UNIVERSITY OF LONDON

# IMPLEMENTING EQUAL EMPLOYMENT-OPPORTUNITIES POLICIES: RACISM AND PATRIARCHY IN THE NHS

IN THE BRITISH NATIONAL HEALTH SERVICE:
AT WORK.

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## ABSTRACT

An analysis is presented of the implementation of equal employment-opportunities policies in the British National Health Service (NHS). It focuses on policy development at national level for the NHS as a whole, and also at local level in a case-study of two District Health Authorities. The material was collected from interviews with over sixty respondents. At national level they included key actors in the policy process. Data from a mail survey of all Health Authorities and Boards in the NHS - undertaken for the thesis - is used to additionally evaluate policy progress at national level. The analysis focuses on the organisation and stimulae behind policy implementation at national level. At local level, interviews were held with personnel specialists responsible for the formulation of policy, and line-managers responsible for policy implementation. The analysis focuses particularly on equal opportunities monitoring, formalisation of the selection process for employment, and positive action measures. The analysis uses concepts of racism and patriarchy to theoretically structure a variety of disparate processes which deny equality of opportunity at work. It also suggests targets and strategies for policy implementation.

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## KEY TO QUOTATIONS FROM INTERVIEWS

The following symbols are used in quotations from interviews:

| | |
|---|---|
| ... | Pause in statement |
| .....//..... | Parts of statement edited out |
| ( ) | Explanatory words inserted, or words substituted to preserve anonymity |

# INTRODUCTION

## Objectives

This thesis is concerned with the provision of equal employment-opportunities for women and men, and black and white workers, in the British National Health Service (NHS). There are four chief objectives.

- To demonstrate the ways in which equal employment-opportunities are denied and the subsequent consequences for the experience of women and black workers.
- To determine what policy measures could be implemented in an attempt to ensure equality of opportunity at work.
- To evaluate the progress of the NHS as a whole in implementing equal opportunity measures.
- To identify processes which have impeded - and are likely to impede - the implementation and success of equal opportunity measures.

The thesis employs concepts of "racism" and "patriarchy" to theoretically structure both the disparate ways by which equal employment-opportunities are denied, and the processes which inhibit the implementation of equal employment-opportunities policies. In using the concepts the aim is not to develop their conceptual properties, but to employ a useful device to indicate targets for policy implementation.

## Background to the research

The initial ideas for the research were inspired by a combination of the author's first career as a psychiatric nurse, and subsequent academic studies on "race relations". In the context of a growing body of anecdotal evidence in the 1980s concerning race discrimination at work in the NHS (cited in chapter one), the initial aim behind the research was to collect more rigorous evidence to guide policy intervention by focusing on the relative career paths and experiences of black and white nurses. But in the context of criticisms levelled against white researchers - particularly in the early 1980s - in the field of "race relations" research, a significant portion of the first twelve months of the research was spent deliberating about the most appropriate focus as the author of this thesis would be classified in terms of ethnic group as "white". The outcome was that the focus of the initial research ideas was considerably re-orientated. It involved - for reasons to be discussed shortly - a shift away from the study of black and white nurses towards a focus on the organisational processes which produce and sustain inequalities in the workplace on the basis of 'race' and sex. The early research interest was solely on issues of 'race' in the mould of earlier research in which the variables of 'race' and sex have been analytically separated. Problems associated with the 'race' of the researcher were therefore of primary concern in re-orienting the focus of the research. But parallel concerns in relation to gender - as will be discussed below - were also involved.

It seems worthwhile at this point to provide a brief overview of the difficulties potentially facing white researchers when studying black people to introduce the focus of the research. Analyses of the difficulties have concentrated particularly on the 'politics' of research (cf. Bourne 1980, Gilroy 1980, Solomos 1988: 6-15) rather more than on the potential methodological difficulties involved. In considering the most appropriate focus

for the research, however, the methodological concerns appeared to demand considerable thought - in addition to the political considerations - as at first sight it seemed that a number of major difficulties face white researchers in relation to black respondents. They may be faced at the outset with difficulties of achieving access to potential respondents. If access is achieved respondents may be inhibited - and less than candid - because the necessary degree of rapport and trust may not be able to be established. There may even be problems of interpreting the data once collected. These problems are - arguably - rooted in the 'whiteness' of the researcher. To place the concern about access in a broader context, it would seem uncontroversial to suggest that members of any social group that have been marginalised in a society are likely to harbour suspicions of the overtures of those who are seen to belong in the society. "Outsiders", it has been suggested, "often reject those who reject them." (Higgins 1980: 183).

In relation to the potential difficulties concerning inhibitions black respondents may feel when faced with white researchers, Errol Lawrence, for instance, accused some white researchers of failing:

> to acknowledge the extent to which the replies they get may actually be determined by their positions as white 'authority figures' in a situation where power relations are reproduced in and through racism. (Lawrence 1981: 9).

An implication behind the accusation is that black respondents are unlikely to be completely open about their experiences of racism, or their attitudes on 'race-sensitive' issues, to a person whom they associate with the social group at the source of that racism and sensitivity. Therefore the researcher's 'whiteness' may not only impede their initial access to black respondents, it might also inhibit the degree of rapport or trust that they can establish with respondents.

To place the argument in a broader context again, this difficulty is not restricted

to the interaction between a white researcher and a black respondent. For example, Janet Finch recognised that some male social workers or counsellors might be able to establish the degree of rapport or trust with their female clients necessary to discuss the most intimate of details, but:

> However effective a male interviewer might be at getting women interviewees to talk, there is still necessarily an additional dimension when the interviewer is also a woman, because both parties share a subordinate structural position by virtue of their gender. This creates the possibility that a particular kind of identification will develop. (Finch 1984: 76).

A further possible difficulty faced by white researchers concerns the interpretation of data once collected. It has been argued that they cannot understand the experience of black people because they have not shared that experience themselves. It follows from this that they lack an 'intuitive understanding' of what it means to be black. Hence, as the majority of race relations researchers are white, 'race relations' and 'black experiences' in Britain have not been adequately theorised. Therefore it has been consequently argued that until "articulate spokesmen" (sic) emerge from the "black communities":

> then the academics can at best write about the blacks from the outside, describing the place they occupy in British society and the way it discriminates against them. They can hardly hope to explain how the blacks view their place and cope with its imperatives. (Parekh 1986: 25).

The issue of interpretation concerns not just the validity of research findings, for it has been alleged that white 'race' relations researchers have reproduced common-sense racist notions of black people at a "theoretical level", concerning issues of cultural "castration", black family "pathology", and the "identity crisis" of black youth. It has been further alleged that these interpretations were informed by a "casual commonsense racism" and they have provided a legitimacy and sophistication to that racism (Lawrence 1981, 1982). The allegations were vehemently resisted by those against whom they were levelled (Cashmore & Troyna 1981, Rex 1981), but the epistemological question behind the

allegations is clear; can white researchers as cultural strangers adequately understand, interpret and represent the experiences of black people ?

In evaluating the potential difficulties, white researchers arguably are not faced with insoluble limitations upon their research. Access to potential respondents, for instance, might be achieved through introduction by acquaintances or informal contacts, hence reducing suspicion. In general this 'opportunistic approach' as it has been called, can be productive when access is potentially difficult. A number of black respondents were interviewed in the course of the research. They featured in a sample of potential respondents across the two organisations and were not specifically selected because they were black. There did not appear to be any particular difficulties of access, but - as was the case for all respondents - the researcher could cite in letters requesting interviews the support of senior managers in their employing organisations with whom access had already been negotiated.

In relation to the question of rapport and trust, inhibitions that black respondents might initially have with regard to white researchers might be diminished when they have been able evaluate the researcher's motives. Additionally, a respondent might become more trusting as a rapport develops and they get to know the researcher better. Some of the comments in relation to racial harassment - as quoted in chapter one - indicate that some of the black respondents were certainly not inhibited about sharing their experiences and views of their employing organisation in relation to those experiences. In addition, some of the comments from female respondents - also quoted in chapter one - similarly indicate an absence of reticence.

With regards to the mis-interpretation of data arising from the absence of a common experience, it has been argued that some black researchers may be just as far

removed as white researchers from the experience of black respondents. For instance, Wilson has argued that:

> although the contrary is sometimes assumed, the black experience is not uniform. Despite the fact that all blacks may have been victimized by racist behaviour, at one time or another, black experiences nevertheless vary by social class, region of the country, and age. Indeed some middle-class black sociologists may have experiences closer to those of middle-class whites than to those of lower-class blacks. (Wilson 1974: 326)

The potential difficulties that might be faced by white researchers - although, as has been argued, they do not appear to be insoluble - suggest that the researcher's 'whiteness' might be an asset when studying other white people. In other words, it is perhaps more likely that they will gain access, establish trust, and understand the way their respondents view their world. Likewise, when studying whites, being black might be a disadvantage. This was recognised by Maureen Stone in her study *The Education of the Black Child in Britain* (1981), as she reported that:

> although being West Indian had certain advantages in the Community groups I visited, mainly in being permitted access in the first place (although this was not always the case and I was refused access to a number of projects), within the school system this could (and I think did) work the other way in terms of what was said to me and what was made available to me. (Stone 1981: 90).

Likewise, a female researcher might encounter difficulties in relation to male respondents, whereas a male researcher might more easily achieve access, establish rapport, and understand the experiences of other males. In this context, it is arguable that some of the statements quoted in the thesis from white and male respondents - particularly in chapter one - would not have been made to black and female researchers.

It seems, therefore, that white researchers might use their 'whiteness' to their advantage in a number of roles. Firstly, they might focus on the attitudes and practices of white people rather than on the facts of black disadvantage (cf. Cashmore 1987). This

shifts the locus of the 'problem' of racism away from black people onto whites. It appears more logical for an understanding of white racism to turn to the individuals who sustain and reproduce inequality. The white researcher might search out and expose the attitudes and practices of individuals which affect black people over whom they exercise some power. This might be particularly applicable in organisations and concern, for example, the relationship between school teacher and school student, employer and employee. The white researcher could also perhaps take advantage of their 'whiteness' by assuming the role of a benign investigator in searching out and disseminating examples of good practice in organisations which have taken active measures to prevent discrimination. For example, they might draw from the experience of those involved in implementing equal opportunities policies to construct model policies or guidelines. From the dissemination of this experience other organisations which have not yet implemented their own policies may draw some strategic guidelines for their own practice. Alternatively, the white researcher might assume a less benign role by exposing gaps where organisations have failed to take measures to prevent discrimination or to implement equal opportunities policies. All of these potential roles have a corollary for the 'male' researcher when studying other males.

It seemed sensible, therefore, when designing the research for the thesis, that a number of these roles could be pursued, particularly as the powerful positions of Health Service organisations are dominated by white males. It was decided therefore to investigate the organisational practices which maintain and reproduce inequalities at work, rather than the experience of those inequalities. This decision was not a comprise in the face of potential difficulties, instead it was a deliberate strategy to make full use of the limited resources, specifically the researcher's 'race' and sex. This particular research

focus seemed to be especially appropriate as at the time the research was initially conceived the experience of implementing equal employment-opportunities policies was under-researched and under-theorized. Research findings published whilst the research for the thesis was being carried out have recently provided insights into policy implementation (Cockburn 1991, Collinson et al 1990) although they have been primarily concerned with gender issues, and have not covered the NHS. Some the findings will be discussed in the concluding chapter. It is the case, though, that although there have been a large number of published policy prescriptions concerning the implementation of equal employment-opportunities policies - which will be referred to in chapter four - there has been little evaluation of the actual experience of implementing policies.

**The research methods**

The analysis presented in the thesis evaluates the equal employment-opportunities policy process at national level for the NHS as a whole, and at local level by focusing on two District Health Authorities. The empirical material on which the analysis is based can be distinguished between the two levels. For the policy process at national level interviews were held with fourteen key informants. Gergen (1968: 207) has recommended that one of the more productive means of studying the process of public policy formation is to concentrate on individuals who exercise considerable 'leverage' or power in the shaping of policy. Accordingly, most of the fourteen respondents were key actors involved in the policy process at national level for the NHS. In addition, there were a few respondents who were only marginally involved but their role afforded them with a view of the policy process overall, and some of them had made a considerable impact on the policy process through their research and publications. The procedure of identifying suitable informants for this aspect of the research began with a written enquiry in the initial stages of the

research to the offices of a Task Force established by the King Edward's Hospital Fund for London (the King's Fund Equal Opportunities Task Force) as it was obvious - on the basis of their publications - that they had played a prominent role in the policy process in the NHS. That enquiry produced the first informant who was asked - in the interview subsequently arranged - to suggest other potential informants to whom written enquiries were also made in the first instance. Subsequent informants were also asked to suggest other potential informants, and consequently informants were identified through a 'snowballing' process. Interviews were also held with four equal opportunities advisers working within the NHS. Their perspectives contributed to the analysis of the national policy process. Three of the advisers were initially contacted during the selection process for the two case-study Health Authorities, and the other was introduced by the adviser in one of the selected Health Authorities.

Unstructured interviews were held with each of the informants using a topic list to guide the discussion. An unstructured approach provides the flexibility to pursue issues raised during an interview and it proved particularly useful for exploring the dimensions of the equal opportunities policy process with informants. Gergen has also suggested that it is particularly advantageous to apply an unstructured approach when interviewing persons of 'high prominence' in the policy process because they might resent the attempted imposition of constraints in a structured interview and also because their role in the policy process may be so distinctive that a rigid approach is simply inappropriate (Gergen 1968: 223). The information collected from the interviews provides the basis of the analysis presented in chapters five and six.

A mail survey of all Health Authorities and Health Boards in the NHS (including Northern Ireland) was also carried out for thesis. It was conducted to meet one of the

objectives of the thesis (as stated on page 9), namely to evaluate the progress of the NHS as a whole in implementing equal opportunity measures. The survey was carried out between September 1990 and January 1991 and achieved an 87% response. It was funded by a grant from the Central Research Fund of the University of London and the survey findings and a discussion of the survey method are presented in chapter four.

With regard to the equal opportunities policy process at local level, case-studies were carried out in two of the 232 Health Authorities (and Health Boards) in the NHS at the time of the research. They were conducted between January 1990 and January 1992. In selecting the two Health Authorities an aim was that one Authority should be considerably advanced in terms of policy implementation compared to other Health Authorities, and the other should be less advanced, so that the policy process could be observed as it occurred for the former Health Authority, and retrospectively constructed for the latter. The intention was to determine whether both Authorities were experiencing similar processes in relation to the implementation of policy. From earlier research on the London District Health Authorities (LACRC 1985, GLARE 1987) a shortlist of eight Health Authorities was drawn up which satisfied the criteria in relation to the policy process.

As researchers have found the achievement of access to organisations "troublesome" (Bryman 1988: 17), and it has been argued that successful entry "involves some strategic planning, hard work, and dumb luck." (van Maanen & Kolb 1985: 11), particular care was taken in the approaches to the Health Authorities. A number of strategies for successful access are suggested by the methodological literature on organisational research. Contacts, friends, and relatives may be useful to the researcher in attaining access to organisations. For instance, Buchanon et al (1988) attained access

to one organisation in particular through the head of the company who was also a friend. They report that the research design was settled over a mixed grill and two pints of beer in a pub across the road from the company which they proposed to study. This approach indicates a second strategy, that is, it is important to attract the interest and - then hopefully the subsequent sponsorship - of someone in the organisation. It would seem that such a person should have sufficient auspices in the organisation to serve as a credible sponsor. This does not necessarily involve approaching organisations 'from the top' which might be problematic because of limitations facing outsiders in contacting and meeting senior managers (Buchanon et al 1988: 56). However, subsequent support should be sought at an early stage from a manager with sufficient seniority to sanction access, as although it might be easier to pursue negotiations with more junior levels of management, access might still be denied by those with greater authority (Crompton & Jones 1988: 69). It may also be useful - according to Crompton and Jones - to prepare a presentation for management and unions.

With the preceding advice in mind, an initial aim was to attract the interest of a senior personnel specialist - and then their subsequent sponsorship - in two Health Authorities. A letter of enquiry was sent to the Director of Personnel - or alternatively, the equal opportunities adviser, if one had been appointed - in each of the eight shortlisted Health Authorities. Four replies were received, and the respondents subsequently interviewed to determine both their suitability and their interest in the research. A written research proposal (appendix 2) was then submitted - at the researcher's behest - to the Directors of Personnel for two selected Authorities which most closely fitted the selection criteria. The proposals were subsequently considered by each Authority's equal opportunities committee without the researcher's presence. Agreement for the research was

achieved at the first attempt. It was agreed that the personnel specialists with whom contact had initially been made - both equal opportunities advisers - would be the first point of contact for the organisations, and a source of introduction to other personnel specialists and managers.

It is also recommended in the literature that it is useful - when attempting to achieve access - to offer something tangible in return for cooperation, as Bryman (1988: 15), for instance, has argued that "research must be 'need-fulfilling' in order to entice admission." At first sight, therefore, it seems that senior managers of an organisation are more likely to agree access if they are going to benefit in some way. Accordingly, in negotiating access with the two case-study Health Authorities the researcher offered to provide assistance with the data analysis for a workforce audit which both organisations were conducting at the time. The offer was taken up by one of the Authorities and it proved to be a mixed blessing. The researcher worked with the equal opportunities adviser on the analysis, and whilst this led to a close rapport, and subsequent use of the data - as presented in chapter two - the time involved was a considerable drain on the fieldwork resources. But, on balance, it is likely that the degree of rapport with the consequent benefits in relation to the fieldwork, could not have been achieved without the cooperation for the workforce audit. For instance, the assistance given to the equal opportunities adviser provided a valuable opportunity for 'hanging around' and observing first-hand the policy making process from within the District. I was also invited to attend the bi-monthly meetings of the Authority's equal opportunities committee which additionally provided a valuable overview of the policy making process.

It seems that one of the most common reservations which can block access to organisations centres on the issue of confidentiality. The researcher offered complete

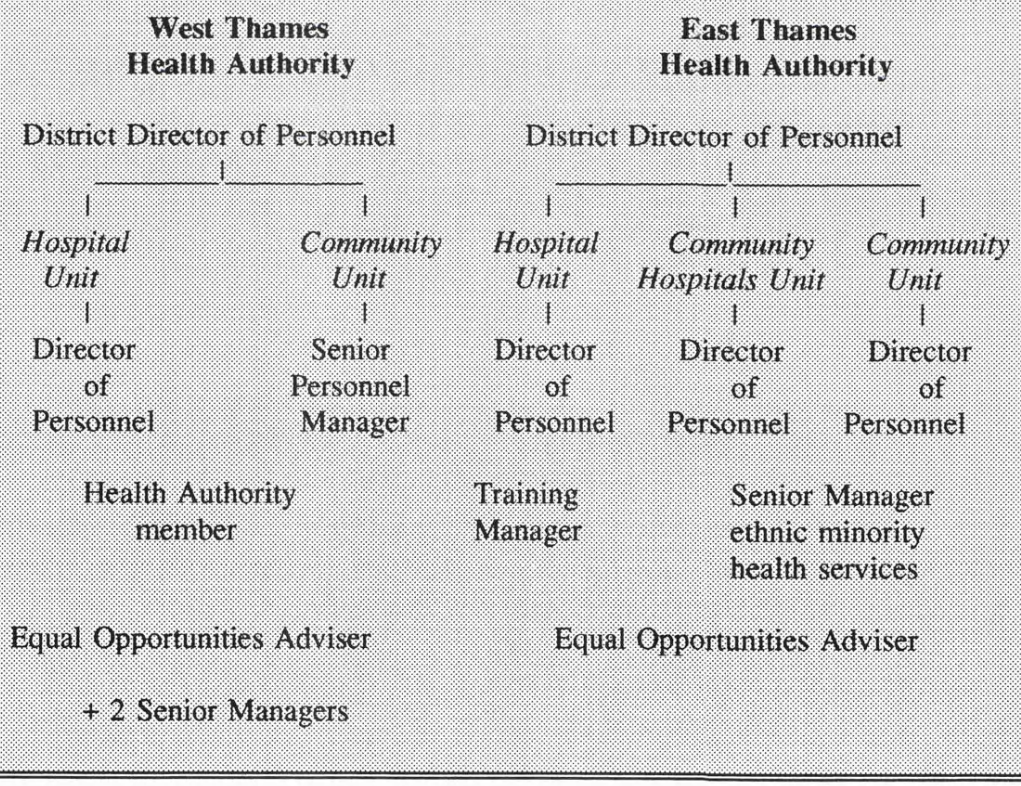
anonymity to the two Health Authorities in the shape of a guarantee that the Authorities would not be named in any discussion the researcher had with anybody outside of each organisation, or in anything written about the research. The two organisations will therefore be called "East Thames" and "West Thames" District Health Authorities. Similarly it was agreed with the Health Authorities that anybody interviewed for the research was not to be named or indirectly identified through their job title or their reported comments.

