td>73% (63/86)</td>
<td>76% (162/213)</td>
</tr>
</tbody>
</table>

The brief indicated that the study should use focus group discussions. This method consists in the initiation of a discussion around key themes, with opportunities being provided to introduce other issues (25). Forty focus groups were undertaken varying in size from 1-8 people with an average size of 4. Each session lasted approximately one hour. The group discussion was recorded manually (verbatim), since there was a good deal of anxiety about the confidentiality issue and about the perceived risks of ‘speaking one's mind’.

The respondents were first offered an opportunity to identify what they saw ‘as the barriers to women's promotion in your area’. They were then asked to identify what they thought ‘increases a woman's chances of being promoted’ and ‘what reduces her chance of being promoted’. In addition to following up the themes and issues which emerged in this context, issues related to their concept of an equal opportunities employer; to the perceived criteria for promotion; the composition of interview boards; training; visibility; strategies for combining work and family; targets and quotas were discussed (26).
Despite the fact that a very generous definition of senior position was adopted, and that the response rates at senior level were for the most part very similar to those at middle level, only just over a quarter of the women (overall) in the focus groups were at senior level and this varied between sectors. Hence this paper is mainly concerned with providing an overall qualitative picture of the trends which emerged in the focus groups rather than describing or explaining differences between women. However where there are major deviations from the dominant trends these will be referred to.

**Concept of an Equal Opportunity Employer and Equality Officer**

Although equality has become part of our way of thinking about the world, in an organisational context it has tended to be interpreted as equality of formal rights, opportunities and access. In this context the focus is simply on the responsibility of an employer to ensure that the same opportunities are available to men and women to enable them to compete for promotional posts. This approach fails to take into account the fact that simply providing equal access does not even guarantee equal participation, not to mention equality of outcome, since the effects of past discrimination may be such that opportunities cannot be grasped, and indeed may not even be perceived.

The statement of Equal Opportunity by the Health Board management, the unions and the Department of Health and Environment includes a commitment to ‘treat and develop all their employees equally regardless of sex, marital status, creed, colour or ethnic origin, within existing legislation’ and to ‘promote changes of attitude and assumptions about traditional career roles which can adversely influence recruitment, placement, promotion and career decisions by individual staff members’ (27). At the time of the study only a quarter of the Health Boards had brought this statement to the attention of their staff.

In this study, for those in the Administrative and Nursing focus groups, being an equal opportunity employer typically meant not discriminating at this minimal level i.e. it meant ‘having the same opportunities for women as for men’; ‘following the guidelines that staff
would be taken on because of their professional qualifications without any emphasis on gender, race or their domestic lives’. Amongst those who thought of equal opportunity in these terms there was a good deal of cynicism about the identification of the Health Board as an Equal Opportunity Employer (‘nice line at the bottom of the ad’). As they saw it, it ‘did not mean a lot’ other than that they were ‘legally covering themselves’. On the other hand the other Professions Allied to Medicine were, for the most part, implicitly operating with an outcomes oriented concept of an equal opportunity employer. As they saw it, equal opportunities meant ‘having a certain proportion of various groups (e.g. women) in senior positions’. Thus, they stressed that they did not believe that equal opportunities existed in the Health Board: ‘looking at the top positions, it can’t be’.

All of the Health Boards had designated one of the Personnel Officers to take responsibility for Equal Opportunity on a part-time basis. The Review Group on equal opportunity for women in the Electricity Supply Board (operating with an outcomes oriented approach) recommended that an Equal Opportunity person be full-time at managerial level. The women in the Health Boards were asked whether the employment of a (full-time) Equality Officer would make any difference. The dominant theme amongst those in Nursing and in the other Professions Allied to Medicine was that a (full-time) Equality Officer would be a good idea: ‘brilliant’; ‘she would be somebody that you could avail of’ because it was difficult to ‘voice your own challenges’. Those who had seen them in action in other countries, saw the appointment of a (full-time) Equality Officer as ‘useful’. They felt that it was essential that that person would have a background in equality issues. There was a good deal of uncertainty about their role. However, references were made in the Administrative and Nursing focus groups to their role in encouraging women to apply for promotion; monitoring male/female ratios at various levels and dealing with sexual harassment and male prejudice in the workplace (‘let them know we are watching out’). However, they went on to note that ‘the biggest thing would be to see women being appointed’ (i.e. at senior management level). As they saw it, even in the rare cases where senior posts did go to women, they tended to be on a temporary basis. Thus they wondered if they were tokenism. There was a strong feeling
that if an Equal Opportunities Policy was to be a reality at the level of outcome, it had to be
driven ‘from the highest level’.