The case-studies in the Health Authorities involved an ethnography of a number of aspects of the policy process - or the development - of their equal employment-opportunities policies. It was possible to achieve a far greater degree of access to East Thames Health Authority, therefore, some aspects of the thesis will be biased towards the material collected from that Authority. A close relationship developed with the adviser in East Thames during the fieldwork period, which subsequently provided a rich insight into the workings of the organisation. In West Thames, the opposite was the case. The personnel specialist who was my point of contact left the organisation shortly after the access was agreed, and I was never able to develop a rapport with their successor, who did not appear to indicate much enthusiasm for the research. To some extent their reticence appeared to be rooted in the sensitivities - discussed above - related to activities of white researchers in "race relations" research. It was considered whether another Health Authority should be approached, but because of unknown potential access problems it was decided to remain in West Thames. The contact with the organisation, however, was largely limited to the interviews with respondents.

The main research method used in both Authorities involved semi-structured interviews with two distinct groups of respondents focusing on particular aspects of the

equal employment-opportunities policy process. The first group consisted of individuals who had the primary responsibility for either developing and/or implementing the equal-employment-opportunities policy as a whole in their respective Districts, and the individuals are indicated in figure 1 below. On the basis of that responsibility they had already been identified - during the early stages of the research - and subsequently served as a core of key informants about the implementation of policy in both Districts. They were additionally useful because their general responsibilities appeared to provide them with more of an overview of employment practices in their organisations than

**Figure 1. Respondents in East and West Thames Health Authorities responsible for the formulation and implementation of the equal-employment opportunities policy**




other managers or employees. This core group consisted of fourteen respondents - seven

in West Thames District and seven in East Thames, and as indicated in figure 1 they were chiefly - although not exclusively - employed in the personnel function. The group included the Equal Opportunities Advisers and the District Directors of Personnel in both Districts to whom they reported.

The organisation of West Thames District was divided into two 'Units' - the Hospital Unit and the Community Unit, and the group of informants included the Director of Personnel for the Hospital Unit, whilst their counterpart in the Community Unit nominated a Senior Personnel Manager as an informant in their place due to the particular responsibility they had been allocated for equal-employment opportunities. The organisation of East Thames District was divided into three Units - Hospital, Community Hospitals, and Community - and the Directors of Personnel for each of the units were included amongst the informants. Also included in East Thames were the District Training Manager and a Senior Manager with responsibility for minority ethnic health services as they had both made a significant contribution to the formulation and implementation of the equal employment opportunities policy. Lastly, a Health Authority member from West Thames District - who was chair of the District Equal Opportunities Committee - and two Senior Managers, were also included because of their particular contribution to the formulation of policy.

At least one interview of approximately 45 minutes length was conducted with each of these respondents, and in some cases - especially in East Thames District - two or more interviews were conducted in addition to numerous informal conversations which also provided a rich source of data. All of the interviews - apart from one where the respondent refused - were tape-recorded and transcribed afterwards, and nobody refused to be interviewed. The material collected from this group of respondents is used in

chapters one, seven and eight.

The second group of interview respondents consisted of thirty line-managers - fifteen in each of the two Health Authorities. Each of the managers were involved in the selection of new employees and - as will be explained in the thesis - as that activity constitutes the main arena in which equal opportunities are either provided or denied, the managers were key actors in the implementation of the equal employment-opportunities policies. The Unit Directors of Personnel in both Authorities were asked to provide a list of managers who they believed were frequently involved in the recruitment and selection of staff and a random sample of managers was selected from the lists in proportion to the representation of their particular occupational group - eg nurses, administrative staff - across the workforce. The selection process is discussed in more detail in chapter eight, and the material collected from this group of respondents is used in chapters one and eight.

Two distinguishing features of qualitative research have characterised the approach to all of the interviews, both at national and local level. Firstly, there is an accent on the interpretations of policy development offered by the informants. For instance, with regard to the policy process for the NHS as a whole, each informant was asked to give their interpretation of the process of development of equal employment-opportunities policy at national level; to identify what factors they thought were influential behind the policy development; and to account for the role of their institution and their own role in the policy process. As a check on the validity of their interpretations each informant was asked to indicate how their role provided them with an informed view of the policy process rather than it being merely conjectural. In the subsequent analysis of the information provided attention is drawn to the dominant themes and explanations - but

with competing themes also cited where relevant - rather than the presentation of a consensual interpretation of the policy process.

The second distinguishing characteristic of the research is that it has involved an inductive process for which an essential strategy according to Mintzberg (1983: 108) is "detective work", "following one lead to another" and looking for "patterns" and "consistencies" in the data. For example, whilst the research initially began without any prior hypotheses, preliminary hypotheses were formulated from the very first interview and they provided part of the topic guide for subsequent interviews. In essence then, the analysis began with the first piece of data collected. Care was taken, however, to avoid the introduction of bias through the premature closure of avenues of enquiry by continuing to investigate variables that did not accord with the emerging hypotheses. The method of analysis used was based on an early version of "grounded theory" (Glaser 1965), in which analytic themes are produced by a continuous comparison of pieces of data.

**Summary of chapters**

Chapters one and two are concerned with the first objective of the thesis, namely, to demonstrate the ways in which equal employment-opportunities have been denied in the NHS and the subsequent consequences for the experience of women and black workers. Chapter one focuses on exclusionary - or discriminatory - processes which disadvantage women and black workers. These processes are conceptualised as the "political" dimension of racism and patriarchy at work. It will be observed that there was a common perception amongst key respondents interviewed in both case-study Health Authorities that discrimination was at work in their organisation. The discrimination will be analyzed - on the basis of a review of the literature on sex and 'race' discrimination in the NHS. The analysis will also include supporting material from interviews with line-

managers in the two case-study Health Authorities. Chapter two focuses on the patterns of domination by white males which characterise the occupational structure of East Thames Health Authority. The dominance will be conceptualised as the "structural" dimension of racism and patriarchy at work. It will be argued by reference to published data - although it is extremely limited - that similar patterns of domination appear to characterise the occupational structure of the NHS as a whole. A key conclusion is that the structure of domination is more than merely a statistical phenomenon, rather it provides the environment in which the exclusionary processes - discussed in chapter one - can operate.

Chapter three is concerned with the second objective of the thesis; to determine what policy measures could be implemented in an attempt to ensure equality of opportunity at work. It discusses three broad policy measures; positive discrimination, positive action, and equal employment-opportunities policy. The meaning and the moral foundation of the principle of equal opportunity is given particular attention, and especially the overriding principle of 'merit' which lies at the heart of equal employment-opportunities policies. Chapter four is concerned with the third objective of the thesis; to evaluate the progress of the NHS as a whole in implementing equal opportunity measures. It is based on a mail survey of all Health Authorities conducted for the thesis.

The remainder - and most substantial part - of the thesis is concerned with the fourth objective; to identify processes which have impeded - and are likely to impede - the implementation and success of equal opportunity measures. It focuses on organisational processes which present significant barriers to policy implementation. The processes are conceptualised as the "institutional" dimension of racism and patriarchy at work. The analysis incorporates both the micro and macro societal levels and the

'macro-micro dimension'. The understanding of the terms 'micro' and 'macro' used here is that proposed by Munch and Smelser (1987) who saw the micro level as:

> involving encounters and patterned interaction among individuals (which would include communication, exchange, cooperation, and conflict) and the macro level as referring to those structures in society (groups, organizations, institutions, and cultural productions) that are sustained (however imperfectly) by mechanisms of social control and that constitute both opportunities and constraints on individual behaviour and interactions. (Munch & Smelser 1987: 357).

The analysis in chapters five and six concern the macro level in that they focus on the role of specific State institutions in relation to the implementation of equal employment-opportunities policies in the NHS as a single organisation. The State institutions included in the analysis are chiefly the Department of Health, the Commission for Racial Equality, and the Equal Opportunities Commission. The perspective of the analysis - which is by no means new (cf. Solomos et al 1982, Omi & Winant 1986: 76-77) - is that the State cannot be regarded as one monolithic organisation with a single purpose in relation to policies aimed at inhibiting racism and patriarchy at work. It is observed that the policy process at the macro level is shaped by the interaction of State institutions with each other, with other institutions - such as trades unions - and with other macro processes such as changes in the characteristics of the available labour pool and the increasing articulation of the need for certain health services to be responsive to the particular requirements of minority ethnic groups. The analysis also pays attention to the interaction between the micro and macro levels for - as will be argued below - the reproduction of racism (van Dijk 1991: 33) and patriarchy at work are a function of that interaction. It needs to be observed at the outset, however, that the interpretation of the 'micro-macro' distinction used in the thesis is analytic, not empirical. This interpretation follows Alexander's argument (1987) that the terms micro and macro are "completely

relativistic. What is macro at one level will be micro at another." (Alexander 1987: 291). This is relevant to the analysis presented, for - as will be indicated - interactions between individuals are influential in shaping the activities of the institutions at the macro level. Chapter five focuses on the macro-micro dimension by evaluating the impact of changing organisational arrangements at the macro level upon policy implementation at the micro level in Health Authorities. Chapter six focuses on the macro-micro dimension by considering the impetus for policy implementation at the micro level generated by macro level processes, chiefly a potential shortage of labour for the NHS due to the "demographic-timebomb" that has been predicted to explode in the mid-1990s.

Chapters seven and eight are concerned with the micro-level through an analysis of the factors affecting the implementation of key elements of equal employment-opportunities policies in the two case-study Health Authorities. Chapter seven focuses on barriers to the implementation of monitoring systems which aim to make selection decisions for employment more accessible to scrutiny and managers accountable for their decisions. Chapter eight discusses the attitudes of line-managers towards the introduction of equal opportunities practices in the recruitment and selection process for employment, as their cooperation is essential to the success of the practices. The concluding chapter discusses the policy implications of the analysis presented in the thesis.

**Concepts of racism and patriarchy as theoretical devices**

As stated in the opening page (page 9) of the thesis, concepts of "racism" and "patriarchy" are used to theoretically structure the disparate ways by which equal employment-opportunities are denied, and the processes which inhibit the implementation of equal employment-opportunities policies. The terms "racism" and "patriarchy" are concepts, that is, they have been constructed to provide an abstract - or theoretical -

summary of events based upon observations of the empirical world. Numerous conceptualisations have been constructed under the labels of racism and patriarchy, but - as they are concepts - none of them are either intrinsically true or false. Some of the conceptualisations, however, are more useful than others in providing both a guide to the analysis of equality of opportunity at work and an indication of potential policy initiatives in relation to those events. Therefore, in this section of the introduction conceptualisations of racism and patriarchy will be considered with a view to evaluating their analytic value in relation to the objectives of the thesis, and the conceptualisations used in the thesis will be explained. When initially designing the research for thesis, the initial interest was with racism at work. However, as will be made evident below, it did not appear to make sense empirically to treat the systems of racism and patriarchy as two distinct entities. The discussion of the concepts of racism and patriarchy, however, focuses more on concepts of racism as an evaluation of the concepts provided the material for the early formulation of racism as a 'system of dominance'. There subsequently appeared to be a close congruence between that conceptualisation and one particularly influential concept of patriarchy in recent years (Walby 1990). When the concepts are used in the rest of the thesis as analytic devices equivalent attention is given to both racism and patriarchy at work. But in some of the analysis - particularly in chapters four and five - a bias towards racism remains which reflects the initial interest and the empirical material subsequently collected.

In considering racism first, three common conceptualisations can be distinguished in the academic literature in Britain. The first is the view of racism as an ideology, a doctrine - which was the product of nineteenth century scientific theorizing - that the world's population can be divided into distinct groups - or races - on the basis of largely

fixed and inherited physical characteristics - associated ultimately with geographic origin - and that the groups are aligned to each other in relationships of superiority and inferiority. This conceptualisation of racism was prominent in the early sociological theorizing on 'race relations' (cf. Banton 1967: 8) but was still used in the 1980s (cf. Cashmore & Troyna 1983: 34). From this perspective racism has been distinguished from 'race'- prejudice. Whilst racism refers to a set of intellectualised and coherent ideas, race-prejudice in contrast has been seen as an attitude - of an affective or emotional character - involving negative 'race'-stereotyping which is inflexible when confronted with contrary evidence (Cashmore & Troyna 1983: 36). For instance, Banton has observed that the:

> essential features of prejudice would appear to be its emotional character, in that it serves psychic functions for the individuals who display it, and its rigidity, in that when someone tries to demonstrate that an opinion is false, prejudiced people do not modify their views but, indeed, often twist new evidence to fit their preconceptions. (Banton 1967: 8).

A distinction has also been made - from this perspective - between racism and 'race'-discrimination. The latter has been used to describe the action in which some persons of a particular 'race' are treated differently - and usually less favourably - than others. Although the term 'discrimination' as most frequently used on the basis of 'race' refers to an exclusionary act it is also used - although less frequently - to signify an inclusionary act in the case, for instance, of positive discrimination policies in the USA.

The conceptualisation of racism as a doctrine of biological superiority is, however, now largely redundant because the idea of 'race' - and consequently the doctrine of racial superiority - have proved to be misconceptions rooted in 'scientific error' affecting a stage in the development of biological science which is no longer attributed any validity (Banton 1970: 28, Miles 1989: 70). Subsequently, the continued use of the term 'racism'

to represent an ideology has been pursued chiefly along two avenues. The first concerns the actual conceptualisation of ideology. Drawing from Gramsci's notion of "common-sense" (Gramsci 1971: 323-43) - which incorporates the interpretations individuals make of their world, their beliefs, ideas, and values - Miles, for instance, has argued that the conception of racism as an ideology should include not only "those ideas which are explicitly and logically formulated", but should also incorporate "'everyday' conversation...characterised as it is by the ascription of negatively evaluated attributes without recourse to explanation'" (Miles 1982: 77). These everyday representations - which appear to amount to 'race'-prejudice as defined by Banton - are commonly contradictory, illustrated by Miles in the competing claims, for example, that "'blacks come over here and take all our jobs'" and alternatively "'they only come here to live on the dole and peddle drugs'" (Miles & Phizacklea 1984: 10). In addition Miles has argued that although the idea of 'race' no longer has any scientific validity, its continued use is still appropriate as it persists as an element of common-sense (Miles 1989: 71). Therefore, the extension of the understanding of ideology in this way by the incorporation of common-sense representations overcomes the erosion of the validity of ideas of biological superiority and enables the continued use of the term racism to represent an ideology.

The second avenue along which the continued use of the term 'racism' has been pursued to represent ideology has concerned an analysis of what has been termed the "new racism" in Britain. The essence of the analysis is that cultural difference has replaced biological superiority as the ideological axis of 'racial' antipathy. This form of racism - according to Barker (1981) - was consciously promoted by leading members of the British Conservative Party from the late 1970s onwards and reproduced by the mass media. The essence of the "new racism" - as conceived by Barker - is an ideology that

it is inherently natural for humans to bond in groups, communities, and subsequently nations with a sense of national identity and difference in relation to other groups (Barker 1981: 21). In this context the presence of outsiders is seen as a threat to the way of life and the institutions of the nation, and "it is in our biology, our instincts, to defend our way of life, traditions and customs against outsiders - not because they are inferior, but because they are part of different cultures." (Barker 1981: 23-24). The usefulness of the ideology of the new racism for those who propose it is that "You do not need to think of yourself as superior - you do not even need to dislike or blame those who are different from you - in order to say that the presence of these aliens constitutes a threat to our way of life." (Barker 1981: 18). Hence, the ideology can be "concealed inside apparently innocent language" which draws attention to the "genuine fears" of ordinary people. In short, the distinguishing characteristics of the "new racism" are that 'race' is reduced to culture - not biology - and the boundaries of culture are coterminous with national boundaries. Therefore, race equals culture equals nation. The "new racism" operates to define who is included and therefore excluded from the British nation on the basis of cultural difference. Chiefly, the distinctiveness of African, Caribbean, and Asian cultures means that individuals who are part of these cultures are seen as an alien presence in British society which must be restricted and controlled because of the threat they pose. In essence, Black cultures and Britishness are seen as being incompatible (Gilroy 1987: 45-46).

A limitation, however, of the conceptualisations of racism as ideology discussed to this point is that they offer little analytic value by themselves for the identification of processes which produce social inequalities in the workplace on the basis of 'race'. (In addition, as will shortly be argued, an ideology of racism is not even a necessary

pre-condition for many of these processes.) Similarly, the potential remedies indicated by these conceptualisations - especially the "new racism" are more appropriate to the macro societal level rather than the micro level of workplace practices.

The second conceptualisation of racism that can be distinguished involves the extension of the concept beyond ideology alone to include the action involved in exclusionary processes, or in other words, discrimination. There is also usually no analytic distinction made between ideology and 'race'-prejudice. This conceptualisation is sometimes used without any analytic justification or explanation of the connection between the two elements of ideology and action, and - although the conceptualisation is not often made explicit - it appears to be common to the more polemic literature and therefore appears to represent the contemporary common-sense interpretation of racism. Some of these extended conceptualisations of racism are equivocal about the inclusion of the action element. For instance, Yeboah has argued that racism "should be defined as 'a set of attitudes and behaviour'", but later retreats towards the concept of racism as ideology by referring to the action or "performance" element as "tendencies to act in particular ways on the basis of knowledge and emotion." He observes that these "tendencies" are not necessarily translated into action as "one may be a racist without the power to act on the implications of one's racist beliefs." (Yeboah 1988: 14). As an example of equivocation in the opposite direction, Cashmore and Troyna - in their recent conceptualisation - initially define racism as a "relationship between 'insiders' and 'outsiders' that is given potency by ill-defined but efficient beliefs" and then proceed to clarify their use of the term "relationship" by focusing on the exclusionary processes (Cashmore & Troyna 1990: 23).

A difficulty with this extended conceptualisation of racism, however, lies in the

connection between ideology and action as it is obvious that they are not always related. For instance, as Yeboah recognises, a person may not always have the power to put their beliefs into practice. In addition, at a particular spatial and/or temporal location an individual might not have the volition or the opportunity to discriminate against others. Merton - in his typology of prejudice - classified this type of person as a "timid bigot" (Merton 1977: 32). Although this condition of timidity cannot be regarded as a fixed state as it is conceivable that in a different spatial and/or temporal context the "bigot" may indeed discriminate or participate in other processes of domination. Therefore, even though their beliefs may not be exercised in a discriminatory act at a particular point in time, they should not be discounted as they potentially remain part of the processes of discrimination. Processes of "indirect discrimination" - as defined by the British 1976 Race Relations Act - would also be excluded from an analysis which connects ideas and action. This form of discrimination involves the application of requirements or conditions which don't have any 'racial' context - such as length of residence qualifications for public housing - which are applied equally to all 'racial' groups, but in practice members of some groups are less able than others to meet the requirements (Race Relations Act 1976: 1(1)(a)). Processes of indirect discrimination can provide a substantial source of structural inequality. In short, a necessary linkage between the ideological and structural dimensions of racism fails to account for the role of either dimension operating independently.

The third and final conceptualisation of racism distinguished here involves a further extension of the concept beyond ideology and action - or exclusionary processes - to include the character of the social structure effected by those processes. Some conceptualisations in this category have been referred to as "institutional racism". They

were initially formulated in the context of political struggles by black people first in the USA and then in Britain in the late 1960s and early 1970s. The focus of the conceptualisation is upon the structural relationship between blacks and whites, and specifically the material inequality between the two groups. At its most simple formulation "institutional racism" describes the exclusion of black people from "equal participation in the society's institutions." (Blauner 1972: 185). The concept extends further than this, however, to refer to a pattern of subordination of blacks by whites at the societal level which is the outcome of the interaction of a number of social institutions such as systems of education, policing and the labour market. This focus on structural inequality - or consequences - appears to be shared by the many analyses of institutional racism (Williams 1985: 330), and is the key defining characteristic. Wellman's analysis presented in his book *Portraits of White Racism* (Wellman 1977) has been cited as an analysis of "institutional racism" (Miles 1989: 55, Williams 1985) - although he does not use the term himself - but it can be distinguished by the emphasis given to group conflicts - between whites and blacks - which maintain structural inequality. Accordingly, Wellman defines racism as:

> a structural relationship based on the subordination of one racial group by another. Given this perspective, the determining feature of race relations is not prejudice toward blacks, but rather the superior position of whites and the institutions - ideological as well as structural which maintain it. (Wellman 1977: 35-36).

A central component of Wellman's analysis is that any activity or process - irrespective of intentionality - which preserves - or inhibits challenges to - the racial status quo can be classified as racism. The emphasis given to processes of exclusion that do not have any racial motive provide a significant guide for the analysis in the thesis of processes which maintain inequalities at work.

In a critique of the literature employing the concept of "institutional racism", however, Williams argued in 1985 that it required redefining as its use had failed to provide "a guide to empirical research, and most importantly, it allows policy developments ostensibly attempting to remedy racial inequalities, to remain at the level of rhetoric." (Williams 1985: 323). This criticism strikes at the heart of the value of the concept for indicating processes of 'race' inequality at work, and subsequent policy initiatives. One concern is the lack of clarity - according to Williams - in discussions of the connection between intention - interpreted here as ideology - and action in relation to the production of 'racial' inequality, as the presence or absence of a connection clearly has implications for strategies of policy intervention (Williams 1985: 339). There does not, however, appear to have been a consensus about the connection. For instance, Carmichael and Hamilton appeared to draw a very close connection between ideology and action when they argued that:

> Institutional racism relies on the active and pervasive operation of anti-black attitudes and practices. A sense of superior group position prevails: whites are "better" than blacks; therefore blacks should be subordinated to whites. This is a racist attitude and it permeates the society, on both the individual and institutional level, covertly and overtly. (Carmichael & Hamilton 1967: 5).

In contrast, Blauner appears to have placed far less significance on the link between ideology and action for the consequence of inequality, as he argued that institutional racism "arises out of indirect processes and from actions that are usually non-intentional, in contrast to 'individual' racism, which tends to be more direct and volitional." (Blauner 1972: 188). A second criticism concerns the use and meaning of the term "institution", which - according to Williams - has been "muddled" in that examples of "institutional racism" have involved on the one hand a conceptual inflation by including processes at the societal level, and on the other hand they have also been reduced to the attitudes and

activities of individuals (Williams 1985: 331). Thirdly, Williams argued that some researchers employing the concept of institutional racism have identified a variety of forms of 'racial' inequality without attempting to discuss the relationships between them. In the same way, a variety of processes producing the inequalities have been identified without any demonstration of their interrelationship or their effect in the production of inequality. Finally, Williams argued - in relation to analyses employing the concept of "institutional racism" - that adequate attention has not been given to the interaction between 'race' and other factors - such as class and gender - in the production of inequality (ibid: 331-334) and that there has been "a taken-for-granted, rather than theorised acceptance of the primacy and autonomy of race." (ibid: 332).

In taking account of these criticisms the dimensions of the conceptualisation of racism used in the thesis will now be specified. Racism is conceived - drawing from van Dijk's conceptualisation (van Dijk 1991: 27) - as a 'system of group dominance'. The 'system' - as conceived in the thesis - has three dimensions; political, structural, and institutional. The political dimension involves a variety of exclusionary processes which on the whole have an ideological basis, and disadvantage women and black workers. The structural dimension involves the domination of white workers in positions of power and authority in the workplace, and it is produced in part by the exclusionary processes characteristic of the political dimension. Whilst these processes in general can be reduced to the activities of individuals, those activities only make sense in an institutional context in which some individuals are able to exercise power over others. The institutions with which the thesis is concerned are concrete organisations in the shape of Health Authorities and the collectivity of organisations in the shape of the National Health Service, and the policy processes which characterise the organisations. In addition to the exclusionary

processes there are other processes at work which have no ideological basis at all, but they provide a significant dimension - the institutional dimension - of the system of dominance as they serve to perpetuate inequality by providing barriers to measures designed to challenge inequality. Neither these processes, nor the individuals involved in the them could be described as 'racist' - according to the contemporary common-sense understanding of the term discussed above - but they make an important contribution to the systems of dominance, and the reproduction of inequalities at work.

An additional dimension to the conception of racism used in the thesis - which perhaps distinguishes it most from the concepts of "institutional racism" and Wellman's emphasis on group conflict - is that it interacts with other systems of dominance which operate, for instance, on the basis of gender, class, and age. Whilst an analytic distinction is made here between the systems it does not make sense empirically to treat them as distinct entities, however, as they are "experienced as a totality" by individuals (Allen 1987: 169-70), although in any particular temporal or spatial context one system may predominate over the others. Despite this seemingly obvious observation, much of the theoretical literature concerning 'race' and 'ethnicity' has been 'genderless', and - in the same way - much of the literature on gender relations has omitted considerations associated with 'race' and 'ethnicity' (Allen 1987: 171-72). The main arena in which the two dimensions have been connected have related to debates concerning feminism and feminist movements, and specifically the challenge against the assumption of "new-wave feminism" (Ramazanoglu 1989) that all women share a common sisterhood - or common interests - rooted in their oppression by men. Such an assumption - it has been argued - obscures the specific experience of black women and the role of white women in effecting that experience. Blacks and whites, and women and men cannot therefore be

regarded as homogeneous groups in either the operation or experience of racism and patriarchy.

But perspectives have differed in relation to the relative significance of 'race' and sex. For instance, Sykes has argued - in the context of Australian society - that the "power relationship" characterizing relations between whites and blacks also characterize the relationship between white and black women, and although black women - in common with white women - suffer sexual oppression, the strength of 'racial' oppression for them is greater. For instance, white women not only exercise a considerable degree of power and control over their lives in comparison to both black men and black women, but they also participate in the oppression of black women (Sykes 1984: 68). Similarly, Fesl has argued - also in relation to social relations in Australia - that:

> as an oppressive agent of women in our society, sexism runs but second to Australian racism, which we have imposed upon us not only by white men but by white women...If one were to measure oppression, on one side of the scale we would see white women being greater oppressors of black women than black men have ever been. (Fesl 1984: 110).

In essence then, these arguments propose that white women exercise power and control and have attained material benefits from which black women and men have been excluded. White women have both participated in that exclusion and have been the recipients of advantages attained through the 'race' exclusionary practices of white men. The arguments suggest a power hierarchy which is ruled by white men at the top, followed by white women who rule over black men and finally black women. From this perspective, black women have less in common with white women than they do with black men as the most significant axis of the power division is racism, therefore contradicting the notion of a common sisterhood assumed by "new-wave" feminism in the 1970s and 1980s. Many of the concepts of what has been regarded as "white

feminism" have also been rejected. One of these is the concept of 'patriarchy', and as the concept provides a key component of the analysis presented in the thesis the applicability of the concept to the material situation of black men and women needs to be considered at this point. The conceptualisation of patriarchy used in the thesis is drawn from Sylvia Walby's formulation of patriarchy as a "system of social structures and practices in which men dominate, oppress and exploit women." (Walby 1990: 20). There appears to be a congruence between this conceptualisation of patriarchy and the conceptualisation of racism as a system of dominance. The conceptualisation of patriarchy in the thesis brings into focus the control that men exercise over women, which is implicit to Walby's definition but stated more explicitly by others (cf. Millett 1971: 23ff). Walby has identified six interacting patriarchal structures, and whilst the thesis focuses on one of these in the shape of patriarchy at work the interactions of other patriarchal structures - specifically concerning the household, and sexuality - are also brought into the analysis in chapter one.

It has been argued that the concept of patriarchy presents analytic barriers between gender based processes and other social processes - for example, based on 'race' - which prevent a full understanding of the pervasive significance of gender across social life. But even critics of the concept admit that the idea of patriarchy maintains a "political sharpness" and an analytic clarity that has not been equalled by other concepts concerning to gender (Ackers 1989). One further criticism of the idea of patriarchy is that it more closely describes the relations between white men on one side and white and black women on the other. Because of the relative powerlessness of black men - in relation to white men in the economic and social structure, for instance - the same concept of patriarchy is not applicable to relations between black men and black women (Joseph 1981).

However, the question of whether the concept can be applied to both white and black women can be evaluated against empirical data. For instance, Tang Nain has argued that:

> If one is to determine whether the lives of black women are affected by patriarchy in societies which are considered racist, and whether black men participate in it, one will have to show that the labour power of black women is controlled in such a way so as to limit their access to income through a gendered division of labour in employment, and to show that the labour power of black men is not controlled in the same way. (Tang Nain 1991: 6).

Accordingly, using macro data concerning income and labour market composition in the USA for the 1960s and 1970s Tang Nain demonstrates that black men were second to white men in the earnings hierarchy ahead of white and black women, and for the period 1963-74 the earnings gap had even increased, and in relation to employment distribution there was greater homogeneity in terms of concentration in particular areas of work on the basis of sex, rather than race. In essence then - according to Tang Nain's analysis - black women are not only subject to racist exclusionary practices, but are also subject to patriarchal control exercised by both white and black men. The structural consequences of the interaction between the systems of racism and patriarchy will be considered further in chapter two. It will be concluded, however, that notions of a linear relationship with regards to white and black, and male and female workers, is too simplistic.

In summary, racism and patriarchy are conceptualised in the thesis as interacting systems of dominance, and political, structural, and institutional dimensions can be distinguished in both systems. The conceptualisations are used as analytic devices to reveal processes against which measures aimed at challenging inequality of opportunity in the workplace can be targeted. The aim is not to theoretically develop the concepts. It would also be beyond the scope of the thesis to consider the interactions of all the

possible systems of dominance. It is not implied therefore that the other systems - operating, for instance, on the basis of social class and age - have no significance. But the restricted focus appears to make sense in the contemporary policy context as, for example, equal employment-opportunities policies are primarily targeted simultaneously on the operation of racism and patriarchy at work. In the longer term, though, it is conceivable that the other systems might be targeted.

# CHAPTER 1

## POLITICS OF RACISM AND PATRIARCHY AT WORK

It is argued in this chapter that a variety of exclusionary processes which discriminate between female and male, and black and white workers. It is observed that the operation of discrimination at work was clearly recognised by senior managers responsible for the development and implementation of equal employment-opportunities policies in both East and West Thames Health Authorities. Three ways in which the exclusionary processes work are conceptualised on the basis of a review of the literature supported by interview material from the case-study Health Authorities. It will be argued firstly that - within the context of a gendered division of household labour - women are excluded from the path to career success, which is, therefore, a male path. It will also be argued that the route to career success additionally follows a 'white' path. Secondly, it will be argued that stereotypical views of women in relation to marriage and family responsibilities affect their career prospects, therefore - at work - their status as women supersedes their status as workers. In a similar way exclusionary processes are also at work for black workers in the NHS with the effect that they are primarily seen as 'black' rather than just workers. Thirdly, it is argued that areas of work in the NHS - particularly within management - are gendered with the effect that women as a group are excluded from positions of power and authority, and in the same way certain areas of work are also racialised.

## Common sense of patriarchy

Data presented in chapter two show an under-representation of women at the upper levels of occupational hierarchies - amongst doctors and nurses for instance - in the NHS. A variety of common-sense explanations discussed in the literature attempt to account for the pattern of inequality between women and men. They can, however, be categorised into two groups. The essence of the first group of explanations is the belief that most women leave jobs to have children, or because of other family responsibilities. There is, therefore, a diminished supply of women who could progress to senior positions. The second group is characterized by the belief that - for a number of reasons - women do not apply the same commitment as men to their work. They are, therefore, less interested in climbing their occupational career ladder - if one exists.

The first group - concerning the belief that most women leave work due to natal or other family responsibilities - is typified by the comments of one senior manager interviewed in a recent survey of NHS clinical chemistry laboratory staff. He stated that: "'Males tend to dominate the higher levels because simply the women drop out to get married, have babies and that sort of thing - there are no sort of sex bars, that is just the fact of life.'" (Homans 1989: 57). Evidence that the economic activity of women with dependent children - and particularly infants - is lower than those without (cf. U.K. 1990: table 11) appears to give some credence to that "fact of life". Accordingly, Homans observed - with regards to medical laboratory scientific officers (MLSOs) in one Regional Health Authority - that women were nearly twice as likely to leave each year than men, and over one-third (35%) of female leavers during a five year period analyzed gave up their jobs completely upon pregnancy. In addition, nearly 9% of female leavers had left because their husbands had wanted to move to a job in another area. However, many

women do return to work, and in general women's employment is characterised by a "bimodal" career pattern in which their economic activity is interrupted by a reduced participation over the childbearing period. Accordingly, Homans also observed that 57% of the women in her survey who left their work due to pregnancy reported that they hoped to return to work in a laboratory in the future (Homans 1989: 70), and a recent survey of doctors and their careers demonstrated that the great majority (89%) of female doctors with children had returned to work (Allen 1988: 28-29).

The availability of part-time employment - in the context of the gendered division of labour - enables many women with children to return to work. For instance, 53% of the women doctors in Allen's survey - that had returned to work in clinical medicine - were working part-time (Allen 1988: 28-29). Many of those doctors believed, however, that part-time working in itself had restricted their career chances, because the part-time posts to which they had returned commonly fell outside of the career structure. But it is not only part-time working which affects their career prospects, for they are disadvantaged by the career break in itself, particularly when in competition for jobs with men who have not taken such breaks (Homans 1989: 57).

Even if the disadvantage due to part-time working and career breaks was justified - and it will be argued shortly that it certainly is not - it does not fully account for the retarded progress that affects women's careers in relation to men. For instance, Davies and Rosser observed - in one District Health Authority - that it took women on average twice as long as men to achieve nursing officer grade and this could not solely be explained by career breaks or part-time working, as even those women who had a continuous full-time work record took longer on average than men to attain a nursing

officer post (Davies & Rosser 1986: 35).

Could it be the case then that women do not apply the same commitment to their work than men, and that this therefore accounts for the under-representation of women in senior positions ? Amongst this second group of common-sense explanations is the belief that most single women are not really interested in their work because they are just biding time until they get married. There is also the view that as the overriding commitment of married women is to their families - and as it is men after all who are the breadwinners - women have no desire, nor indeed no need, to strive in their occupations. A further belief is that the demands inherent to the family responsibilities of working women prevent them from applying the necessary effort for career success. Women doctors with children are assumed to be particularly unable to apply a full commitment to their careers, and it has been argued that the same would apply to men who tried to combine another pursuit with their medical careers (BMJ 1980). Whereas male doctors know that their commitment rests upon a female support system at home which keeps their private lives in order, it is unlikely that female doctors will have the same support system provided by a male partner (Bourne & Wikler 1978: 433-34).

Estimates of job satisfaction have been used to evaluate the relative work commitment of females and males (cf.Reid & Strata 1989: 170), and some of the literature concerning employment in the NHS enables a similar evaluation. For example, Davies and Rosser observed that their female respondents in administrative and clerical work were more likely than males to report that in their present posts their skills were underutilised, and they were also more dissatisfied both with their prospects and training opportunities. In addition, only approximately one-third of women in one of their surveys reported that they chose to enter and remain in posts where there was little potential for

advancement. Their findings therefore suggest a strong commitment to work amongst female administrative and clerical staff. A similar commitment was also found amongst female nurses. In contrast, however, Allen has produced evidence which appears to provide some support for the diminished commitment hypothesis, as 40% of women doctors returning to work after having children reported that they had restricted their commitment in some way (Allen 1988: 173-76) although in what way is not specified by Allen. However, the number of hours that the part-time women doctors worked appears on the contrary to suggest a high commitment, as three-quarters of women doctors who worked part-time worked twenty or more hours each week (Allen 1988: 173-76).

By way of a preliminary conclusion, there is some validity in the common-sense explanations for the under-representation of women in senior positions in the NHS, as *some* women do give up their jobs to have children, *some* work part-time, and *some* take career breaks, there is, therefore, a diminished pool of women who could progress to senior positions. But these factors do not provide a full explanation. Neither do they provide any justification, as the participation of men in work and their subsequent domination and control over women in the workplace rests upon a gendered division of labour within households. However, the home is not the only source of male advantage as will be made apparent shortly in a discussion of the exclusionary processes at work.

**Perceptions of discrimination**

The common-sense explanations for the under-representation of women in senior positions of the NHS labour force negate the possibility of sex discrimination at work. At first sight this omission might appear to be justified by a small amount of research evidence which indicates that there does not appear to have been a widespread feeling amongst women in the NHS of having suffered employment discrimination. For instance,

only 15% of respondents in Allen's study of female doctors believed that they had ever failed to get a job because they were women (Allen 1988: 193), and even smaller proportions of respondents amongst administrative and clerical staff in Davies and Rosser's study of two District Health Authorities believed that they had suffered discrimination (Davies & Rosser 1986: 20). These findings for the NHS, however, seem to be at variance with other research findings concerning perceptions about discrimination against women at work in general. For instance, in the *British Social Attitudes* survey of 1987 44% of respondents agreed that it happens "a lot" that "Women are generally less likely than men to be promoted at work even when their qualifications and experience are the same" (Witherspoon 1988: 188). Some possible reasons why the belief in discrimination against women at work in the NHS should be less than discrimination against women at work in general will be proposed shortly. Before that, however, it should be observed that perceptions of discrimination against black employees in the NHS appear to be much stronger. For example, it has been alleged that racial discrimination occurs throughout the NHS (Alibhai 1988: 27), and even that "Every black professional employed in the National Health Service has experienced racism in one form or another." (Torkington 1984: 4). Yet in contradiction of these allegations it has been observed that the presence of black and other minority ethnic staff in the NHS is held up as an example that discrimination does not occur (Pearson 1987: 25). (It will be observed in chapter five that this view was also held by the Department of Health and Social Security - now called the Department of Health - in the early 1980s). It has also been argued that claims of racism are met by "surprise and indignation" (Agbolegbe 1984: 19) and are rejected by managers who claim that all the evidence is "anecdotal, exaggerated and impressionistic" (Alibhai 1988: 27).

Because of this apparent variance in perceptions about discrimination at work in the NHS a group of key respondents in the two District Health Authorities - in which fieldwork for the thesis was undertaken - were asked directly for their views on whether discrimination occurred in their District. As explained in the introduction to the thesis (pages 21-23) the respondents had the primary responsibility for either developing and/or implementing the equal employment-opportunities policy in their respective Districts. They were chiefly - although not exclusively - employed in the personnel function and their general responsibilities appeared to provide them with more of an overview of employment practices in their organisations than other managers or employees. Ten of the key informants were asked about the occurrence of discrimination in their District and they were unanimous in their view that both race and sex discrimination was at work in their organisation. Some of them framed their perceptions of the existence of discrimination at work in the context of an inevitability that it would occur in their District because of the prevalence of discrimination and 'prejudice' in society in general. For instance, one personnel specialist observed that:

> I'm of the opinion that everybody is prejudiced to an extent. I don't think I'd be surprised if you turned round and told me you are totally without prejudice. But I wouldn't believe you. I don't believe anybody who turns round and says "I am totally without prejudice". I'm not a biblical man at all but I remember "ye among you without sin cast the first stone". I apply the same logic. In the training courses I've been on people have sort of said well "there's no problem with me I don't discriminate do I ?" But that's a sure sign that they do. I think that there is discrimination in the Authority. I think there is discrimination in recruitment, I think there is discrimination in training opportunities, in promotion. (R39)

For two of the respondents, discrimination occurred through the unconscious influence of prejudices. For example, whilst one respondent (R61) stated that 'race' discrimination occurred in the District, they described it as "indirect discrimination", meaning that people's prejudices work unconsciously in selection decisions in contrast to overt

conscious discrimination. The same view is evident in the following exchange with one personnel specialist:

> there are certain pockets. There's pockets in my Unit that I'd like to eradicate once and for all. They're not blatant but does anything need to be blatant ?
>
> Q What do you mean by "not blatant" ?
>
> I mean sometimes you know that someone is being discriminate but they don't know it. Do you see what I mean ? (R39)
>
> Q So it might be unconscious ?
>
> Yes, sometimes people are consciously...I mean I would say there's no conscious discrimination within the Unit I would hope, and I can only think of a couple of isolated departments that I have concerns about that there is conscious discrimination and it is well concealed. But there is a little bit of unconscious discrimination from...naivety, from fear, that I'm aware of that I would like to eradicate. (R39)

This respondent was keen to point out that whilst they believed that discrimination was at work in their District they did not think it was widespread:

> these are very isolated pockets, very isolated, I do stress that because I'm painting what is a fairly filthy picture but I do believe that. But that may only be the one incident that I've ever come across yet, but one incident is enough. (R39)

It will be observed in chapter eight that similar views about discrimination being "unconscious" were held by a large proportion of the line-managers interviewed for the thesis.

A number of respondents expressed views on the relative extent of discrimination on the basis of sex and 'race'. For instance, one of the personnel specialists (R61) in West Thames District felt that whilst discrimination did occur against women in their District, it was not as extensive as race discrimination, and suggested that the distribution of women in senior management posts demonstrated this. They suggested that this was also manifest in the focus of the equal opportunities policy in the District which had

concentrated primarily on issues of 'race'. Another respondent in the District shared this view on the relative extent of discrimination:

> I think in West Thames we have...two of our unit general managers are women and I suppose in those terms there is a fair...they would have probably less difficulty perhaps in comparison to black people generally but there's no doubt that there are barriers there for them and I think a simple look at the numbers of general managers who are women would give evidence of that. Also I think it's very difficult for women who are not already in managerial positions to break that barrier and get into managerial positions. It's probably extremely difficult for women in the lower levels, the secretaries and so on. No matter what their potential or capabilities are...no doubt there's a great deal of prejudice against women as well which acts against them. (R57)

The view that sex discrimination was not as prevalent as 'race' discrimination was not restricted to West Thames as a personnel specialist in East Thames District (R42) suggested that because the workforce is "80% female men are used to seeing women", but - in contrast to the previous respondent - believed that at the senior posts - the "dizzy heights" - it does occur. Another respondent also drew attention to potential discrimination at senior levels in the organisation:

> certainly at the higher levels it seems to me that one of the more damaging things is the way in which word of mouth recruitment takes place, the way in which people are judged in terms of which schools they went to and their class, their specific background and whether it's compatible with certain other people and so on. All these things are very powerful as you know in many situations and certainly it is very strong in the health service particularly at the senior level both in terms of clinical professionals and in terms of administrators and bureaucrats. I think that will probably be one of the more difficult things to dismantle, and that must happen if equal opportunities is going to have any impact or credence at all. (R57)

Not all of the respondents felt that discrimination was not as extensive for women. For instance, one personnel specialist (R59) in West Thames felt that 'race' discrimination was not as prevalent as sex discrimination, and another respondent in the District suggested the same view and stated that "you basically have to work twice as hard to prove yourself." (R58). One of the personnel specialists suggested some ways in which

discrimination against women at work might operate:

> I'm sure there are people that are still the way of thinking that "she's of childbearing age, and this that and the other...that's perhaps too heavy work", I think people will be influenced by past experiences, will stereotype. (R43)

Another aspect of the perceptions of discrimination that can be distinguished is that the views of some of the respondents were based upon their impressions of what was going on rather than on concrete instances of discrimination. One respondent (R58), for instance, associated this with the difficulty of actually proving that discrimination has occurred. Similarly, another respondent stated that their belief in the existence of discrimination was based on "my opinion of major organisations not based on facts." (R42). I did not attempt to push such respondents into revealing any suspicions of discrimination that they might have had concerning particular areas of their organisation because I felt that it would have compromised their professional integrity. For instance, if they reported their suspicions of discrimination whilst having not done anything about it they would be admitting to professional negligence. Two of the respondents, however, did provide concrete examples of potential race discrimination at work. One of them (R60), for instance, reported that they believed that minority ethnic doctors were being discriminated against in appointments to a particular speciality. The other respondent (R40) reported that a senior manager had said to her that she couldn't appoint black managers as white staff would object to working under them.