Overall then, the women in this study thought in terms of an access model of equal
opportunity and were critical of its potential. Many of their comments implicitly recognised
the usefulness of an outcomes oriented equal opportunity model, although they did not
identify it as such.

**Criteria for Promotion**

It has been shown that the more subjective and informal the criteria for promotion the less
likely they are to facilitate equality at the level of outcome. Goss and Brown noted that
where patronage and head hunting were used as opposed to a more public process and more
objective criteria, the net effect was to reduce women's chances of being promoted (28).
Studies of, for example, civil servants in Mahon's study and managers in Fine Davis’ study
also stressed the importance of such clear promotional criteria (29). As the women in the
present study perceived it, clear criteria generally did not exist and where they did, they were
‘not the real ones,’ ‘you know what would be an advantage, but people come in without this’.
In the case of particular jobs, such as community welfare officer, ‘pull’ and being ‘well
connected’ were seen as critical in affecting the possibility of promotion. Amongst those at
ward sister level, the criteria as regards promotion were ‘all a mystery’. They gave specific
elements of men who had got posts for which they seemed less qualified, in terms of both
clinical and management courses and experiences, than women who did not get such posts.
In the case of other Professions Allied to Medicine, it was noted that although a management
element was important for senior and chief posts, men who had no management experience
had gone for such posts and had got them. They felt that there was a glass ceiling at Health
Board management level and this indeed was reflected in their own attitudes: ‘I would find it
hard to visualise a female Chief Executive Officer’. They felt that ‘if a man and a woman go
for a job, the man is likely to get it......gender is an important factor in the selection of
people’. They noted that ‘every top post in County Clare is held by a man.’
In Nursing and in the other Professions Allied to Medicine references were specifically made to the importance of being compliant as one of the real criteria for promotion: ‘If you make too many waves, they tend to cover you.’ Promotion was also seen as a reward for discharging existing responsibilities well: ‘Just reward for the work you put in.’ In this context they felt that: ‘If you go for it once (i.e. promotion) and don’t get it, you are not going to go again’. The whole question as to why an organisation would promote people who had shown that they were willing to discharge higher level responsibilities at a basic grade salary simply did not occur to them.

Wanting to work part-time whether in a job share or part-time position was widely seen as something which obliterated a woman's chance of being promoted: ‘You cannot be a senior unless you are full time’. Overall then there was a strong feeling that the criteria for promotion were by no means clear. The perceived existence of discrimination in favour of men was an underlying theme in many of their comments.

**Composition of Interview Boards**

Traditionally, notions of interview bias have been dismissed out of hand. However, the First Report of the Third Joint Committee on Women's Rights noted that ‘discrimination cannot be discounted in all confined competitions within the civil service’(30). Studies of the British civil service have shown that senior management (predominantly composed of men) typically scored men and women similarly on their abilities, but when they were assessing them for posts at senior management level, they took into account ‘overall style and approach’. On these criteria, the men were perceived as ‘more suitable’ (31). It is not surprising that in a society where gender is very much a socially constructed reality, many men at the upper echelons of management will be incapable of identifying with women, and hence will identify with and promote people who are ‘like themselves’. Hence the composition of interview boards is a critical factor affecting equality at the level of outcome.
There have been difficulties in identifying the gender composition of interview boards in the civil service and in state sponsored bodies (32). What evidence exists suggests that a sizeable minority of interview boards for management positions are still all male. Furthermore, even where these boards are described as mixed, there is typically only one woman on them. Amongst the women in the present study, the composition of interview boards was seen as important. A three person interview panel was not seen as helpful in getting a gender balance. In the Administrative sector and in the other Professions Allied to Medicine, the issues revolved around the perceived attitudes of those on these boards to ‘women's place’ within the organisational hierarchy, and to women's perceived need for maternity leave (‘It is a question of economics from management's point of view’). As these women perceived it, all male boards still existed and this led to ‘men who had less to offer’ getting the jobs. They were particularly dissatisfied with the presence of what they saw as retired men who were out of touch with the changing position of women on (and often chairing) interview boards. Some men on interview boards were seen as being intimidated by strong women: ‘If a woman is pushy, she's aggressive’; and they were seen as being more ‘comfortable’ with trusting a senior appointment to men. Where women were competing against men, or for jobs that had previously been held by men, there was a strong feeling that interviewers should be recently qualified; or at least trained so that they were less likely to have stereotypical views about women. Experience of sitting on interview boards at lower grades before moving on to senior appointments was also seen as highly desirable. These criticisms were also made about interview boards put together by national agencies such as the Local Appointments Commission.

Amongst those in the senior Administrative Grades, the internal Health Board interviews were seen as 'fair enough of late'. Overall however, as the women in this study perceived it, there was a lot of ‘buddy buddy’ at middle and senior management level, and this networking militated against women. Furthermore amongst those who had presented for interview in the past three years, there was a perception of inappropriate attitudes to actual or anticipated pregnancy. Women presenting for senior posts were seen as being asked rather different
questions from men and this was seen as reflecting outdated assumptions about gender differences.

Within the Nursing area, the issues were somewhat different. Those in this sector were dissatisfied with the fact that, as they perceived it, many of those on the interview board were non-nursing personnel (such as doctors or administrators). They were dissatisfied with the fact that typically they were not told how far down they were on the ‘panel’ (i.e. the list of those qualified to be appointed to a post should one arise); and with the fact that this list expired within a year (an ‘insulting’ procedure).

Overall then, although there were some issues which were specific to particular sectors, there was general agreement that changes needed to be made in the composition of the interview boards so as to create structures which were more conducive to women’s promotion.

Visibility

The issue of visibility has been recognised as important in affecting outcome. Organisational ‘housekeeping’ areas (such as accounts, finance and personnel) are typically less likely to provide opportunities for such visibility. There is evidence to suggest that ‘high visibility’ jobs in some parts of the civil service are not given to women, and this reduces their chances of being promoted (33). In the present study, there were frequent references to the fact that women's chances of promotion were affected by the difficulty of getting a variety of experiences and/or access to ‘acting-up’ jobs (i.e. temporary promotion) or to ‘opportunities to be in contact with people from the top’. Mechanisms for increasing visibility, such as performance appraisals or career planning evaluation sessions were not perceived as existing. It was thought that they could potentially make an important contribution -particularly if it was an ‘open thing’ between worker and line management (and if ‘Personnel were kept out of it’). Amongst the Administrators, the usefulness of job appraisal sessions was linked to a system of job ‘try-outs’ or ‘swops’ (of roughly a year’s duration) which they felt would help them gain experience in various areas and so see where their skills and talents lay. In this
situation, women's fear of going for a job ‘in case they got stuck there’ would be reduced. Supervisors were seen as frequently unwilling to ‘release’ reliable staff: ‘a lot who are interested don't get the opportunity to gain experience which would stand to them in terms of promotion’. As they perceived it, a lot of this unwillingness to allow staff to move had no logical justification: it ‘came from the top down’ where ‘there were a lot of divisions caused by money and territory’.

Within Nursing ‘acting-up’ positions existed. However, typically those who ‘acted up’ at ward sister level got no preparation, and in some cases, taking such positions involved a substantial net drop in salary. Such positions could carry on for years and might well not lead to a permanent job appointment at senior level.

Issues related to visibility are inextricably interwoven with a gendered organisational culture which is reflected in differential access to resources (34). Women in the Nursing sector and in the other Professions Allied to Medicine were relatively remote from access to main line management and operated within the financial constraints imposed by these predominantly male (lay) Administrators. Typically, they saw this male hierarchy as intimidating, and felt that ‘if it has to go to Admin you are in trouble’. This stress on ‘keeping quiet’, ‘keeping your head down’ made it very difficult for them to achieve visibility. This was exacerbated by the typical geographical dispersion of the other Professions Allied to Medicine; and by the fact that many were too busy doing routine work to take the time to make themselves ‘visible’ to what they perceived as a very rigid male hierarchical management structure. Indeed it is fair to say that there was some ambivalence about doing this.