Only one respondent suggested that sex discrimination also operated against men as well as women:

> I mean I can't give you specific instances...but if you ask me for a gut reaction...my gut reaction is yes. I'm quite sure that male managers will discriminate against females, and in the same way I'm equally sure that some female managers will discriminate against men.

Q On what basis ?

On the basis that they'd prefer to work with women. (R59)

The same view was also presented hypothetically by one respondent to explain what they meant by "unconscious" discrimination:

> The type of thing that "Oh, there's a man. We've got all girls up here in the Department, it might be safer to stick with another woman." But the man might be the best person for the job I mean maybe just a little bit better than the woman but I wouldn't mind betting that the appointing officer's mind would be swayed by the fact that it's a woman when she's got nine women in the Department already. That's unconscious because it's almost like a split decision. They go with what they've always had. It's almost like a safety valve isn't it ? It shouldn't be. (R39)

This hypothetical view was actually borne out in the practice of one of the line-managers interviewed in West Thames Health Authority. He stated that:

> I have to tell you that I do discriminate. I don't necessarily discriminate - I hope I don't discriminate on the question of the colour of a person's skin, but I do discriminate very often on the sex of the individual. I've got eighteen...they're all girls, they run along together well, you introduce the wrong male into that situation and you've got problems. I would rather leave it all female. It works well. (R56)

In summary, all of the respondents believed that both 'race' and sex discrimination was at work in their District Health Authorities affecting the employment opportunities of women and black workers. Whilst one of the respondents suggested that discrimination sometimes works against men none suggested that white workers are ever subject to discrimination. For some respondents their views about discrimination were impressionistic in that they were not derived from concrete examples of discrimination. But the lack of hard evidence could be due to the covert way in which discrimination commonly works when it is prohibited by legislation and subsequent employment policies. For instance, if employment decisions - concerning recruitment and promotion, for example - are affected by discrimination, even if it is due to the unconscious influence

of prejudice as suggested by two of the respondents, the rationale for the decisions may be justified either consciously or unconsciously on plausible non-discriminatory grounds. In essence, then, the act of discrimination will be a private act which is not exposed to public scrutiny. It certainly remains a private act for the person who has been the object of discrimination as they will not normally have access to the decision-making process (cf.Coote & Campbell 1982: 111-12) and subsequent records that are kept. They will also not normally be aware of the qualities and characteristics of the other candidates. They will therefore not normally be aware that discrimination has taken place. The likely lack of awareness by victims of discrimination possibly accounts in part for the discrepancy observed earlier between the low proportion of women in the NHS who reported that they had experienced discrimination in comparison to the higher proportion of respondents in the *British Social Attitudes* survey who believed that women were discriminated against in promotion decisions in general. The discrepancy between perceived experience and belief in discrimination at work was apparent in Anwar and Ali's survey of overseas doctors in the NHS (1987), in which large proportions of both white (40%) and "ethnic minority" doctors (52%) believed that "overseas" doctors were discriminated against in their region. Some believed that "overseas" doctors were less likely to get jobs in the popular hospitals and specialities, and approximately 25% of both white and "ethnic minority" doctors believed that if two equally qualified doctors applied for a post, the white doctor would be successful. Approximately 10% of overseas doctors believed that this would occur even if the "overseas" applicant was more qualified than the white one, and even 20% of white consultants believed this to be the case, which is significant as the majority of consultants sit on interview panels. In contrast to the widespread perceptions of discrimination, however, only 3% of overseas trained doctors reported that they had

experienced discrimination themselves (Anwar & Ali 1987: 75). This was, however, much lower than the proportion of "coloured" doctors (22%) in Smith's earlier survey for the Policy Studies Institute in 1977-78 who believed that they had been unsuccessful in applications for hospital appointments because of 'race' discrimination (Smith 1980: 138). It was also notable in that survey that there was little difference between perceived experience and belief in discrimination amongst "coloured" doctors. Such a discrepancy has though been apparent in surveys of the general population. For instance in Brown's 1982 survey for the Policy Studies Institute the belief in 'race' discrimination in employment amongst "Asians" and "West Indians" in the labour market was substantially higher than their reported experience of actual discrimination. The extent of perceived discrimination was much higher, however, than that reported in Anwar and Ali's survey of overseas doctors. For example, 26% of "West Indian" male and 23% of "West Indian" female respondents believed that they had suffered discrimination in applications for employment. Smaller proportions of "Asian" males (10%) and females (8%) also reported such discrimination, and it is notable that for both "West Indian" and "Asian" respondents the extent of perceived discrimination was lower amongst women (Brown 1984: 218-20).

Even if discrimination is suspected the fear of victimisation - for those already in work - may inhibit complaints. For instance, Agbolegbe has reported that when some black senior nurse managers discussed their concern about discrimination with white colleagues they were advised: "Think carefully about your promotion prospects", and in one instance were asked "Have you decided not to advance any further in your career ?" (Agbolegbe 1984: 19). One of the line-managers interviewed in East Thames District similarly identified the constraints upon the potential complainant:

> I'm talking about myself that as a young woman of child-bearing age I can't prove that if I went for an interview that I didn't get shortlisted for

> a second one because I was a woman. Very recently, that's just happened to me. I went for an interview and a colleague on a management course that I'd been on was also interviewed, and he was male, the same age. And in terms of the job I'm doing now, it's identical to the job that I applied for, but it was a bigger hospital and a general management position. This person I know, this man I know, he wasn't doing a general management job, he wasn't a hospital manager, and he got shortlisted and I didn't. And I can, you know there might be lots of reasons why he got shortlisted and I didn't, but there's still that underlying theory. Especially when I looked at the management breakdown of the organisational chart and I realised that there was a general manager with nine managerial jobs under them and each one was filled by a man. And it's those kinds of things that I think are very difficult to, because if you actually, because if I'd written back to them and said "look, I think I've been discriminated against." It's all about where will that leave me, will I get a reputation as being a trouble maker, or is it seen that I'm making excuses because of sex for not getting shortlisted. (R46)

Neither perceived experience nor belief in discrimination at work provide evidence of actual discrimination, but - in the case of 'race' discrimination - such evidence has been provided by a number of experimental investigations (Daniel 1968, Jowell & Prescott-Clarke 1970, Mc.Intosch & Smith 1974, Hubbuck & Carter 1980, Firth 1981). In the most recent investigation in which "White", "Asian" and "West Indian" testers made telephone and mail applications for employment in response to advertised vacancies, both the "Asian" and "West Indian" applicants were unsuccessful whilst the "White" applicant was either offered an interview or appointment in 25% of the valid tests, that is, when at least one applicant was offered an interview or appointment. There was no statistically significant difference in the test results for male and female applicants (Brown & Gay 1985).

A number of industrial tribunal cases have provided evidence of both 'race' and sex discrimination in the NHS (Anwar & Ali 1987: 84-87, Brindle 1990), but there has only been one research investigation which has produced unequivocal evidence of discrimination and that concerned the selection for interview of applicants for places as

student doctors at St.George's medical school (CRE 1988a). In that case The Commission for Racial Equality observed that discrimination was written into a computer program used to shortlist applicants which was intended to mimic the selection decisions made over a number of years. "Non-Caucasian" and female applicants were given a negative weighting, with a larger weighting given to the former. The effect was that for the academic year 1985/86, the Commission estimated that 57 applicants were denied an interview due to the discrimination written into the program. For earlier years for which records were no longer available the Commission's best estimate was that approximately 60 applicants were similarly denied an interview each year. In addition to the finding of discrimination at St.George's, the CRE's investigation strengthened the suspicions produced by earlier investigations of applicants to other medical schools (Mc.Manus & Richards 1985, Collier & Burke 1986), particularly as the high proportion of minority ethnic students at St.George's relative to other schools might have provided grounds to believe that discrimination was not occurring there, or at least that there was less discrimination.

None of the investigations of discrimination at work - cited above - have provided a 'micro' analysis of discriminatory processes in the workplace. Such an analysis is now presented in relation to the experience of women and black workers in the NHS, and it is argued that the discrimination works in the shape of a number of exclusionary processes. In relation to these processes, it is argued firstly that the path to career success in the NHS has been a 'male' and 'white' path.

**Male career path, white career path**

The common-sense explanations for the under-representation of women in senior occupational positions - discussed earlier - are concerned with tensions between the family and domestic roles of some women and the requirements for a successful career. There

are also other similar tensions which disadvantage women in their careers. It has been observed, for example, that career success for health service administrators is predicated upon a male career path, characterised particularly by the need for geographical mobility and the concentration of career effort, such as taking professional examinations, in the early years of the career (Davies & Rosser 1986). Married women in general, however, are disadvantaged by both requirements. For example, in Allen's investigation, over two-thirds of women doctors compared with just over one-third of male doctors reported that marriage had imposed a constraint on their careers, and the chief constraint reported by women was that they had to obtain employment in the areas in which their husbands worked, often having to change their speciality (Allen 1988: 174). In medicine, frequent geographical mobility, particularly in the early postgraduate years appears to have been an important factor in promotion. Yet married women are restricted due to the norm that it is the husband's career that determines where they live. In addition, the most intensive years of career effort also correspond to the conventional time of starting a family, and therefore women who take career breaks in those years are disadvantaged by far more than a simple interruption in the chronology of their careers. To succeed, therefore, women have to delay having children and, accordingly, Allen found that a high proportion of women doctors in the two most recent cohorts she studied had made a definite decision either to postpone or abandon the idea of having children (Allen 1988: 22-23).

Some women are less likely then to be able to follow the path to career success because they are constrained by their family and domestic commitments. The path to career success is therefore a male path. Implicit in this conceptualisation is the notion that the health service occupations are characterised by two occupational hierarchies. The hierarchy which provides the greater rewards - described by Davies and Rosser as the

"golden pathway" is dominated by men (Davies & Rosser 1986). The other hierarchy which is dominated by women offers only limited career opportunities, and it services and enables the functioning of the other, predominantly male hierarchy. Yet the work and skills of those on the predominantly female hierarchy are undervalued, and they are provided with less encouragement to progress in their careers than those on the male or the golden pathway.

It appears also that the path to career success in the NHS has been a 'white' path, evident, for instance, in the path to entry for nurse training and medical training, as black applicants are less likely than white applicants to fulfil the entry requirements. With regards to nursing, the CRE observed from its survey of nursing schools in England and Wales that black applicants had a lower success rate than other applicants, only 15% of them compared to 34% of white applicants being accepted (This is based on returns from twelve schools of nursing, the only ones out of thirty respondent schools which kept statistics on the ethnic origin of applicants for RGN training). Even if all of the applications still under consideration at the time of the survey were successful, the proportion of black applicants accepted would have been only 30% compared with 44.5% of white applicants. The difference could have been entirely due to the minimum academic requirements for RGN training of five 'O'levels, for as the Commission observed;

> Given what is known from the Swann report about the academic achievement levels of Afro-Caribbean youths, it is likely that they will be disproportionately rejected or discouraged from applying for admission to nursing schools by academic requirements which may or may not in fact be necessary for successful completion of the training course. (CRE 1987: para 14).

But on the basis of the Swann Committee findings (U.K. 1985) and other more recent research (Drew & Gray 1990 & 1991), applicants of Asian origin would stand a near

equal chance of acceptance as white applicants. Yet the Commission also noted a number of non-academic requirements that could potentially discriminate against both Afro-Caribbean and Asian applicants. The most common non-academic quality expected of candidates was a demonstration of "motivation" or "interest in the caring profession", and this was evaluated by a number of schools on the basis of candidates' involvement in any voluntary work of a caring nature. More subjective criteria such as "'emotional stability', 'intelligence', 'imagination' and the ability to integrate without undue difficulty." (CRE 1987: para 12) were also sought and such attempts to assess candidates for employment on the basis of subjective criteria are susceptible to bias. One such bias might be that which was identified by the Principal of the Commission's employment division (public sector), who in commenting on the findings, observed that a stereotypical conception of the ideal applicant for nurse training is of a white middle-class female. He concluded that: "'If that stereotype looms large in the minds of selectors - and one gets the feeling it perhaps does - that is something that needs to be looked at very hard because certainly that will militate against ethnic minority groups.'" (Cole 1987: 30).

It appears that similar stereotypes might have operated in the selection of students for medical school, although in this case the ideal applicant would be a white middle-class male. In its investigation of admissions to St.George's medical school, the CRE noted that, for the academic year 1985/1986, there was a statistically significant difference between the proportions of "Caucasian" and "non-Caucasian" applicants offered medical school places following interview, which was not due to their relative ranking at shortlisting. In the absence of records concerning the reasons for rejection following interview, the Commission was not able to conclude that discrimination had occurred, but an earlier investigation (Mc.Manus & Richards 1985) indicates what might have been

occurring at the interview stage. Judgements made during shortlisting were analyzed for applicants to medical school in 1981, who had included St.Mary's medical school amongst their choices. It was observed that UK nationals with non-European surnames were more likely to be determined on the strength of their application forms as being unsuitable on non-academic criteria such as "interests" and "contribution to the community". A smaller proportion of them were interviewed, and following interview those with non-European surnames were again more likely to be assessed as being unsuitable on non-academic criteria, even though they were assessed as having equivalent academic ability to those with European surnames. In short, it appears therefore that the path to entry to nurse training, and to medical training, is a white path, since black applicants are less likely to be able to comply with the requirements on either academic or non-academic criteria.

**Female and black: primary status**

Some common-sense explanations of why women are under-represented in senior positions - as discussed earlier - are that marriage, family responsibilities, and children, interfere with their careers and consequently there is a diminished supply of women who could climb the occupational hierarchies. However, whilst some women do indeed give up their jobs to raise families, many return to work. Not all women have children, and not all women give up their jobs for family and domestic reasons. Women also do not necessarily have a lesser commitment to their work than men. Yet these stereotypical assumptions about women affect their career chances, influencing for example, selection and promotion decisions (Homans 1989: 46). Therefore - at work - the status of women as potential wives and mothers supersedes their potential as workers. For instance, Homans observed that many managers in clinical chemistry laboratories believed that at some stage in their career women would give up their jobs to have children. It was

assumed, therefore, that women were either not interested in promotion or, alternatively, that they would soon leave after being promoted and consequently disrupt the organisation. The view of women being potentially disruptive because of child-care and family commitments was illustrated by one line-manager interviewed in East Thames District in discussing the experience of two of the staff that she managed when they applied for a training course in the District:

> and they were asked "have you got young children, and if so, how do you think you're going to cope with this job ?".../...and they were actually members of my staff who were applying for something else, and they came back and told me this and I thought "bloody cheek". And you felt like saying, and they were both quite vocal girls, they felt like saying, mind your own damn business. But if you actually want a job.../...you're not going to say that. Even though, you know, one of them came back and said "why did they ask me that, I thought it wasn't allowed anymore?" And I said "well it's not". (R52)

One line-manager interviewed in West Thames Health Authority clearly indicated his belief in the potential for disruption by working women with childcare responsibilities:

> With regard to people with young babies and this sort of thing, may I first tell you that one always receives an assurance - in days when we tended to ask these questions - you always received an assurance that there was no problem.../...there is a disadvantage in not finding out whether someone does have a child say of nine months old - I use that purely as an example - it wouldn't stop me employing someone, in fact that (person) you saw coming through the door she joined me on Monday, she's got a child of ten months old, something like that. But she lives very close at hand, she's able to walk in and she's got a baby minder, I mean clearly if the child became seriously ill or something I would expect her to be off that sort of thing. I'm not agin it, but you cannot afford to have everybody on your staff with that sort of commitment.../...Now I'm not agin people having families.../...but when you are working in a hospital it depends what you are doing. If you are engaged in that part of a practice that has a night-duty commitment...you really can't afford to have people who - for very obvious reasons - might say "I'm afraid child wasn't well this morning and mum's on holiday, I can't come in". By and large you'll find that professional people, you don't get that. But with non-professionals they tend to take as much, some...some, tend to take off as much time as they can.../...it's been my experience it takes about two years to catch the rogues by which time the taxpayer and the Health Service have suffered somewhat. (R56).

Such beliefs affect the promotion prospects of all women whether they are married or not and to succeed, therefore, women have to prove themselves to be especially dedicated to their work (Homans 1989: 57). The operation of these beliefs is evident in Homan's finding that both male and female respondents in her survey felt that men were being "groomed for management" through the allocation of work in a way in which women were not. It was felt that male employees were "pushed harder", and they were given the more prestigious jobs which would enhance their promotion prospects, whilst women of the same grade were allocated the less desirable jobs (Homans 1989: 60-63). Davies and Rosser also found that males were given more informal encouragement to progress to higher jobs. It is apparent then that common-sense assumptions about women affect their career chances by influencing, for example, selection and promotion procedures.

Research evidence and other literature concerning black employees in the NHS suggests that they share a similar experience. They are seen as *black workers* first rather than workers, and the negative character of common-sense beliefs about black people affect their career prospects. One of these beliefs is that black workers, and particularly those of Afro-Caribbean origin, have an attitude problem in that their behaviour is seen to be at variance with the norms expected for progress into management. For example, 'West Indians' have been regarded as uncooperative and "bolshy" (Doyal et al. 1980: 81), and it has been suggested that many black people "'do not have the right experience or frame of mind for senior posts'" (Mc.Naught 1988: 98-99). It is not only the supposed attitudes of black staff that impede their prospects, however, as it has been argued that when some black nurses apply for senior positions managers are concerned that white staff will resent their authority (Alibhai 1988: 27). One District Nursing Officer has been reported as admitting that "'It is very difficult to promote people who one knows would

have difficulty in getting their white subordinates to work with and for them.'" (Agbolegbe 1984: 19), and as noted earlier, the same observation was made by a senior manager to one of the informants for the research in East Thames District. The difficulty may be due to the threat to the status of white staff that working under black superiors may pose, as, to accept black workers as equals, white workers would need to reconstruct their view of the world so that black people are no longer associated with subservient or dependent labour. The easiest means of dealing with this problem, however, is to keep black workers in an inferior position (Rex 1973: 89).

Racist sentiments can have contradictory elements (Miles & Phizacklea 1984: 10-11). For instance, in contradiction to the attitude that black workers are difficult or non-compliant is the belief that black people, and particularly black women, are naturally suited to a servile role. This may be due in part to their long association with service work from their slave and colonial history, and in the post colonial era when the only available work for many was in domestic service to the middle and upper classes (Black Women's Group 1974: 226). Accordingly it has been argued that the early black women migrants to the NHS were "responsive to the idea of service." (Ramdin 1987: 310). But the bitterness and anger felt by some black nurses, however, indicates that not all of them have been resigned to a servile role, and it is not surprising that because of their experiences some do not want their daughters to go into the profession (Alibhai 1988: 26). The demise of the black nurse by the year 2000 has even been predicted unless remedial measures are taken to recruit them (Pearson 1987: 26), and, even though this is conjectural, it indicates the depth of feeling on the issue.

In short, the essence of racist attitudes towards black workers in the NHS is that they are better suited to serve than to lead. Whilst this is a strong contention in the light

of the very limited research evidence available and other literature which is largely anecdotal, there is enough evidence to suggest the hypothesis. One obvious effect of the belief is that the promotion prospects of black workers are limited, and it could account for the feeling of some black nurses that they have been given less informal encouragement than white nurses to progress in their careers (Torkington 1984, CRE 1988b). A further effect is that the status of black nurses on the ward can be ignored, and those at sister level particularly face humiliation when doctors ignore them, as Torkington for example, in recalling her nursing experiences reported that "Doctors used to come into the ward and go straight to the white nurse, no matter how junior she was" (Torkington 1984: 4). This experience is not unique as other black nurses have reported similar occurrences (Black Women's Group 1974: 230). Such anecdotal evidence further suggests that black workers may commonly be perceived as *black workers* before workers, and as their "blackness" then becomes their primary status, they share a common experience with women workers whose status as women supersedes their status as workers.