Visibility then was affected by access to ‘high profile’ tasks and by the very structure of the organisation which meant that areas of predominantly female professional employment were relatively remote from (male) areas of decision making about resources. In these ways it had implications as regards women’s promotion.
Training

Even in the 1977 Employment Equality Act, single sex training was seen as having an important role to play in facilitating equality at the level of outcome. Those at the senior and middle Administrative grades stressed the need for more training and ‘not just functional training’. Those who had participated in the multidisciplinary management workshops had found them to be very useful, but for the most part only those at senior level had been invited to participate. Those at basic grade in the other Professions Allied to Medicine felt that they were not seen as ‘appropriate material’ for management courses. They felt that there was a need for courses to demystify the whole business of management; as well as for courses in management skills; accounting; personal development and assertiveness skills.

Within the Nursing area, the Matrons were acutely aware of their responsibility to develop their own staff. However, because of restrictions on their control over budgets and the other effects of the insertion of a layer of male managers between them and the Health Board Management Team, they had neither ‘the money, time, or energy to develop their staff’s potential.’ Those who did ask for additional cover to facilitate staff’s participation in training courses were put under considerable pressure: ‘if you asked, you were the worst in the world’. Hence, as ‘responsible people’ it ended up ‘falling back on us’. These were sharply aware of what they perceived as discrimination against women even within their own predominantly female hierarchy as regards funding for courses (‘all a fellow has to do is turn up’). In this context women typically ended up doing courses that were ‘cheap and convenient’, in their own time (‘just to be doing something’), while recognising that these were not likely to be helpful in terms of promotion.

Some of the focus groups in the Nursing area stressed that there was ‘very good in-service training in the Health Board’. Yet they felt that ‘maybe women have to be approached- given a nudge - you would almost have to speak to them personally, if you felt they had potential’. They saw this timidity as reflecting the nature of nursing education. They noted that the
young people now in Nursing ‘could see themselves at the top. When we started, we never saw ourselves at the Top Table.....in Nursing you would always have to be the handmaiden’.

In this study assertiveness courses were seen as being needed for women at all levels- with even senior Administrators noting that if women at their own level ‘go into a room with five men, they (i.e. the women) don't think they are as good as them’. Those in both the Administrative and Nursing sectors referred to women's lack of confidence, particularly in situations where women were competing against men, or for jobs that had previously been held by men. Those at ward sister level saw women as poor at presenting themselves and at taking credit for their achievements, particularly in an interview setting (saying ‘I did this’). This was seen as a very doubtful skill (i.e. ‘dressing up the truth’) but one where men were seen as ‘having the edge,’ ‘being good talkers’, and having the ‘cute element of bluff.’ Amongst those in the Nursing sector, there were strong feelings of fear and lack of confidence anyway about going for an interview: ‘to put yourself in the position of being humiliated - especially when you knew the jobs were gone’. In general, there was strong resistance to going for an interview several times: ‘if you are knocked twice, what is the point of going again’.

It is worth noting that within these Health Boards even where some of the course fee was covered, there was a greater net financial cost for women with children attending courses than men with children, since typically the woman was responsible for child care activities, and hence these had to be paid for while she was away. In many cases the actual financial arrangements as regards course attendance were not clearly spelt out, and in this situation women were deterred from participating in courses because they were less willing to ‘pursue it’ or to argue about costs. However a minority of the Administrators said that, as they saw it, the Health Board had been ‘going out of its way to encourage people to attend courses’(e.g. paying their fees and giving them time off to attend courses). On the other hand, those working outside the central offices, particularly those working in small rural sections, were typically not aware of the extent of financial support available. Amongst the other
Professions Allied to Medicine the perception was mostly that there was no cover for courses so that those who went felt guilty for leaving their colleagues ‘in the lurch’. In parts of this sector the possibility of being released to do courses was remote since there was no cover even for annual leave. In other areas, such as Radiography, Physiotherapy, Laboratory Technicians and Speech Therapy, the Health Board was seen as facilitative of those who sought training.

Overall, there was a clear perception of the importance of training for women in areas such as assertiveness and management skills. There was a great deal of variation both within and across sectors as regards women's perception of the availability of training. However women's own lack of confidence in asking to go on courses and in negotiating around costs was important. There was no evidence that women were disinterested in attendance at courses, although there was a good deal of uncertainty about the relevance of courses in terms of promotion.

**Combining Work and Family Responsibilities**

There is an increasing recognition that since women in our society still remain overwhelmingly responsible for child care, it makes sense, in economic terms, and in terms of staff morale, to create structures which facilitate combining paid work and family responsibilities (such as maternity leave; job-sharing; flexitime and the provision of child care facilities (35)). It is obviously crucial that availing of these is not seen as negating women’s entitlement to promotion. However, even yet, Maternity Leave is far from unproblematic because of the practice of not replacing women who are on maternity leave - and expecting their colleagues to ‘carry them’. Job sharing (which entails the agreement of two workers to share the responsibility and salary of a full-time job) is still seen as militating against promotion in many areas (36). Use of flexitime (involving a ‘core’ period during which employees are expected to be present, with variation allowed around this) can have similar consequences. Like job sharing, it is not a recent phenomenon: even in the early 1980s, one third of the labour force in Europe was on flexitime (37). In Ireland these are
increasingly being seen as solutions to the problem of inequality. However, it has been noted that such ‘family friendly’ policies ‘play around at the margins of work, enabling some employees with family commitments to adapt to but not challenge traditional work structures’. Furthermore even where such possibilities exist there may be a lack of a sense of entitlement to them (38).

According to the Staff Handbook in the Health Boards, job sharing was officially available to all staff, regardless of level. As the women in this study perceived it: ‘it was not made easy.’ This type of pattern was not peculiar to these Health Boards: ‘you would be told that you could be moved out of your own area into a more difficult one... now tough areas - they are ideal for job sharing’. This sort of personnel strategy was seen as an attempt to intimidate women into foregoing their desire for job sharing. As such, it was bitterly resented.

Those in the Nursing sector noted that job sharing ‘would create jobs’ and was helpful for both the service provided and for the individuals involved. Typically, at ward sister level or above, those who had experienced job sharing were in favour of it: ‘the work is being done, there is no problem with it’. In both the Nursing sector and in the other Professions Allied to Medicine the reservations that were expressed were by those who had no experience of it, or who went on to declare themselves to be single. Some of those who were uncertain about it suggested that an attempt needed to be made to pilot it in various disciplines and in different settings and to look at the kinds of factors that affected its viability. There was widespread agreement in the Nursing sector and in the other Professions Allied to Medicine that if you wanted job sharing ‘that is your promotion gone out the window’.

Flexitime was seen by the women in this study as something that could work in certain jobs, and that it should be available since ‘anything can work if you put enough effort into it’. It was noted that in many areas it already existed (to the employers’ benefit) in the shape of longer days than were strictly laid down. Other than in these situations, the perception was
that male Administrators in the Health Board were not interested in facilitating it; and the Trade Union ‘had been looking for it and seemed to be getting nowhere.’

Workplace Child Care was actively promoted by the Irish Congress of Trade Unions in the 1980s (39). At the time of the study none of the Local Authorities or Health Boards provided such facilities. Many of the women stressed that they would expect to pay for these. Their attractiveness for them lay in their perceived reliability and in the ease with which children could be brought to them (as opposed to ‘tearing to the other side of the town’). The women felt themselves to be in a ‘no-win’ situation within a society where on the one hand, their family responsibilities were expected to be their own affair, and on the other hand, clinic appointments for children were in the working week, so necessitating them taking time off.

A minority of the women, both at middle and senior levels had adopted ‘male’ attitudes. Disregarding the focus of the study (as defined by the Chief Executive Officer) they dismissed the possibility of any barriers: ‘There are no barriers. Have’nt we got promoted?’