Further occasions when the statuses of gender or 'race' override the status individuals have as workers are in instances of sexual and racial harassment. On these occasions, the individual's sexuality or 'race' become the focus of attention superseding other status attributes. In the case of sexual harassment Walby (1990: 39 & 52) has argued that it is used by men both to control women at work and to exclude them from certain areas of work. In relation to the exclusionary function Di Tomaso (1989) has observed - on the basis of her research in three organisations in 1980 - that women who enter 'male' jobs are most likely to become aware of sexual harassment. On these occasions - according to Di Tomaso - men engage in "a type of power play by which they use

sexuality to put women in their proper subordinate role in relation to men." (Di Tomaso 1989: 72). Hence women are maintained in subordinate positions and their access to 'male' jobs limited. It is implied in Di Tomaso's argument that men harass women at work in this way because women present a competitive threat to their jobs. In addition, the belief that women are potentially disruptive to an organisation as a consequence of pregnancy and family responsibilities, provides a further reason why their presence in positions of authority should be restricted. These arguments suggest a conspiracy on the part of men which has not yet, however, been empirically demonstrated. However, whether harassment is the product of a conspiracy or whether alternatively it is reducible to the independent action of individual males, it seems reasonable to argue that actual - or potential - harassment will inhibit the entry of women into traditionally male areas of work such as management, and it is therefore one of the factors accounting for vertical sex segregation in the workplace. Research which has indicated the high prevalence of sexual harassment (Leeds 1983) suggests that it might be a significant factor.

In comparison to theorizing about sexual harassment there has been little attempt to theorise the consequences of racial harassment at work. Indeed, whilst a significant body of research has investigated the extent of racial harassment in the context of housing in Britain (U.K. 1981a, Hounslow CRC 1986, Newham 1987) racial harassment at work has been neglected. Again, however, it would seem reasonable to argue that - as is the case with sexual harassment - actual or potential racial harassment operates to restrict the entry of black workers into predominantly 'white' areas of work such as - as will be indicated in chapter two - management.

There has been little published material on sexual and racial harassment in the NHS and as the overall philosophy of the research was not to study the experience of

women and black workers the interest in harassment was on the way it is managed in the workplace, particularly when the harassment is by patients or clients. But a number of respondents volunteered their experiences during interview. One line-manager (R62) interviewed in West Thames District suggested to me that racial harassment from patients occurs "all the time". The approach from the staff is to avoid confrontation by ignoring it. The manager stated, for instance, that a member of staff might be told "get away from me you black bastard", and they will go into the office, have a smoke, kick the door, and the manager will speak to them offering support. It was suggested that in casualty there are frequent difficulties, and where racial abuse is anticipated, perhaps in the case of an aggressive patient, a member of staff from the same ethnic group will be delegated to deal with them. Whilst this manager demonstrated an awareness of the extent of racial harassment he demonstrated less of an insight into sexual harassment suggesting that "it doesn't go on", but then proceeded to say in relation to some of the female staff "trouble is, with a couple of them, we don't half fancy them". One female manager, though, was philosophical about dealing with sexual harassment:

> I think it depends how people deal with it, what you class as sexual abuse. I mean I've had remarks made to me, and I just personally laugh them off. For me it's part of the job almost. It's like, nurses, a lot of nurses seem to get more offended if they get sworn at than anything else. For me it's part and parcel of the job, and I might say to the person, "come on that's unnecessary, and you don't have to use that sort of language" if it's really foul. But, for me it doesn't mean a lot. You find that the younger nurses find it difficult to deal with. But I find that if you actually ignore most remarks that are made to you, it's only when you react...//...and they think, "oh that's good I got a reaction, let's do it again." (R52)

Another manager (R47) when discussing harassment from elderly patients appeared also to play down its impact - in this case when discussing racial harassment - by suggesting that it was just one manifestation of elderly people losing their inhibitions. Similarly, a Health Visiting manager evaluated harassment in the context of a patient's mental state

in general:

> I've had clients who've said to me, "I don't want that health visitor to visit", and they try to dress it up as all sorts, and what it basically comes down to is that person is uncomfortable with having a black health visitor, or an Asian health visitor in their own home...//...When people sometimes refuse the service, it's bound up not just in their views about a black person but it can be that person's mental state as much as anything else, and the pressures they're under, so you have to take those things into consideration. When you make a decision and when you see them you can't just think well you're being pretty awful, you have to think well what's happening to them and what's happening in their lives really, before you can say well this person's being racist. Being racist is probably just the easiest expression of their frustrations really, and you usually find that when you deal with that, and you give them another health visitor who's black, you know, it's the best health visitor they've had. (R51)

This manager was referring to white clients rejecting the services of black nurses. Whilst such rejection might not at first sight be classed as harassment, a number of managers raised the issue when discussing harassment and they therefore clearly interpreted the rejection in that way. Although the Health Visiting manager was sanguine about the rejection another manager reported the pain that it can cause:

> It's still very painful to some nurses because you feel spite when you are rejected...the pain where, it's worse than physical pain of a good beating on the body, that you cannot express. You cannot actually go home and cry about it but you're just seething for a long time and you feel better. It does affect the quality of care whatever you say as well because if I'm not happy and if you do something to me, then I just see the rest of you being tarnished with the same brush. (R48)

For a number of managers their strategy for dealing with the rejection was to point out to the client the professional abilities of the black nurse involved. In other words, they attempted to re-negotiate the status of the nurse to establish their professional identity - rather than their 'racial' identity - as their primary status:

> "If you are not quite happy I am quite willing to bring somebody else but you have got to give me a tangible reason why you find that you are not even going to let the person who is a qualified professional give you a service that she trained to do." Sometimes it's worked, sometimes people have begrudgingly accepted...and in the end it's turned out alright. But of

> course I'm aware of the animosity that there is between the two parties once they have started off on that footing. (R48)

That same nurse illustrated the process of renegotiation on her own behalf:

> I'll tell you this, I know it's taking up your time, but personally this had happened to me...where I had been rejected and I had to deal with this myself. This was an emergency, I stood there and explained to the woman...//...how much agony she would go through because there wouldn't be a white nurse that would come along and remedy the situation. I did a lot of campaigning anyway, let's put it that way, on the doorstep. She eventually decided that yes she agrees that would be better than having to wait to the following day...she decided to take a chance. At the end of the three days this woman could not help but be full of apology and tell me how awful she felt because she's never given the likes of me a chance. She said that three doors down she has got some coloured people, but she has never spoken to them so she does not know what they are like, and by going through the fact that, she has actually realised that if I cut myself and she cuts herself and we put the blood together she cannot define which one is hers. I mean if she lays in a hospital bed and she is critically ill and needs a blood transfusion she is not going to be in a position to check first and make sure that the blood is from a white person because they wouldn't know. (R48)

### Gendered jobs, racialised jobs

A further exclusionary process concerns the gendered nature of work with the effect that some areas of work, and some jobs, are perceived as either 'men's work' or 'women's work'. This affects both male and female workers, but it works to the advantage of men in relation to attaining positions of power and authority in the occupational structure. For example, the promotion of women into management in the NHS, or to senior positions in the health service professions, is inhibited by norms governing expectations of the personal qualities of managers, which amount to an ethos of 'masculine' or even 'macho' management. It has been observed, for example, that managers in clinical chemistry laboratories are expected to display "drive", and to "push themselves" and "press their claims", and such attributes are regarded as being more typically male than female (Homans 1989: 57). Similarly, for women to succeed in

administrative management they must assume supposed male characteristics, for as one female administrator reported; "'You do have to be very tough to stick with it, you have to keep your cool and not burst into tears'." (Davidson 1979: 232). Successful doctors must also "demonstrate the stereotypically 'male' competency cluster traits of assertiveness, egoism, and independence." (Bourne & Wikler 1978: 431). In short, when the ethos of masculine or macho management exists, managers and potential managers are expected to demonstrate stereotypical masculine characteristics. This has the effect of restricting the opportunity of women to enter senior positions, and they are indirectly channelled therefore into the lower levels of the occupational hierarchy, which in consequence is gendered vertically. In order to climb their career ladder it appears then that a woman must assume 'male' characteristics, but in doing so, as Bourne and Wikler have observed, she will be confronted by a "double bind" as she faces the disapproval of men because she does not conform to their expectations of women. This was illustrated by one line-manager interviewed in East Thames District who reported that:

> one of the consultants who I've worked with, said all I needed was a whip and a pair of leather boots because I'm assertive. I don't think I am aggressive, but I am assertive, and I feel that I do a good job, I feel that I'm good at what I do and I know what I'm doing, and I'm not prepared to be put down with comments. (R46)

The same manager suggested additionally that if women do conform to male expectations of them at work they conform to male dominance:

> Especially with being a manager, it's about you having to fit into a role, you have to be perceived as a particular sort of person, you have to play the game, and the game's a man's game. The rules are men's...and they're not explicit rules, they're not objective rules, but they are rules that everybody knows about...//...and I think there are rules about being the right sort of woman, being attractive, but not too attractive so that you threaten men. Being intelligent, but not too intelligent because that threatens men, being bossy. When I think there are any number of instances...that you are praised for having male qualities, but if they're going to criticise you, then you'll be waspish or bitchy, and it's all those

> underlying things. And it's about being good, it's about being conforming, it's about being ladylike, it's about being nice, it's all about those kind of stereotypes about women that keep women in their place. (R46)

Women can also be channelled into a gendered fraction of a particular occupational grade, as has been indicated by Lawrence's study of general practitioners in Birmingham and the West Midlands (Lawrence 1987), from which she concluded that some female GPs are "ghettoized" into dealing mainly with female patients (For a similar process in nursing see; Webb 1982, Pollock & West 1984). This occurs through the normative expectations of seniors, colleagues and other practice personnel such as receptionists, and in some instances the female GPs themselves, that women doctors want to attend to women. Such an organisation of health care would appear to be responsive to consumer preference as research evidence indicates that a substantial proportion of women would prefer to see a female GP if they had the choice, especially for health concerns that are specific to women (Women's National Commission 1984). Yet the channelling of female GPs into gendered fractions of work restricts their choice and opportunity and, whilst Lawrence observes that many female GPs are happy to attend to female patients, she also observes the irony of the consequent specialization in obstetrics and gynaecology which it involves, whereas the initial attraction of general practice for many doctors is the variety of work it offers.

There are also indications that certain areas of work in the NHS might also be racialised in that some work has been regarded as more appropriate for black workers, and some for white workers. Although the data are limited there appears to be a tendency for black workers to be concentrated in semi and unskilled work such as in the ancillary and maintenance sectors, and, even though they have a strong presence in the skilled occupations of nursing and medicine, they are concentrated - as will be indicated in

chapter two - in the lower reaches of those professions (Doyal et al 1979, Torkington 1983, GLARE 1987: 19). With regards to the medical profession, from data produced by Anwar & Ali (1987) concerning the distribution of "overseas" doctors by grade and speciality for 1981, it is apparent that "overseas" doctors were just short of being numerically dominant in the two least popular specialities of Geriatrics and Psychiatry.

It does not always follow though that black workers have been channelled into the areas of work in which they are concentrated through the operation of racism in recruitment and promotion decisions. For example, the evidence from Anwar and Ali's survey hardly indicates that "overseas" doctors in general have reluctantly taken jobs they did not want. When asked whether the specialities in which they were employed were the ones in which they had originally intended to work when first qualifying, a higher proportion of those trained overseas (55%) replied that this was the case compared with white doctors (44%) and "ethnic minority" doctors trained in Britain (50%). The majority of overseas trained doctors in the survey were working in their preferred speciality or another speciality which they had chosen for positive reasons, and only 14% of all "overseas" doctors reported that they were not working in their preferred speciality because they had not been able to get a senior job in it.

In the case of nursing, however, it has been alleged that black nurses have been channelled into the less popular specialities. In this vein, a nurse manager (R47) interviewed in one of the case-study Health Authorities reported a prevailing view that black nurses were deliberately being channelled - by a senior nurse - away from the acute sector to the supposedly less popular work of caring for the elderly and people with a mental illness. Correspondingly, there was a flow of white nurses in the other direction. The nurse manager was so sensitive about this information that she refused to be tape-

recorded and ensured that she could not be identified - directly or indirectly in the research reports.

There is also some evidence, although it is only anecdotal, of the channelling of black migrant women into the lower training grade (SEN) (Black Women's Group 1974: 226). Disproportionate numbers of black migrant nurses were recruited to train as SENs rather than as SRNs, and it has been argued that this practice continued for overseas nurses up until the early 1980s (Hicks 1982: 789). It appears that many black migrant women were forced into SEN training unwittingly as they did not know that two tiers of training existed (Torkington 1987: 27, Pearson 1987: 25-26, Baxter 1988: 25). In the lower grade they provided a source of cheap labour (Black Health Workers and Patients Group 1974: 226). The exploitation of black labour in Britain's slave and Colonial history was - arguably - justified by racist sentiments, as too it could be argued was the exploitation of black migrant women in the NHS, for it was perhaps regarded as legitimate to channel them into the low-paid, low-status, menial nursing work. It was acceptable to treat them in this way because they were black.

## Policy implications

A variety of exclusionary processes have been discussed in this chapter which discriminate against and disadvantage women and black workers. Some of the processes of exclusion - described in this chapter - have an ideological character which is manifest, for example, in the way that stereotypical and prejudiced views of women and black workers affect their career prospects, and therefore they are primarily regarded as female and black rather than just workers. Other processes of exclusion have no ideological basis at all, evident in the way that requirements of geographic mobility and the exclusion of part-time working from the career structure disadvantage women in relation to men in the

context of a gendered division of household labour, and hence the path to career success is a male path. Many of the processes - as described in the chapter - operate in a covert and concealed way and therefore individuals who have suffered as a consequence of the exclusionary processes may not even be aware of them, or if they are, they would find them difficult to prove. A prime objective of policy initiatives aimed at confronting racism and patriarchy at work must be to bring out into the open the practices around which the exclusionary processes operate. It will be argued in chapter three - in a discussion of potential policy initiatives - that the elucidation of those practices has been a primary objective of equal employment-opportunities policies.

# CHAPTER 2

## STRUCTURE OF RACISM AND PATRIARCHY AT WORK

This chapter focuses on the structural dimension of racism and patriarchy at work by observing the domination of men, and particularly white men, in relation to the distribution of power and authority in the British National Health Service. Data collected for a workforce audit in East Thames Health Authority are used to discuss the structure of domination, and although East Thames was only one Health Authority out of 232 Authorities in the NHS at the time of the research, it is argued that similar structures of domination appear to characterise the NHS as a whole. There are some limited published data available concerning the relative distribution of female and male workers in the NHS, although they are only routinely published for medical and dental, and nursing and midwifery staff (cf. U.K. 1991a). There are even less data available concerning the distribution of employees on the basis of ethnic origin as the NHS nationally does not collect such data. This chapter adds to the available material by presenting data on the distribution of workers in the NHS according to the variables of sex and ethnic group - treated both independently and combined. It is argued in the chapter that the pattern of domination indicated by the data is more than just a statistical phenomenon, as those in the dominant group - particularly white males - enjoy a higher income, status, and autonomy in their work, and exercise control over the work of other employees. In concluding the chapter it will be argued that the structure of dominance is produced and sustained in part by the exclusionary processes discussed in chapter one. The processes

are operated by those in the dominant group to the disadvantage of women and black workers.

### The structure of domination

Women workers constitute approximately 80% of the NHS workforce. Their distribution across the workforce, however, is characterised by horizontal segregation. In other words, women are concentrated in particular occupations in comparison to males (Hakim 1979, 19). Data on the sex composition of NHS workforce are not routinely published, but the most recently published data for the years 1988/89 are provided in tables 1 and 2.

**Table 1: Percentages of female and male workers in the NHS employed in the main NHS occupational groups for the years 1988/89.***

Column percentages

| Occupational group | Female % | Male % | Males & Females % |
|---|---|---|---|
| Ancillary | 15.53 | 22.50 | 16.91 |
| Administrative & Clerical | 15.19 | 11.79 | 14.52 |
| Medical & Dental | 1.37 | 15.48 | 4.16 |
| Nursing, Midwifery & Health Visiting | 58.53 | 25.86 | 52.07 |
| Professions Allied to Medicine | 4.99 | 2.59 | 4.52 |
| Scientific & Professional | 1.11 | 2.86 | 1.46 |
| Professional & Technical | 3.09 | 6.93 | 3.85 |
| Works & Maintenance | 0.18 | 11.98 | 2.51 |
| Total | 100.0** | 100.0** | 100.00 |
| N= | 906154 | 223545 | 1129699 |

* Source: Data adapted from EOC 1991: 21.
** The totals do not precisely equal 100% due to rounding.

Table 1 shows that the proportion of the female NHS workforce employed in the Nursing,

Midwifery & Health Visiting group is over twice the proportion of males employed in the group, and as shown by table 2 just over 90% of all nurses employed by the NHS are women. The balance of distribution is reversed in favour of males in the Medical and Dental group. Table 1 shows that the proportion of males is over eleven times greater than the proportion of females employed in the group, and as shown by table 2 nearly three-quarters of all doctors employed the NHS are male. The Works and Maintenance group provides the most marked illustration of horizontal segregation. The proportion of the male NHS workforce employed in the group is sixty-six times greater than the proportion of females, and nearly 95% of all Works and Maintenance staff are male.

**Table 2: Female percentage and male percentage of employees in the main NHS occupational groups for the years 1988/89.***

Row percentages

| Occupational group | Female % | Male % | N |
|---|---|---|---|
| Ancillary | 73.67 | 26.33 | 191047 |
| Administrative & Clerical | 83.93 | 16.07 | 164006 |
| Medical & Dental | 26.39 | 73.61 | 47012 |
| Nursing, Midwifery & Health Visiting | 90.17 | 9.83 | 588219 |
| Professions Allied to Medicine | 88.63 | 11.37 | 51013 |
| Scientific & Professional | 61.17 | 38.83 | 16493 |
| Professional & Technical | 64.39 | 35.61 | 43502 |
| Works & Maintenance | 5.75 | 94.25 | 28407 |
| Total workforce | 80.21 | 19.79 | 1129699 |

* Source: Data adapted from EOC 1991: 21.

The data for the NHS as a whole in tables 1 and 2 are an aggregation of data on the sex composition of the workforce at District, and then at Regional level. Table 3 presents data

composition of the workforce at District, and then at Regional level. Table 3 presents data from the first level of disaggregation - Regional level - for staff employed in 1991 in the area covered by the Southern Regional Health Authority (The name is fictitious to ensure the anonymity of the Authority, and the Region does not include either of the two case-study Health Authorities). The data have not been published but were provided for the thesis by the Authority's Human Resources Division.

**Table 3: Percentages of female and male workers employed in the main occupational groups in Southern Regional Health Authority in 1991.**

Column percentages

| Occupational group | Female % | Male % |
|---|---|---|
| Ancillary | 7.87 | 16.73 |
| Administrative & Clerical* | 18.20 | 15.71 |
| Medical & Dental | 4.75 | 28.00 |
| Nursing, Midwifery & Health Visiting | 59.35 | 21.32 |
| Professions Allied to Medicine | 5.65 | 3.05 |
| Scientific & Professional | 1.33 | 1.72 |
| Professional & Technical | 2.83 | 5.59 |
| Works & Maintenance | 0.01 | 8.28 |
| Total** | 100.0*** | 100.0*** |

* Includes staff classified as "managers" in the original data.
** Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.
*** The totals do not precisely equal 100% due to rounding.

The distribution of female and male workers across the Southern Regional Health Authority workforce closely matches their distribution across the NHS as a whole, although in contrast to the whole NHS the largest proportion of the male workforce in the Southern Regional Health Authority is employed in the Medical and Dental group, exceeding the proportion employed in the Nursing, Midwifery and Health Visiting group.

The unequal distribution of the sexes between the occupational groups in the NHS workforce - or in other words, the horizontal segregation - corresponds to an unequal distribution of power and authority between the occupational groups. The most powerful positions - in relation to the organisation and control of the workforce as a whole - are occupied by senior staff in the Medical and Dental, and Administrative and Clerical groups (cf. Doyal 1979: 179-188). The relationship between doctors and nurses, for instance, has been conceptualised by Garmarnikow (1978) as patriarchal in character. From her analysis of the establishment of the nursing profession - Garmarnikow has argued that the division of labour between nurses and doctors is a sexual division, as they are partners in an unequal relationship of domination and subordination. For example, Garmarnikow argued that nursing practice is dependent upon medical intervention - as doctors control the initiation and direction of the treatment process - and the nursing role has been "defined by its responsibility for executing medical orders and directions." (Garmarnikow 1978: 109). Nurse training has subsequently been concerned with the socialization of nurses in learning the boundaries of their role in relation to medical practice. For Garmarnikow, an "ideology of naturalism" has been significant in determining this division of labour, as the development of their different roles has rested on appeals to the supposed differences in gender specific attributes. Doctors, for example, occupy the rational and instrumental male role - with their domination resting on appeals

to their supposed superior scientific and technical expertise - whilst nursing on the other hand, has been equated with the application of specifically female characteristics; femininity, motherhood, and domestic skills. The consequence of nursing being gendered in this way is that its association with female traits - which are acquired before nurses begin their training - devalues their work and limits any claims to professional autonomy and to higher rewards commensurate to the contribution they make to the health care system. In addition, the assumption that the supposed caring and nurturing attributes of women are more suited to a clinical nursing role may contribute to what has been suggested (Pollock & West 1984: 10) is a reluctance of female nurses to move away from clinical work into management. The opposite applies for male nurses to their advantage. They are assumed to reject masculine attributes and compromise their sexuality (Levine 1983), and the effect of this stereotype is perhaps one of the reasons why they are more likely than female nurses to escape into management.

In addition to the horizontal sex-segregation of the NHS workforce, limited published data have also shown a vertical sex-segregation of the workforce. In other words, there is an unequal distribution of females and males across the jobs hierarchies within the occupational groups (Hakim 1979, 19). Earlier research has provided evidence of gender inequality and exclusionary processes at work affecting doctors (Allen 1988), clinical chemistry staff (Homans 1989), nurses (Nuttall 1983), and - in one instance - a comparison of the experience of nurses, and administrative and clerical staff (Davies & Rosser 1986). For all of those health service occupations - which in aggregate amount to a majority of NHS employees - the research evidence indicates that men are over-represented in senior positions. Tables 4 and 5 present data on the distribution of female and male hospital doctors according to grade for the NHS as a whole for 1989. Table 4

shows that the greatest representation of males is at the most senior level of the Consultant grade where the proportion of male doctors employed in the grade is almost twice the proportion of females, and as shown by table 5 nearly 85% of all consultants are male. In contrast, the greatest representation of female doctors is lower down the hierarchy at the Senior House Officer grade where they constitute nearly 31% of doctors in the grade.

**Table 4: Percentages of female and male doctors across the medical grades - 30th September 1989.***

Column percentages

| Grade | Female % | Male % | Males & Females % |
|---|---|---|---|
| Consultant | 18.27 | 36.36 | 31.61 |
| Staff Grade 3 | 0.06 | 0.07 | 0.07 |
| Associate Specialist | 2.60 | 1.34 | 1.67 |
| Senior Registrar | 7.42 | 6.84 | 6.99 |
| Registrar | 11.63 | 13.33 | 12.88 |
| Senior House Officer | 30.99 | 19.64 | 22.62 |
| House Officer | 10.22 | 4.86 | 6.27 |
| Other staff | 0.04 | 0.04 | 0.04 |
| Hospital Practitioner | 0.56 | 2.20 | 1.77 |
| Clinical Assistant | 18.22 | 15.31 | 16.07 |
| Total | 100.00** | 100.00** | 100.00** |
| N= | 12345 | 34625 | 46970 |

* Source: U.K. 1991a, 37.
** The totals do not precisely equal 100% due to rounding.

**Table 5: Female percentage and male percentage of doctors in each medical grade - 30th September 1989.***

Row percentages

| Grade | Female % | Male % | Males & Females % |
|---|---|---|---|
| Consultant | 15.19 | 84.81 | 14847 |
| Staff Grade 3 | 24.24 | 75.76 | 33 |
| Associate Specialist | 40.84 | 59.16 | 786 |
| Senior Registrar | 27.88 | 72.12 | 3285 |
| Registrar | 23.74 | 76.26 | 6050 |
| Senior House Officer | 35.98 | 64.02 | 10625 |
| House Officer | 42.87 | 57.13 | 2944 |
| Other staff | 25.00 | 75.00 | 20 |
| Hospital Practitioner | 8.30 | 91.70 | 831 |
| Clinical Assistant | 29.79 | 70.21 | 7549 |
| Total workforce | 26.28 | 73.72 | 46970 |

* Source: U.K. 1991a, 37.

Data concerning the distribution of NHS workers by ethnic group are even more limited than the data for females and males. It is not possible to determine the extent of either horizontal or vertical segregation by ethnic group for the NHS as a whole, as the data are not collected. But limited research evidence - although consisting of only a few investigations - indicates a similar pattern of inequality between black and white workers when compared to female and male workers. For example, for Whittington hospital in 1979, Doyal et al observed that nurses of Afro-Caribbean origin were found to be under-represented in the senior grades of ward sister and above in comparison to their

representation amongst the more junior level of staff nurses and nursery nurses. In contrast, nurses of Irish origin were over-represented at senior level. Afro-Caribbean staff were also over-represented among the lower grades of SEN and pupil nurses, and also amongst nursing auxiliaries (Doyal et al 1980: 83-84). Similarly, data provided by Macquisten (1987) on the ethnic composition of the nursing workforce in Southern Derbyshire Health Authority indicated that Afro-Caribbean nurses were under-represented amongst senior nurses. In contrast, however, Asian nurses were over-represented, but because of the small number of Asian nurses involved that finding should be regarded with caution. Lastly, a study of the experience of overseas doctors by Anwar and Ali (1987) in one Regional Health Authority, indicated that they were similarly under-represented in senior positions, as 67% of white British trained doctors in the survey were at consultant grade, compared to 36% of those trained overseas, and 30% of minority ethnic doctors trained in Britain.

In the light of the limited published data available concerning sex and race inequality in employment in the NHS, data are presented here from one of the case-study Health Authorities - East Thames - to more fully discuss the structural dimension of racism and patriarchy in the NHS. In 1990 the Health Authority conducted an audit of their workforce in which self-classification - or "monitoring" - forms concerning a number of characteristics - including ethnic origin - were sent to employees with their wage slips. An earlier audit in 1988 and subsequent recording of the characteristics of new employees had already provided the required information for a majority of the workforce. The 1990 audit covered the remaining employees and information about ethnic origin was available for approximately 90% of the workforce when the audit was completed. Part of the agreement for attaining access to the Authority for research was the provision of

assistance by the author with the analysis of both the information collected on ethnic origin and information about the composition of the workforce on the basis of sex which the Authority already held on its computerized personnel records. A report of the analysis was subsequently published by the Authority. As a further condition of the research agreement was that the anonymity of the Authority should be preserved, the data presented in this chapter does not appear in the same form in the audit report published by East Thames so that an obvious connection cannot be made between the two sets of data.

A segregation index - called the "index of dissimilarity" - is used in presenting the data to quantify the extent of both horizontal and vertical sex and race segregation for the Health Authority. The segregation index - originally proposed by Duncan and Duncan (1955) - is calculated as follows:

$$S = \frac{1}{2} \sum_{i=1}^{N} | F_i - M_i |$$

where S is the value of the segregation index,
$F_i$ is the proportion of the female labour force employed in the $_i$th occupation, and
$M_i$ is the proportion of the male labour force employed in the $_i$th occupation, and,
N is the total number of occupations

N.B. $| F_i - M_i |$ equals the absolute value (or in other words, the value without the sign) of $F_i - M_i$

The index has already been used by Chiplin and Greig (1986) to evaluate sex-segregation in the NHS in England for the years 1979-1981. They calculated separate indices for a

number of occupational groupings - on the basis of payscale codes - using data derived from the annual census of non-medical manpower submitted by Regional Health Authorities in England to the Department of Health and Social Security, and also from data published in *Health and Personal Social Services Statistics*. The index used here differs in that it is calculated for the whole labour force of one District Health Authority and - whereas Chiplin and Greig used payscale codes as indicators of occupations - the indicators used here are the broad occupational groupings themselves as they more closely reflect the division of job responsibilities, and might perhaps be more readily recognised by those unfamiliar with the payscale codes.

The index of dissimilarity is easy to compute and it has a clear operational meaning. The calculated value of the segregation index is always between 0 and 100 - the former indicating no segregation at all, and the latter complete segregation - and it signifies the proportion of either women or men who would have to change their occupations for an identical distribution of the sexes to be achieved. The index is also preferable to the "sex ratio index" previously utilised by the Employment Department (cf. Hakim 1979). One considerable advantage is that it is not affected by changes in female labour force participation relative to males when evaluating changes in segregation over time (Siltanen 1990). But the index of dissimilarity does have a number of limitations (Carlson 1992, Watts 1992). Firstly, the use of a few highly aggregated occupational classifications relative to more detailed classifications produces conservative estimates of the extent of segregation. This will not affect the comparison of separate sex and race indices for the same occupational group - as produced in the analysis below - but it will affect comparisons between occupational groups which contain different numbers of occupational grades. Therefore, such comparisons must only be made with caution. A

second limitation of the index of dissimilarity is that it is sensitive to changes in occupational structure in that changes in the value of the index over time could be due to changes in the proportions of the overall workforce employed in different constituent occupational groups. This limitation does not affect the data for East Thames Health Authority as the analysis below is cross-sectional, rather than an evaluation of trends over time. It does, however, affect comparison between the indices for East Thames, Southern Regional Health Authority, and the NHS as a whole, as they each have different proportions of their overall workforce employed in the main constituent occupational groups. A third limitation to the index of dissimilarity is that only two categories - eg. females and males - can be compared at any one time, which produces an unreal separation of 'race' from sex. This problem, however, was also inherent to most of the data produced by East Thames, in that separate tables were generated on the basis of 'race' and sex for their workforce audit. With these limitations in mind - and the consequent qualifications - the index of dissimilarity maintains the advantage of its operational clarity. If a more detailed analysis were to be made than that which follows, involving comparisons of different data sets or comparisons over time, then the limitations would need to be given much greater attention.

The data from the workforce audit in East Thames Health Authority indicate that the occupational structure of the Authority is characterized by both horizontal and vertical sex and 'race' segregation. In considering horizontal sex segregation first, on the basis of the data presented in table 6, the Health Authority has a sex segregation index of 43.45. In other words, approximately 43% of women (or men) in the workforce would have to move between the occupational groups for equity in the distribution of the sexes to be achieved. The sex segregation index in East Thames is greater than the index of 38.47 for

the NHS as a whole (calculated from the data in table 3), but it is very close to the index of 43.33 for the Southern Regional Health Authority (calculated from the data in table 2).

**Table 6: East Thames Health Authority: Percentages of female and male workers employed in the main occupational groups.**

Column percentages

| Occupational group | Female % | Male % | Female % - Male % (Absolute value) |
|---|---|---|---|
| Ancillary | 9.3 | 21.3 | 12.0 |
| Administrative & Clerical | 22.9 | 17.2 | 5.7 |
| Medical & Dental | 4.1 | 21.3 | 17.2 |
| Nursing, Midwifery & Health Visiting | 53.5 | 15.9 | 37.6 |
| Professions Allied to Medicine | 4.2 | 4.5 | 0.3 |
| Scientific & Professional | 2.0 | 2.1 | 0.1 |
| Professional & Technical | 3.9 | 6.7 | 2.8 |
| Works & Maintenance | 0.0 | 11.2 | 11.2 |
| Total* | 100.0** | 100.0** | 86.9<br>$\Sigma$ F%-M% (Absolute values) |

Segregation index = $\Sigma$ F% - M% (Absolute values) ÷ 2 = 86.9 ÷ 2 = 43.45
(Absolute values represent the result of F%-M% without the signs)

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.
** The totals do not precisely equal 100% due to rounding.

As is the case for the Southern Regional Health Authority, the data in table 4 for East Thames show that the Medical and Dental group contains the largest group of males as a proportion of the whole workforce, whilst the largest group of females is in the Nursing, Midwifery, and Health Visiting group. As is the case for the NHS as a whole, males as a group in East Thames constituted a majority amongst medical staff. They were also over-represented amongst senior medical staff in relation to their proportion of the medical group as whole. In focusing on vertical sex segregation within the occupational groups in East Thames, males were over-represented in the managerial/supervisory positions of

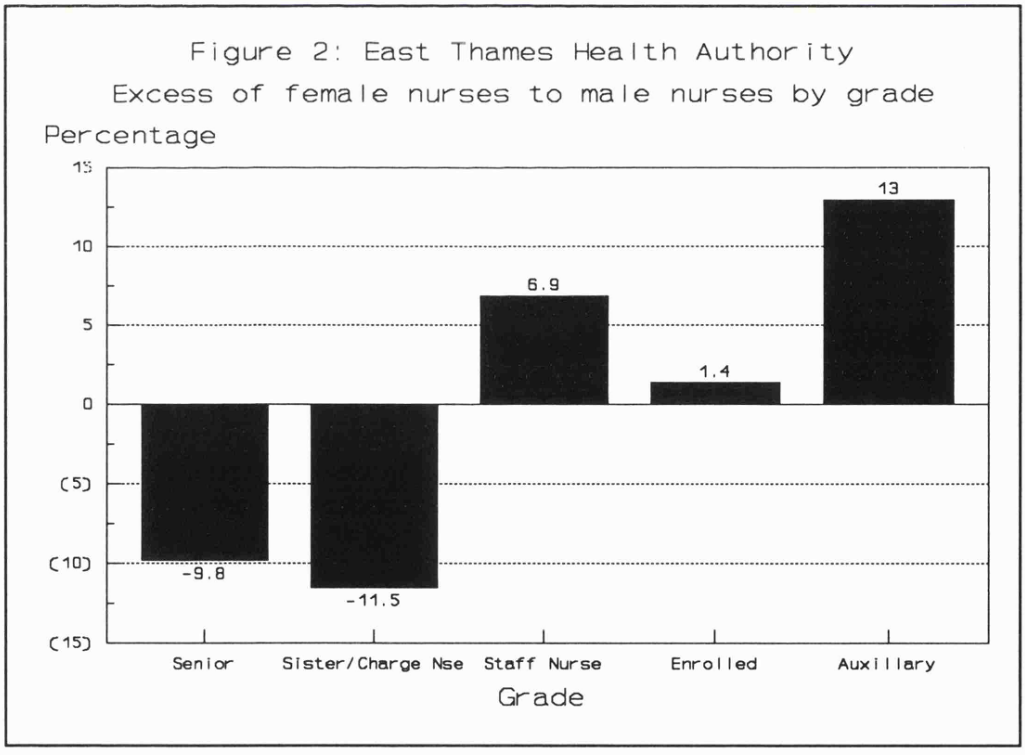
**Table 7: East Thames Health Authority: Percentages of female and male nurses in the main nursing grades**

Column percentages

| Grade | Female % | Male % | Female % - Male % (Absolute value) |
|---|---|---|---|
| Senior | 7.3 | 17.1 | 9.8 |
| Sister/Charge Nurse | 29.3 | 40.8 | 11.5 |
| Staff Nurse | 29.3 | 22.4 | 6.9 |
| Enrolled | 10.6 | 9.2 | 1.4 |
| Auxillary | 23.5 | 10.5 | 13.0 |
| Total* | 100.00 | 100.00 | 42.6<br>$\Sigma$ F% - M% (Absolute values) |

Segregation index = $\Sigma$ F% - M% (Absolute values) ÷ 2 = 42.6 ÷ 2 = 21.3
(Absolute values represent F%-M% without the signs)

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.



every occupational group. The pattern of vertical segregation between male and female nurses in East Thames District is shown by table 7. It is notable - on the basis of the segregation index - that the degree of segregation within the nursing workforce is less than the segregation between the occupational groups. However, it is clearly evident that a higher proportion of males - when compared to females - are employed amongst senior nurses as shown by figure 2. The greatest degree of the over-representation of males in senior occupational positions was amongst senior managers in the Administrative and Clerical group who occupied some of the most powerful positions within the Health Authority. Data for this group are provided in table 8 which shows the over-representation

**Table 8: East Thames Health Authority: Percentages of female and male Administrative, Clerical and Senior Managerial staff employed in each grade.**

Column Percentages

| Grade | Female | Male | Female % - Male % (Absolute value) |
|---|---|---|---|
| Senior Managers | 5.53 | 22.34 | 16.81 |
| A & C 8 | 0.00 | 3.19 | 3.19 |
| A & C 7 | 0.23 | 3.19 | 2.96 |
| A & C 6 | 3.46 | 10.64 | 7.18 |
| A & C 5 | 3.46 | 13.83 | 10.37 |
| A & C 4 | 11.98 | 9.57 | 2.41 |
| A & C 3 | 40.55 | 24.47 | 16.08 |
| A & C 2 | 34.56 | 12.77 | 21.79 |
| A & C 1 | 0.23 | 0.00 | 0.23 |
| Total* | 100.00 | 100.00 | 81.02<br>$\Sigma$ F% - M% (Absolute values) |

Segregation index = $\Sigma$ F% - M% (Absolute values) ÷ 2 = 81.02 ÷ 2 = 40.51
(Absolute values represent the result F%-M% without the signs)

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.

of males in senior positions. There was an even greater over-representation of males at the District Headquarters where the organisational centre of the Health Authority was located.

It can be observed from tables 3 and 6 that the proportions of the male workforce employed in the Administrative and Clerical group in East Thames and the Southern Region - and similarly for the NHS as whole - are less than the Ancillary group which exercises little power in relation to the workforce as a whole. Therefore, the entire male workforce cannot be regarded as a monolithic power group, but males *as a group* do dominate the Health Authority - on the basis of their occupational distribution overall - both in terms of the division of power and authority between the occupational groups and within the two most powerful groups of doctors and administrators.

The workforce audit in East Thames District also revealed both a horizontal and vertical 'race' segregation characterising the occupational structure. The pattern of horizontal segregation is presented in table 9. A segregation index has been calculated on the basis of a black/white division by substituting those two categories for 'male' and 'female' in the formula - indicated above - for the calculation of the index. Workers included in the 'white' category classified themselves as either "UK" or "Irish" on their monitoring forms returned for the audit, and workers included in the 'black' category classified themselves as either "African", "Asian", "West Indian" or "Chinese/Oriental". The two additional categories of "Other European" and "Other" were included on the monitoring forms and were marked as a category of classification by 5% of the workforce, but they have not been incorporated in this analysis into either of the categories 'black' or 'white' because it is impossible to determine which would be the appropriate category for them.

**Table 9: East Thames Health Authority: Percentages of black and white workers employed in the main occupational groups.**

Column percentages

| Occupational group | Black % | White % | Black % - White % (Absolute value) |
|---|---|---|---|
| Ancillary | 7.4 | 13.2 | 5.8 |
| Administrative & Clerical | 8.9 | 32.9 | 24.0 |
| Medical & Dental | 7.4 | 5.3 | 2.1 |
| Nursing, Midwifery & Health Visiting | 67.7 | 32.3 | 35.4 |
| Professions Allied to Medicine | 2.6 | 5.3 | 2.7 |
| Scientific & Professional | 0.9 | 2.9 | 2.0 |
| Professional & Technical | 5.0 | 4.7 | 0.3 |
| Works & Maintenance | 0.3 | 3.4 | 3.1 |
| Total* | 100.0** | 100.0 | 75.4<br>$\Sigma$ F%-M% (Absolute values) |

Segregation index = $\Sigma$ F%-M% (Absolute values) ÷ 2 = 75.4 ÷ 2 = 37.7
(Absolute values represent the result of F%-M% without the signs)

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.
** The total does not precisely equal 100% due to rounding.

A 'race' segregation index of 37.7 was calculated for the District, therefore - in other words - nearly 38% of white (or black) workers would have to move between the occupational groups to achieve an equitable distribution between the two groups. It is notable that the index has a lower score than the sex segregation index, but the patterns of sex and 'race' segregation have similarities in respect of the inequitable distribution of power and authority. For instance, the largest proportion - and a significant majority - of black workers is employed in the Nursing, Midwifery and Health Visiting group, and it is more than double the proportion of white workers employed in the group. Indeed, just over half of all nurses were 'black' on the basis of the classifications used for this analysis. In contrast, the largest proportion of 'white' workers were employed in the more

powerful administrative and clerical group where they constituted a large majority of the workforce in that group.

The workforce audit also indicated that 'white' workers were over-represented in senior positions in each occupational group. In the case of nurses this is shown in tables 10 and 11 in which data on the distribution of female nurses by grade is presented according to the classifications of 'black' and 'white'.

**Table 10: East Thames Health Authority: Percentages of female nurses by ethnic group in the main nursing grades**

Column percentages

| Grade | Black % | White % | Black % - White % (Absolute value) |
|---|---|---|---|
| Senior | 5.1 | 10.0 | 4.9 |
| Sister/Charge Nurse | 25.8 | 33.5 | 7.7 |
| Staff Nurse | 33.7 | 23.2 | 10.5 |
| Enrolled | 10.8 | 10.6 | 0.2 |
| Auxillary | 24.6 | 22.7 | 1.9 |
| Total* | 100.00 | 100.00 | 25.2<br>$\Sigma$ F% - M% (Absolute values) |

Segregation index = $\Sigma$ F% - M% (Absolute values) $\div$ 2 = 25.2 $\div$ 2 = 12.6
(Absolute values represent the result of F%-M% without the signs)

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.