A small number felt that the Health Board should not even know about their family responsibilities: ‘your children are yours and your husbands; I don't expect any allowance should be made’; ‘Monday to Friday I belong to the Health Board. When Saturday and Sunday are demanded I can give that as well’. They did not see child care facilities as ‘a realistic option’; or as ‘going to help promotion’. They felt that ‘special arrangements’ for women were ‘separating women and men and defeating the point of equality’. As they saw it, the fact that women had the babies was adequately covered by the fact that they had statutory maternity leave and the possibility of a one year's unpaid career break. Others felt that the real problem was men not taking more responsibility in the home. Until this occurred, as they saw it, it was inevitable that women would ‘lose out for a few years.’

Overall then (arguably because of their age and their level in the organisation) the overwhelmingly majority of the women in this study did not see arrangements for combining work and family life as the key barrier to women’s promotion. They did however see the
Health Board's lack of interest in and/or flexibility around these issues as indicative of its lack of concern for them as women employees: ‘they'd rather not have these types of women’. This was a ‘Catch 22’ situation since if women did not have children ‘they wondered what was wrong with her.’

**Targets and other initiatives**

In this study the focus was mainly on targets, although the respondents' attitudes to quotas and to the Health Board offering financial incentives to sections which increased the proportion of women in senior positions was also explored. Setting realistic targets as regards the proportion of women at management and/or supervisory level was seen as ‘a good idea’; that it would ‘start it’; that ‘if you get one woman in you might change attitudes’; that it would ‘make them encourage women’. These were seen as the ‘structural stuff that gives women confidence,’ which would ‘leave an opening for women’. For some, any strategy (including quotas and offering financial incentives to particular sections) was to be welcomed ‘to get the ball rolling’; ‘to get a more balanced situation in senior Management’; ‘to give younger women the idea that women can do it’. They saw such strategies as ‘short term devices to get a footing, because hopefully we should progress’.

There was some opposition in the Administrative focus groups and amongst the other Professions Allied to Medicine to measures such as quotas because they saw them as creating a hostile environment; that it ‘might worry other people’ (i.e. men); ‘create resentments so that we could be more likely to be intimidated’. Others indicated a reluctant assent to this course: ‘you probably need that sort of thing, but it is a pity to pursue that course’. There was an anxiety that women without skills would be promoted, and that women would be there ‘just there to make up the numbers’; getting the jobs ‘because they are women’. This view was challenged by those who felt that women ‘had to prove themselves more than men’; that, as it was, competent women were being passed over in a situation where women had ‘to be twice as good as a man to get the job’. This ambivalence was summed up by one participant who said that ‘I'd like to compete equally with men if we got a fair shot’.
Overall however there was a general support across all three sectors for the idea of targets as a short term device, and as a way of ensuring that women would not be ‘squeezed out,’ that ‘they’d have support from their own sex’. There was however a good deal of pessimism about the possibility of getting a ‘level playing pitch’ since ‘it is not in management anywhere’ (in the world).

Conclusions
The public debate about equality in Ireland has barely moved beyond a quasi legal approach to equality at the level of access within an organisational context. Within this context the fact that women in the Health Boards, as in many other state and semi state structures, constitute 71 per cent of the employees, but only 7 per cent of those in management positions and none of those at senior management level, is popularly seen as reflecting women’s lack of ability or interest in such positions. This paper draws on qualitative material which emerged in focus groups with 162 women in the Midland and Mid-Western Health Boards. These women constituted a stratified random sample of women at middle and senior levels in the hierarchies of the Administrative, Nursing and other Professions Allied to Medicine. There were differences between women, both on the basis of the sector within which they were employed, and their level within that area. Within the limitations of a focus group methodology, these have been flagged up within the paper.