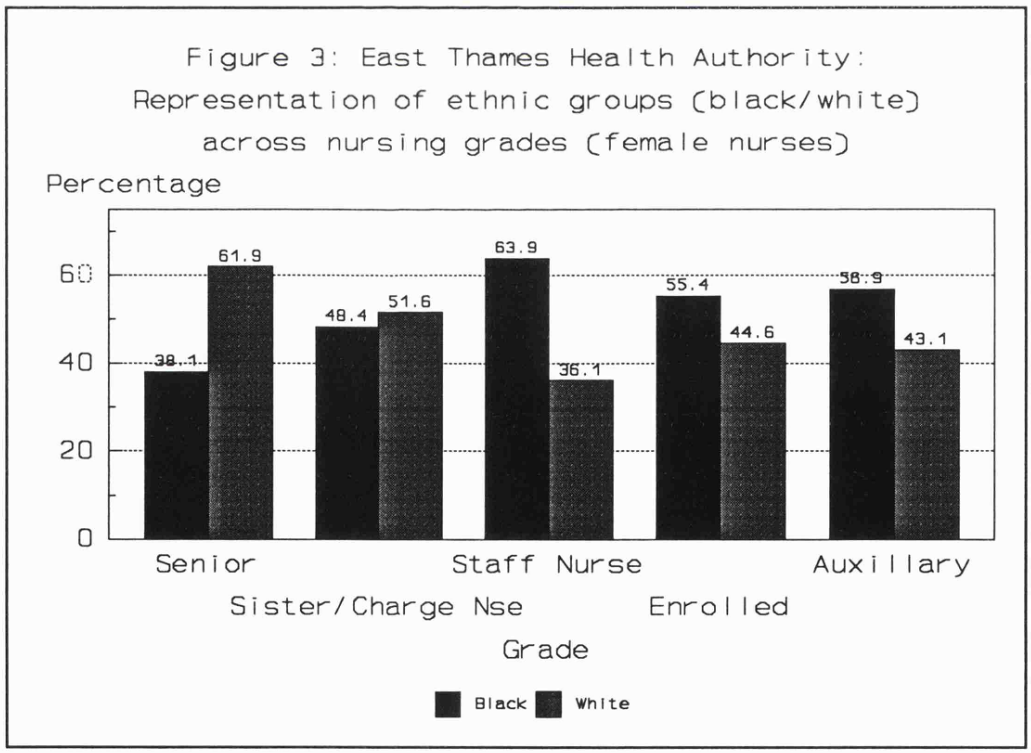
Whilst the different groups of 'black' nurses shared the common experience of under-representation in senior positions, it is apparent from table 12 that they had different patterns of distribution across the occupational hierarchy. For instance, the representation of the "West Indian" group consistently declined with rises in seniority of nursing grade,

**Table 11: East Thames Health Authority: Percentages of female nurses in the main nursing grades by ethnic group**

Row percentages

| Grade | Black % | White % | Total* % |
|---|---|---|---|
| Senior | 38.1 | 61.9 | 100.00 |
| Sister/Charge Nurse | 48.4 | 51.6 | 100.00 |
| Staff Nurse | 63.9 | 36.1 | 100.00 |
| Enrolled | 55.4 | 44.6 | 100.00 |
| Auxillary | 56.9 | 43.1 | 100.00 |

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.



although it levelled out at the senior nurse grade. In contrast, the representation of the "African" group increased up to staff nurse level from where it began to decline. Whilst the "Asian" group showed a similar decline at the sister/charge nurse and senior nurse grades, their representation also declined amongst enrolled nurses. Finally, the representation of the "Chinese/Oriental" group rose with increases in seniority up to staff nurse grade where it levelled off with sister grade but declined amongst senior nurses.

**Table 12: East Thames Health Authority: Percentage of 'black' female nurses by ethnic group in the main nursing grades.**

Column percentages

| Grade | West Indian | African | Asian | Chinese/ Oriental | All |
|---|---|---|---|---|---|
| Senior | 5.9 | 3.75 | 2.9 | 5.9 | 5.1 |
| Sister/Charge Nurse | 21.0 | 32.5 | 26.1 | 41.2 | 25.8 |
| Staff Nurse | 29.8 | 41.25 | 37.7 | 37.3 | 33.7 |
| Enrolled | 12.5 | 10.0 | 5.8 | 9.8 | 10.8 |
| Auxillary | 30.9 | 12.5 | 27.5 | 5.9 | 24.6 |
| Total* | 100.00** | 100.00 | 100.00 | 100.00** | 100.00 |

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.
** The totals do not precisely equal 100% due to rounding.

In summary, although there was inequity in the relative distribution of the 'black' groups - both in aggregate and on their own - and the 'white' group of nurses across the occupational hierarchy, each of the 'black' groups did not share an identical distribution. They did, however, share the common experience of being under-represented in positions of power and authority within the nursing workforce and although in aggregate the 'black' group accounted for a majority of all nurses they were a minority amongst senior nurses.

The data presented in tables 8 and 9 also indicate the 'double disadvantage' confronting black women at work for they not only occupy a disadvantaged position as women in relation to men in the occupational structure, but they are also disadvantaged in relation to white women.

The vertical 'race' segregation of the workforce is also illustrated in table 11 which presents data from the workforce audit in East Thames District for Administrative, Clerical, and Senior Managerial staff on the basis of ethnic group and grade. It will be noted - as is the case for nurses - when comparing the data in the table to table 6, that the 'race' segregation index is considerably lower than the sex segregation index.

**Table 13: East Thames Health Authority: Percentages of Administrative, Clerical and Senior Managerial staff by ethnic group and grade.**
Column Percentages

| Grade | Black | White | Black % - White % (Absolute value) |
|---|---|---|---|
| Senior Managers | 1.51 | 8.82 | 7.31 |
| A & C 8 | 0.00 | 0.73 | 0.73 |
| A & C 7 | 0.00 | 0.24 | 0.24 |
| A & C 6 | 7.58 | 4.17 | 3.41 |
| A & C 5 | 1.51 | 5.88 | 4.37 |
| A & C 4 | 9.09 | 12.50 | 3.41 |
| A & C 3 | 59.09 | 35.29 | 23.80 |
| A & C 2 | 21.21 | 32.35 | 11.14 |
| A & C 1 | 0.00 | 0.00 | 0.00 |
| Total* | 100.00** | 100.00** | 54.41<br>$\Sigma$ F% - M% (Absolute values) |

Segregation index = $\Sigma$ F% - M% (Absolute values) $\div$ 2 = 54.41 $\div$ 2 = 27.21
(Absolute values represent the result of F%-M% without the signs)

* Actual numbers of employees are not provided in the table to preserve the anonymity of the Health Authority.
** The totals do not precisely equal 100% due to rounding.

In Anwar and Ali's (1987) survey of overseas doctors - cited earlier in the chapter - it is possible that different age structures of their samples of overseas and British trained doctors could have accounted for the observed differences in seniority between the two groups. In the same way, it was feasible that differences in the age profiles of the 'black' and 'white' groups of workers in East Thames could have accounted for their inequitable distribution. It was, however, possible to investigate this further in the case of nurses from data held on the District's computerized personnel records. When analyzed the data indicated that age was not a factor at all behind the vertical 'race' segregation as the mean age of black female nurses (43.3 years, standard deviation 8.406 years) was considerably higher than the mean age of white female nurses (35.1 years, standard deviation 11.027 years). On the basis of these data it can be further concluded that the different age profiles of black and white nurses in East Thames District under-represents their differential distribution across the occupational hierarchy. It was not possible - due to limitations of the personnel records - to apply other controls to the data for nurses in East Thames. But it is notable that in the research by Doyal et al (1979) - cited above - controls were made for a number of variables including length of service; number of years since qualification; and the characteristics of the local labour market (although they do not support this by presenting their data), and the variables did not account for the under-representation of "West Indian" nurses in the sister/charge nurse and senior nurse grades revealed by the research.

In evaluating the composition of the medical and dental group in East Thames the representation of 'black' doctors in the group appears to present an anomaly in respect of the inequitable distribution of power and authority across the workforce - discussed to this point - on the basis of 'race'. For instance - as indicated in table 9 above - the proportion

of the 'black' workforce employed in this group (7.4%) was greater that the proportion (5.3%) of the 'white' workforce, and 'black' doctors constituted over one-third of all doctors. However, despite occupying an advantaged position in relation to the exercise of power and authority within the health care system, the 'black' doctors were disadvantaged within their own occupational group as they were under-represented amongst senior medical staff in comparison to their representation within the medical and dental group as a whole. It is notable that the 'white' group was also under-represented amongst senior medical staff, but not to the same extent as the 'black' group. The under-representation of the two groups appeared to be due to a significant over-representation amongst senior medical staff of doctors who classified themselves as "Other European". But that conclusion should be circumspect as it is apparent that there was no information concerning 'race' classification for nearly half of the senior medical staff. This was due to the transfer of consultants during the workforce audit from the Regional payroll to the payroll of East Thames District. In consequence the consultants were included in the audit on the basis of their computerized personnel records but they brought with them Regional 'race' classifications that were not compatible with the District's classifications. Therefore, they were counted in the audit under the category of "no information". Despite the limitations to the data the presence of black doctors occupying powerful positions in the health care system indicates that blacks and whites, and women and men, cannot be regarded as homogeneous groups in either the operation or the experience of racism and patriarchy.

In the introduction to the thesis it was observed that a power hierarchy has been suggested which is ruled by white men at the top, followed by white women who rule over black men and finally black women. It has been suggested that white women

exercise power and control and have attained material benefits from which black women and men have been excluded. White women have both participated in that exclusion and have been the recipients of advantages attained through the 'race' exclusionary practices of white men. From this perspective, black women have less in common with white women than they do with black men as the most significant axis of the power division is racism. The presence of black doctors, however - even though there is apparent vertical 'race'-segregation - provides an exception to the proposed power hierarchy. In addition, when comparing the relative significance of 'race' and sex in relation to segregation at work it is notable from the data presented to this point that the sex segregation indices have been greater than the indices based on 'race'. This is the case both for the horizontal segregation for the whole workforce of East Thames, and the vertical segregation amongst nurses, administrative, clerical, and senior managerial staff. It has similarly been observed for the macro-level - in the case of the USA - that there has been a greater homogeneity in terms of concentration in particular areas of work on the basis of sex than on the basis of 'race' (Tang Nain 1991: 7). In summing up, the point is that it would be too simplistic to suggest that whites as a group, and in particular white men, are homogeneous groups with regards to power relations with blacks as a group, and in particular black women. There are exceptions - as indicated in this chapter - that would certainly contradict such a proposition, and therefore different structural contexts will be characterised by different patterns of relations. Whilst avoiding generalisation, however, it is apparent - on the basis of the data presented in the chapter - that there is a tendency for men, and particularly white men, to dominate the positions of power and authority within the occupational structure of East Thames Health Authority, and - on the basis of the other research evidence cited - the same structure of domination appears to characterize the National

Health Service as a whole. The pattern of domination was clearly recognised by a senior manager interviewed in West Thames Health Authority, who stated that:

> it seems to me - working in the NHS - that we have the most extraordinary situation in terms of equal opportunities because the organisation is dominated - the senior power source in the organisation - is dominated by the medical profession, who as you know, especially in the higher echelons are predominantly men, and the lower grades are dominated by women, nursing, therapies and so forth, cleaners...and racially, there's this odd skew as well, that there's an under-representation in power positions of ethnic minorities, and over-representation in the lower grade jobs of ethnic minorities, you know, most of the support staff on the site are not English...//... So when it comes to the scrabble for resources the fact that I, although theoretically a senior member, a senior officer/manager in the Health Service, the fact that I'm a woman, I'm representing a predominantly female group...//...It does undermine the resources, I think, it actually affects the resources that come to my patient group. I feel very, very strongly about that, I don't care so much about what it does to the profession. (R69)

The pattern of domination is more than simply a statistical phenomenon because as this manager suggests it arguably affects the way in which resources are allocated within the health care system.

**Policy implications**

It was stated in the introduction to the thesis that racism and patriarchy are conceived as interacting systems of group dominance which have both a structural and a political character. The structural aspects of domination are characterised by the over-representation of men - and particularly white men - in positions of power and authority, controlling the activities of the rest of the workforce which consists mainly of women, of whom a substantial proportion are black women. The structural domination of males over females in the NHS is characteristic of the British occupational structure in general (cf. Equal Opportunities Commission 1990), and the structure of health services in many other countries (International Labour Organisation 1992). The political aspects of domination - as conceptualised in chapter one - consist of a number of exclusionary processes which

disadvantage women, and black women in particular. The structural and political aspects of domination are interacting elements of the system of dominance as a whole as they both sustain each other. For instance, the structural domination is reproduced and sustained by the exclusionary processes. Similarly, the operation of many of the exclusionary processes is only possible because males - and particularly white males - dominate positions of authority in which they have the power to exercise the processes of exclusion.

The structure of domination characteristic of racism and patriarchy at work involves an exploitative relationship between male and female, and white and black workers, as the power, autonomy, status, and earnings of men, and white men - as a group - are dependent upon the confinement of women, and black women - as a group - through the various exclusionary processes to comparatively low-status, low-paid work. However, it is not being argued that men, and white men, constitute a monolithic group conspiring to maintain their position of dominance in that all men are either consciously or unconsciously involved in the exploitation of women in the workplace, and all white workers are involved in the exploitation of black workers. To propose either argument would seriously challenge - without any evidence - the integrity of some men, and white staff, observed in both case-study Districts to be actively involved in pursuing and shaping equal opportunities practices. Without doubt, some individuals are consciously involved in the processes of exclusion, however, the focus of the argument is that the exclusionary processes at work benefit men, and white men - as a group - and potentially benefit them all as individuals whether they like it or not, whilst disadvantaging women, and black women, both as individuals and as a group.

The key point in relation to the analysis presented in this chapter is that the

processes of exclusion operate because the individuals who benefit from them - white staff, and particularly white males - occupy and dominate positions of power and authority. Their power and authority provides the possibility and the opportunity for them to operate the exclusionary processes. It would seem, therefore, that a significant goal of policy intervention would be to break down the pattern of dominance by increasing the representation of women and black workers in senior occupational positions. At the very least, equal opportunities measures need to be applied to all levels of the workforce, and senior management cannot be immune. In addition, employees responsible for equal opportunities policy implementation will require - to be effective - unfettered access to scrutinize the practices of senior management. These policy implications will be explored further in the conclusion to the thesis.

# CHAPTER 3

## POLICIES AGAINST RACISM AND PATRIARCHY AT WORK

The objective of this chapter is to discuss the dimensions of potential policy measures targeted against racism and patriarchy at work. The rest of the thesis will focus on the implementation of some of the measures. Three prominent policy measures are considered; positive discrimination; positive action; and equal employment-opportunities policy. Chapters one and two have presented an analysis of the political and structural dimensions of racism and patriarchy at work, and positive discrimination is targeted at the structural dimension alone. Positive action challenges both dimensions, and an equal employment-opportunities policy is aimed primarily - although not exclusively - at the political dimension. Positive discrimination has been the subject of much controversy in the USA. However, as it is unlawful in Britain, greater attention will be given to positive action, although objections to the practice of positive discrimination provide an indication of the potential objections to positive action were it to be implemented much more fully in Britain. Accordingly, some nascent objections to positive action which emerged from interviews in the two case-study Health Authorities will be indicated. In discussing the dimensions of the third potential policy measure - equal employment-opportunities policy - both the meaning and the moral foundation of the principle of equal opportunity will be made clear, as it has been argued that they are obscure (Solomos & Jenkins 1987). It will be noted, though, that in contrast, clear prescriptions for equal employment-opportunities policy have been specified - in particular - by the Commission for Racial Equality and the Equal Opportunities Commission.

## Positive Discrimination

Positive discrimination - as has been practised in the USA - involves the preferential selection of blacks and women - in relation to whites and males - for employment and college studentships, in some instances to fill numerical quotas which are sometimes set to match the demographic characteristics of the population which the organisation serves. It has also been referred to as "reverse discrimination", "affirmative discrimination" (Glazer 1975), and perhaps most commonly in the USA as "affirmative action". Whilst the term affirmative action has been used to refer to a variety of measures (Young 1986: 10) including positive action and equal opportunities policies, when discussion has focused on the controversy of affirmative action it has normally been concerned with preferential treatment - or positive discrimination. The term 'positive discrimination' has also been applied to a range of social policies in Britain, and the most prominent perhaps have been 'area based' policies whereby resources have been allocated to particular geographic areas of urban and social deprivation (cf. Edwards 1987: 4-33). Positive discrimination as practised in the USA, however, in the form of preferential treatment of individuals, is unlawful according to the 1975 Sex Discrimination Act and the 1976 Race Relations Act. The discussion below focuses on positive discrimination as understood in the USA.

The practice involves a direct intervention against structural inequalities between blacks and whites, and women and men, by aiming to achieve a more equitable share of social resources, such as employment and education. Whilst it has been targeted at inequalities at the micro-level - primarily in relation to employment and college studentships - it also in effect involves a direct intervention against inequality at the macro - or societal - level by intervening in the distribution of socio-economic resources. It has

arguably produced some significant gains in the USA in relation to job opportunities, income disparity (Iganski 1988a, 1988b) and college attendance, although the connection between the gains and positive discrimination is disputed (cf. Glazer 1987).

Defence of the practice of positive discrimination in the USA appears to have chiefly been on the grounds of compensatory justice and distributive justice (Greene 1989). The claim for compensation is concerned with redressing past injustice - or discrimination. Whilst the principle of compensation to individuals who have been wronged appears to be widely established, the principle is weakened when on the one hand individuals who benefit from the compensation have not specifically been wronged themselves, and on the other hand when individuals who incur the debt of compensation - by, for example, failing to attain a particular job or college place because others have been preferentially selected - are not themselves personally culpable for the particular wrongs (cf. Sher 1980). In such circumstances compensatory justice is in conflict with distributive justice (cf. Edwards 1987: 128-67), and particularly one principle of distributive justice that individuals have a right to 'equal consideration'. This 'right' is fundamental to dominant consensual liberal notions of social justice, and, as will be explained in more detail when discussing the principle of 'equal opportunity', it usually means that 'merit' is the overriding criterion for the distribution of social resources - such as jobs.

Positive discrimination has, though, been defended on grounds of distributive justice, and therefore different principles of distributive justice have been pitted against each other. For example, Dworkin (1979: 223-39) has defended positive discrimination on the utilitarian grounds that the practice may achieve a 'more equal society', arguing that this does not deny anybody's right to equal consideration. Alternatively, Edwards

(1987) has argued that there is a conflict with individual rights, and 'considerable' utilities would have to be attained before those rights could be overridden. The conflict is rooted in the meaning of the right to equal consideration, and specifically, the meaning of merit, which will be elaborated upon in the discussion below of the principle of equal opportunity, because the guiding principle of merit is fundamental to an equal employment-opportunities policy.

In addition to the moral objections to positive discrimination, a number of dominant empirical objections can be noted. It is useful to discuss them as they indicate potential objections to the practice of positive action. It will be noted shortly, though, that the potential common objections are due to some confusion between the meaning of positive discrimination and positive action. One empirical objection to positive discrimination is that in the context of limited social resources, such as jobs and college places, only some members of a group - for example blacks or women - can be compensated. But benefits for a few do not appear to compensate the group as a whole. In this context, it has been suggested that the practice might provoke discontent amongst members of a favoured group who have not themselves benefitted from preferential treatment (Roberts 1981: 163). Secondly, the groups will contain a variety of individuals who have had different experiences of discrimination and who therefore have different claims to compensation. Yet, it has been argued that individuals that benefit from positive discrimination policies are usually the least disadvantaged members of their group. In the case of preferential hiring for employment, for instance, employers would select the most able candidates from the group singled out for preferential treatment. A similar point has been made by Burney (1988: 2) about the so called 'area based' positive discrimination policies in Britain, that those who benefitted most were not necessarily the most

disadvantaged. Furthermore, some of the individuals that benefit may even be less disadvantaged than some members of a group that is not favoured by positive discrimination policies. Accordingly, Janet Radcliffe Richards has argued in the case of positive discrimination for women:

> Why should one discriminate generally in favour of women, when it might involve benefitting an already well off woman at the expense of a badly off man ? If compensation is all that is at issue, why not have the rule that the worst off (of either sex) are to be compensated ? To say that women's grievances should be redressed in preference to men's is to be unfair to men: it gives women the privilege of having their lack of privilege take precedence over men's lack of privilege. (Richards 1980: 109-10).

In a similar vein, in relation to positive discrimination in the USA on the basis of 'race', Nathan Glazer has argued that the consignment of all whites to one non-favoured group does not take into account the discrimination suffered by some white ethnic groups. Glazer has also pointed out that not all ethnic groups have suffered discrimination to the same extent, and has questioned, for instance, whether immigrant groups that entered the USA voluntarily deserve the same preferential treatment as those who had been previously conquered or subject to slavery. A fourth objection is an argument that policies of positive discrimination have the negative effect of provoking inter-group conflict and encouraging the polarisation of communities according to ethnic divisions. Individuals will supposedly experience 'subtle pressure' to adhere to ethnic affiliations, not through any inherent desire to do so, but because it becomes the basis for the achievement and maintenance of advantages. A reactive response is provoked amongst the ethnic groups of the dominant white majority that have not been singled out for preferential treatment, as they compete with those that have been favoured as a means of self-defence to protect their advantages. Lastly, a number of 'socio-psychological' consequences are allegedly caused by the practice of positive discrimination (Roberts 1981: 160). For instance, preferential treatment

may emphasise a sense of inferiority for a favoured group by making explicit their need for special assistance to achieve parity with other groups. It allegedly may also bolster negative stereotypes by casting doubt on the merit and achievements of individuals from favoured groups who have succeeded under their own steam and perhaps leads them to self-doubt as they will not be sure whether their attainments have been due to merit or special treatment. The self-esteem of favoured individuals is also allegedly damaged when they become aware that they have been appointed to positions beyond their abilities (Roberts 1981: 161-2). In sum, the empirical objections indicate serious potential deficits to the practice of positive discrimination, which might impede policy implementation even if it was desired on moral grounds.