At the most basic level it is clear that there is a need for public education concerning equality at the level of outcome within an organisational context. The importance and the widespread perceived absence of clear criteria as regards employment also needs to be tackled. Gender balanced interview boards; access to opportunities to ‘show form’; various kinds of management training as well as assertiveness training; and access to ways to facilitate combining work and family responsibilities, without prejudice to promotion opportunities, are also important. Finally the identification of targets- and even in some cases of quotas- was seen as important at least on a short term basis.
Such changes in procedures will not in themselves be sufficient since the entire organisational culture is permeated by a lack of parity of esteem, which is reflected and reinforced by the low value attached to areas of predominantly female as opposed to predominantly male work. Furthermore it is obvious that a much wider range of legal, social and cultural factors need to be taken into account if equality, even within organisations, is to become a reality since ‘No society in the world treats its women as well as its men’ (40).

References
(3) see P.O' Connor ‘Organisational Culture as a Barrier to Women's Promotion in two Irish Health Boards’ Economic and Social Review, Vol 27, No.3 (1996) p 205-234 and P. O' Connor Report on the Barriers to Women's Promotion in the Midland and Mid-Western Health Boards (Mid Western Health Board, Limerick, 1995)
(6) M. Honan ‘Recent developments on indirect discrimination; Equality News, No.9 (1997) p16. It is worth noting that in Ireland such quotas have long been in existence as regards the appointment of disabled persons to the public service.
(8) Department of Equality and Law Reform, 1994, op cit p55
(9) Platform for Action (Government Publications, Dublin, 1995 ) p 78
(10) D. Doherty ‘Brief for the study’ Unpublished Ms, 1994
(11) N.E.S.F. op cit, p.16-17
(12) T. Callan, & A. Wren Male-Female Wage Differentials: Analysis and Policy Issues
(ESRI., Dublin, 1994) p.88
(13) The First Progress Report of the Monitoring Committee on the Second Commission on
the Status of Women (Government Publications, Dublin, 1994)
(14) Callan and Wren op cit p.78
(15) A.Lester ‘Strengthening the legal framework: Learning from International experience’
Paper presented at the EEA 1977-1997 Anniversary Conference Look Beyond 2,000 Royal
Hospital Kilmainham, Dublin, 1997
(16) Community Workers Co-Operative and the Northern Ireland Council for Voluntary
Action Equality and the Structural Funds (Combat Poverty, Dublin, 1995)
(17) Callan and Wren, op cit p.68
(18) European Commission Social Europe: Progress Report on the Implementation of the
Medium-Term Social Action Programme Supplement 4/96 (Brussels, Luxembourg 1997)
(21) P. Moss. ‘Reconciling Employment and Family Responsibilities’ In The Work-Family
(22) See N. Folbre, Who pays for the Kids? Gender and the Structures of Constraint
(Routledge: London, 1994)
(23) The term Paramedics is the term used by the Health Board for a varied group of
professions, including Physiotherapy, Laboratory Technician, Occupational Therapy,
Environmental Health, Radiography, Social Work, Psychology, Speech Therapy, Pharmacy.
It is recognised that it has para-professional connotations and hence reference is made to
‘other Professions Allied to Medicine’.
(24) For further details on sample and methodology see P.O’ Connor, 1996, op cit; and
(25)For a discussion of the method see D. Morgan Focus Groups as Qualitative Research.
(Sage, 1988). It has been used particularly in American studies, for example U.S. Merit Systems Protection Board *A question of Equity: Women and the Glass Ceiling in the Federal Government* (A Report to the President and Congress of the United States. Washington, 1992)

(26) see O’Connor, 1996, op cit, Appendix

(27) Department of Equality and Law Reform, 1994, op cit p55


(30) *First Report to the Third Joint Oireachtais Committee on Women’s Rights* op cit :X 12


(33) E. Mahon "The Barriers and Difficulties Women Experience in Getting to Decision Making Level" Paper presented at the *Participation to Partnership* Conference in Waterford, November, 1991B.


(36) In the *Sixth Annual Report on Equality and Opportunity in the Civil Service* (Dublin, Government Publications, 1994) noted there was a suggestion that job sharing was seen as inhibiting promotional prospects.

(37) CREW, Vol 3, no 8 (Centre for Research on Women, Brussels, 1983)
(38) S. Lewis, ‘Family Friendly Employment Policies: A route to changing organisational structures or playing about at the margins?’ *Gender Work and Organisation*, 4,1: 21


(40) United Nations, op cit