**Positive Action**

As already observed, the practice of positive discrimination is unlawful in Britain according to the Race Relations and Sex Discrimination Acts. The Acts primarily outlaw discrimination, but they also incorporate a recognition - in the shape of exceptions for 'positive action' provisions - that outlawing discrimination alone will not automatically lead to equality of opportunity. That recognition was made clear in the British Government's 1975 White Paper *Racial Discrimination* which presented proposals for the 1976 Race Relations Act:

> if the principle of non-discrimination is interpreted too literally and inflexibly it may actually impede the elimination of invidious discrimination and the encouragement of equal opportunity...The Government considers that it would be wrong to adhere so blindly to the principle of formal legal equality as to ignore the handicaps preventing many black and brown workers from obtaining equal employment opportunities. (U.K. 1975: para 57, p.14)

Similarly, in the case of women, the 1974 White Paper *Equality for Women* which presented proposals for the 1975 Sex Discrimination Act stated that:

> An anti-discrimination law is relevant only to the extent that economic and social conditions enable people to develop their individual potential and to compete for opportunities on more or less equal terms. A woman will obtain little benefit from equal employment opportunity if she is denied adequate education and training because economic necessity or social pressures have induced her to enter the labour market at an early age. Some mothers will derive as little benefit if there is inadequate provision for part-time work or flexible working hours, or for day nurseries. (U.K. 1974: para 21, p.5)

The subsequent Acts were both clear and specific about the positive action measures that could be taken 'voluntarily' by employers. In relation to 'race', employers are allowed to encourage job applications from members of particular 'racial' groups when there are either no persons of the group employed in a particular area of work at an establishment, or when the proportion of the group employed is "small" in comparison to their proportion amongst all those employed at the establishment or amongst the population of the areas from which an employer normally recruits its workforce (Race Relations Act 1976: sec.37-38). Under the same conditions, special training can be provided for members of particular 'racial' groups to help them acquire the skills for particular work. Although there is no legal obligation for employers to make use of the positive action provisions, the CRE has recommended in its *Code of Practice* (CRE 1984a: 20) that they are implemented where particular 'racial' groups are under-represented in particular work - under-representation being the interpretation of "small" as stated in the Act.

Positive action provisions on the basis of sex are permissible under sections 47 and 48 of the 1975 Sex Discrimination Act when there have been no members of one sex in particular work for the previous twelve months, or where the numbers are "comparatively small". In such an instance, particular encouragement to job applicants and special training can be provided for the minority sex (EOC 1985: 15). In addition, employers are encouraged to evaluate their working arrangements to aid the continuity of employment

of working parents (EOC 1986: 15-16). Such arrangements might include job-sharing, flexible working arrangements, assistance with child-care facilities, skills training such as 'women in management' courses, and the provision of training - such as nurse training - on a part-time basis.

In essence, the objective behind positive action practices is to reduce structural inequalities at work chiefly by helping women and black people to compete on level terms with males, and white males in particular. The condition which clearly distinguishes positive action from positive discrimination is that preferential treatment in the actual selection for work is not permissible according to the Acts, and therefore all candidates must be considered on the basis of merit. Whilst in principle positive action could be used to assist white males where they are under-represented in particular areas of work, the practice is normally not considered that way round.

One of the objectives in the interviews in the two case-study Health Authorities was to gauge how receptive managers might be to positive action measures. The objective was considerably frustrated, however, by a general lack of understanding and some confusion - amongst line-managers in particular - about the meaning and practice of positive action. Where some understanding was demonstrated, the practice was largely justified on the utilitarian grounds of making health-care delivery more sensitive to minority ethnic groups by the recruitment of health-care workers from those groups:

> certainly, positive action to encourage selective groups into an interview situation, then I would support that, because its blatantly obvious that we have a staff group here that does not represent the client group we're working with. (R38)

Similarly when asked - in interview - whether he was in favour of positive action practices, another line manager stated:

> I think when it helps us to look after our patient and client population

> more effectively, or even to put it more bluntly, where it enables us to provide a safe level of care to some patients and clients who cannot speak the language, and not accustomed to the culture, then I certainly believe we need to be very positive in our approach to recruiting and finding people who are from that culture and that background. Otherwise we really fail in our duty to our patients, and that's evident often by people who are coming in an acute stage of their illness, and you can't ask them simple questions to identify what their illness is. So I mean, it's not just a case of the language, but the culture too, that people do feel embarrassed or awkward or are unaccustomed to being spoken to in a certain way or having certain personal questions asked of them. So whereas if there is somebody there from their community that's handled in an appropriate way to enable us to proceed with our investigations. Plus the fact that this particular...//...we're moving more and more towards community care, and that means going to people's homes, health professionals going to people's homes, to see people there who are not maybe acutely ill, but have an illness, and health care in the home has to be handled very professionally, and they're very much aware of individual preferences, and priorities and background of people, and we have sought actively to find people from the relevant ethnic backgrounds to suit the type of care we give. (R64)

As an indication though of the general lack of understanding concerning positive action this manager appeared to be confusing the practice with the provision - according to the 1976 Race Relations Act - of recruitment on the basis of genuine occupational qualification. According to section five of the Act 'race' is a genuine occupational qualification in circumstances of "authenticity" in dramatic performances, artistic representations, and establishments providing food and drink. 'Race' is also a genuine occupational qualification when "the holder of the job provides persons of that racial group with personal services promoting their welfare, and those services can most effectively be provided by a person of that racial group." (Section 5(2)(d)) Sex is also a genuine occupational qualification in similar circumstances and additional circumstances listed in section seven of the 1975 Sex Discrimination Act. Accordingly, the manager had used the genuine occupational qualification provisions to try and recruit staff from the local minority ethnic community:

> we have in fact over the last two or three years, advertised specifically, and

> got permission in advertising to actually say what ethnic background person we're looking for, at least somebody who could speak the language. And that's been tough going to find people from the relevant background who are appropriately qualified, but we have been doing, and we've got two people who are working as community staff now and that resulted from our adverts. (R64)

One manager had used the principle of positive action to recruit staff from the local community in general - not specifically from particular ethnic groups - with the aim of improving services to the local community as a whole:

> I think it's very useful really...I mean I'm aware that there are many women, for example, out there who could contribute quite effectively to the health care systems in (the District), who perhaps wouldn't ordinarily apply for the jobs. I think it just gives people extra encouragement if they know they're specifically asking for somebody from that community. We have had a good response from local people which seems to have helped really. We haven't sort of used any specific parts of the Act for that, but I think we've said something on the ad like applications from people who live in (the District) would be particularly welcome. (R37)

Notably, only one manager stated that they had used positive action as a means of helping either women or men overcome disadvantage:

> we are tending to try and get closer to the ethnic minorities groups through their own papers, for two reasons really, one is obviously that we need to find people to fill those posts, but the other is that we are responding to requests from the community at large to try and help that particular group to get better established on the job market - the young (Asian) group that we've got here, and where they're not actually being able to get on to the ladder...//...but with a bit of initial help, and initial training they really are perfect. (R36)

A number of difficulties behind the practice of positive action were suggested, some echoing the empirical objections to positive discrimination. One female manager clearly did not want what she regarded as preferential treatment:

> On a personal level, I would hate to think that somebody positively.... how can I say it....sort of gave me a job, put me through a women in management course and things like that, because they felt it was the thing to do. I'd much rather get to that position on my own steam thankyou. That's my personal view. (R55)

This manager believed that positive action might even alienate colleagues who have not benefitted from the practice:

> I think the person also has to work then with the rest of their colleagues who maybe didn't get any opportunities to go on management type courses, but have, and there are a lot of managers who haven't had any formal management training and I think there is a danger there that those managers will look...she got the job, and got sent off on a course...they just had to have a woman, that sort of thing. And I think that then is a disadvantage for the female coming in that she's going to have to fight that as well as, you know, prove her own worth. (R55)

This manager did not seem to be confused about the difference between positive action and positive discrimination, rather she felt that positive action would be interpreted as preferential treatment. For example, in relation to positive action statements in advertising job vacancies she suggested that the practice may commonly be perceived as a form of positive discrimination operating under the guise of positive action. In her view this deters potential applicants from groups that are not specified in the advertisements:

> When I advertised for posts, and said about women and (Asian language) speakers, I had quite a few people came up and more or less said, "well I won't get a job will I because I'm white", and I said, "well that's absolutely rubbish, if you're any good for the job, you'll get the job just as much." But that's where the danger comes, it's seen by staff, that is, you know, you're positively discriminating, and I think equal opportunities policy should be for all staff irrespective. (R55)

This manager even alleged herself that positive discrimination does go on under the guise of positive action:

> these policies are often written for one group of people in mind instead of taking it for everybody, and that's what I would like to see, them actually do training programmes and things to get managers much more aware that it should be for everybody and then I think people would accept equal opportunities. Until they do that, people will see it as some form of positive discrimination. (R55)

Another manager also seemed to believe that positive action measures amounted to positive discrimination. When asked about positive action he stated:

> I believe policies like that - if they are implemented - are implemented for the wrong reasons. If they are not socio-political, they are quasi-socio political, and if I have the funds I'm quite happy to play ball. I was quite happy to play ball and have 15% of the staff...at one time of different ethnic groups...all I said was "give me the money and I'll do the job for you." "Oh no, there's no more money", well immediately there were problems. I mean I can get someone from the West Indies, I've got Nigerians here who are first-class and no problems employing people like that. But just say because he comes from Nigeria, he comes from the West Indies or something, I must employ him because you haven't got enough coloured people on your staff, does seem to me to be the wrong reason. (R56)

This manager indicated his support - during the interview - for the principle of equal opportunity, but he was opposed to the practice of positive discrimination. Surveys in the USA have similarly revealed a widespread support for affirmative action when interpreted as equal opportunity, with concurrent opposition to preferential selection (Kluegal & Smith 1981, Sigelman & Welch 1991). There appears then to be a potential resistance to positive action policies, even by managers who believe in equal opportunity. That resistance could be due not only to a confusion between the meaning of positive action and positive discrimination, but also to a belief that the hidden practice behind positive action is really preferential treatment. That belief is perhaps not surprising as the inherent goal to positive action is the greater representation of black workers and women across all levels of the workforce.

### Equal employment-opportunities policy

Positive action provisions are normally incorporated into an equal employment-opportunities policy (cf. CRE 1985: 6). The core of such a policy is primarily targeted at the political dimension of racism and patriarchy at work, although the subsequent effect if successful, and the implicit goal, is a reduction in structural inequalities in the workplace. The meaning of 'equal opportunity' is seemingly uncertain (Solomos & Jenkins 1987: 3, Solomos & Ball 1990: 212) and the philosophical - or moral - foundation

behind the principle of equal opportunity is perhaps even more difficult to pin down. As the thesis is largely concerned with the implementation of equal employment-opportunities policy, the meaning of equal opportunity will be clarified. The moral foundation will also be considered as it provides the parameters for the policy dimensions. In contrast to the lack of clarity concerning the meaning and morality of equal opportunity the dimensions of equal employment-opportunities policy are perfectly clear as specified in policy recommendations - in the case of the NHS - by the King's Fund Equal Opportunities Task Force (1987), the National Steering Group for Women in the NHS (1989), and the NHS Training Authority (1989). The policy dimensions will also be spelt out as the thesis focuses on their implementation.

With regards firstly to the meaning of equal opportunity, Anthony Flew has provided a clear definition:

> what has usually been meant by 'equality of opportunity' would be better described as open competition for scarce resources. The equality here lies in the sameness of the treatment of all the competitors in an open competition, and the only opportunity which is equal is precisely the opportunity to compete on these terms. (Flew 1981: 45).

This succinct definition - although grasping the essence of equal opportunity - can be elaborated further by considering the moral foundation to the principle, whereby open competition for scarce resources is a 'right' of individuals. Accordingly, two supposedly "standard" and "popular" conceptions of equal opportunity have been suggested by Fullinwider (1980), and they will provide the starting point for the discussion here. The two conceptions are; "Formal Equal Opportunity" and "Liberal Equal Opportunity". The essence of Formal Equal Opportunity - with regard to employment - is that no person should face any legal or 'quasi-legal' barriers to employment opportunities that are not faced by others. The essence of this principle - for Fullinwider - is that "each job

applicant has a right that the successful applicant be chosen solely on the basis of his (sic) job-related qualifications." (Fullinwider 1980: 24). This right therefore requires "careers open to talents" in that only "the applicant's ability to do the job should count" (Fullinwider 1980: 104). Therefore, the use of 'race' or sex as selection criteria would violate this 'right', unless they are genuine qualifications for a job. The principle of Formal Equal Opportunity is embodied in sections 1 and 2 of the British 1975 Sex Discrimination Act and the 1976 Race Relations Act. In these sections the Acts outlaw what they define as "direct" and "indirect" discrimination and they lay down the right to open competition. Direct discrimination involves the treatment of some individuals "less favourably" than others on the grounds of 'race' or sex. Indirect discrimination involves the equal treatment of individuals in the application of "requirements" or "conditions" - for employment for instance - with the effect that "considerably smaller" proportions of one group - on the basis of 'race' or sex - are able to comply with them in comparison to the other group(s), and where the conditions cannot be justified in respect of the job requirements, and where they are to the detriment of members of the group in question.

In short, the essence of the principle of Formal Equal Opportunity is that individuals have a 'right' to 'equal consideration' (Fullinwider 1980: 24), or in other words, a right to open competition. This right is central to dominant consensual liberal notions of social justice. Fundamental to liberal social justice is the Aristotelian equality principle according to which individuals have a claim to treatment as equals. This does not require equal shares of social benefits - such as jobs - between individuals, but that inequalities - or differences - between individuals are recognised and social benefits distributed accordingly. On this basis there are commonly only a few criteria by which it is considered fair to discriminate between individuals in the allocation of social benefits.

Edwards (1988) has called them "morally relevant criteria" and they include "merit", "contribution to the common good", "rights", "need" and "desert". By these criteria practices which discriminate between individuals on the basis of 'race' and sex are prima facie unjust as they are characterised by the distribution of benefits to individuals on the basis of morally irrelevant criteria. Therefore, in the case of employment - individuals have a right - according to liberal social justice - that merit will be the deciding criterion for job selection. In a broader context individual merit provides the foundation of the systems of social stratification in liberal democracies as Prager has observed:

> Operating like a free market, the meritocracy selects those individuals - anonymous except for their demonstrated performance - best suited to occupy the given positions of power and responsibility...Because merit is identified as an essential possession of the individual, society is viewed as composed of individuals hierarchically arranged according to merit. (Prager 1986: 24-25).

In the same way, an organisation which applies the principle of equal opportunity to its selection practices could also be regarded as incorporating a hierarchy of individuals arranged on the basis of merit.

A serious limitation, however, to the concept of Formal Equal Opportunity as clearly recognised in the White Papers for the Race and Sex Discrimination Acts is that some individuals are prevented - because of their group characteristics - from competing on level terms with other job applicants. This is due to earlier discrimination producing a "cycle of cumulative disadvantage" (U.K. 1975: para 11, p.3) or, in the case of women in particular, barriers to open competition due to normative expectations regarding their domestic and child-care responsibilities. Concepts of 'Liberal Equal Opportunity' recognise and take into account this limitation. One such concept - which in Fullinwider's view "probably commands wide acceptance" - is characterised by the following dimensions; two individuals have equal employment-opportunities when:

> (i) each has equal basic education (ii) neither faces a legal or economic barrier to further education or training based on race, sex, or other factor not related to ability to benefit from such further education or training, (iii) neither faces a legal or quasi-legal barrier to employment based on race, sex, or other factor irrelevant to job competence, and (iv) neither faces pervasive special labor market barriers to demonstrating job competency not faced by the other. (Fullinwider 1980: 107-8).

The principle of Liberal Equal Opportunity provides the parameters for the dimensions of equal employment-opportunities policy as prescribed in Britain. Accordingly, the policies incorporate both anti-discrimination measures and positive action measures, although in practice - as will be demonstrated for the NHS in the next chapter - positive action measures have barely been implemented. At the heart of the notions of both Formal Equal Opportunity and Liberal Equal Opportunity is the principle that 'merit' is the determining criterion for the allocation of social resources - in this instance, jobs. Accordingly, the principle that job selection must be determined by merit in relation to job requirements lies at the heart of equal employment-opportunities policies. The heart, or the core, of policy as recommended in Britain in the 1980s - applying the principle of merit - involves the rationalisation or formalisation of the recruitment and selection process for employment, promotion, and the re-deployment of individuals within organisations.

Formalisation involves the removal of subjectivity from the recruitment and selection process which will therefore - in theory - be guided by objective criteria. Beginning with recruitment, informal practices - such as word of mouth recruitment - can potentially discriminate - indirectly when judged according to the Race Relations and Sex Discrimination Acts - against groups on the basis of 'race' and sex that are under-represented amongst a workforce (CRE 1984b) as they are less likely as a group to become aware of a vacancy. To ensure equality of opportunity according to policy

recommendations, therefore, job advertisements should be placed with a sufficiently wide coverage so as not to exclude particular groups of applicants (cf. KFEOTF 1987: 11). To provide the basis for objectivity in selection a job description should be produced for each vacancy and specifications identified of a desirable candidate concerning - for example - experience, educational qualifications, and abilities, which should exactly match the job requirements as stated in the job description. To further protect against subjectivity and bias it is recommended that shortlisting and interviewing should be carried out by the same panel of more than one person with representation as much as possible from personnel specialists - who in theory should be experts in objective selection techniques - and generally only those trained in the appropriate - objective - selection skills should be involved in the process (KFEOTF 1987: 9-12). It is further recommended that records should be made of all shortlisting and interview decisions, indicating the ways in which the applicant's competence was measured in relation to the person specifications. Such records would force selectors to rationalise their selection decisions. In addition - as discussed in chapter seven - the records can also both serve as a potential check on the selection process if it needs to be scrutinised for objectivity and provide documentation in the event of allegations of discrimination. Collectively, these practices constitute the core of equal employment-opportunities policy as recommended in Britain in the 1980s. The aim behind them is that all job applicants should be considered solely on the basis of merit in relation to their ability to do the job, they will therefore ensure that the most qualified person is appointed.

Selection on the basis of merit is also - arguably - the most efficient means of organising a workforce. As Anthony Flew has argued in relation to equal employment-opportunities policies:

> Such policies may of course be implemented, and often have been, not so much to benefit the newly enfranchised potential competitors, as to make the institutions to which they may now be recruited more efficient. For it seems obvious that completely open competition, with incentives to win, must, all other things being equal, be the most efficient means of ensuring that the best qualified and most competent people get the jobs needing such training and competence. (Flew 1981: 46).

Efficiency in this context can be viewed from two perspectives. The first - already mentioned - concerns the recruitment and selection process itself in appointing the most able candidate, and from the second perspective the appointment of the most competent person means that the productivity of the incumbent of the job - in relation to other potential candidates - is maximised, hence the efficiency of the particular job is maximised. In addition the productivity - or the efficiency - of the organisation as a whole is similarly maximised as it will consist of an aggregate of the most competent individuals. Likewise if the most competent individuals are excluded from jobs through the processes of exclusion as discussed in chapter two then the productivity of particular jobs and the organisation as a whole is reduced. It will be argued in chapter six that this efficiency principle behind equal employment-opportunities policies has been a central justification behind policy implementation at the macro-level for the NHS, and it will be observed that it has similarly been a common justification at the micro-level.

Whilst the principle of merit is the guiding principle behind equal employment-opportunities policies, Young (1990) has argued that the principle is only just if a number of conditions are satisfied. Chiefly, the conditions involve the evaluation of merit by the use of 'technical' criteria, and other measurable aspects of competence, to the exclusion of normative judgements. As Young argues:

> If merit criteria do not distinguish between technical skills and normative or cultural attributes, there is no way to separate being a "good" worker of a certain sort from being the sort kind of person - with the right background, way of life, and so on. (Young 1990: 201).

Yet Young also suggests that many jobs are too complex for their tasks to be precisely defined. Many jobs also involve a high degree of discretion, but the potential for discretionary activity is difficult to evaluate in a candidate. Additionally, due to the nature of the division of labour, Young argues that the selectors are often not familiar with the job requirements. In reply to these supposed difficulties, though, practice in the two case-study organisations indicates that the tasks of many jobs can be distinguished adequately enough to indicate the skills required. Some of those skills must be evaluated on the basis of previous experience, which might provide some indication of discretionary ability. In addition, most of the line-managers interviewed had risen through their own particular occupational hierarchy, and they were therefore quite familiar with tasks associated with jobs of lesser seniority than their own. They were also involved in the day to day management of people in such jobs.

Whilst the formalisation of the recruitment and selection process provides the core of an equal employment-opportunities policy, there are a number of other anti-discrimination dimensions of policy. In outline, they include; the monitoring and analysis of the characteristics of applicants for employment, promotion and training; measures concerning the prevention and management of harassment; recruitment and selection training; and equal opportunities training. A number of additional policy elements are usually included in an equal employment-opportunities policy to facilitate the organisation of the anti-discrimination and positive action measures. Chiefly, they include; a written policy document; a programme of action and a timetable for implementing the policy; the establishment of working parties or committees to oversee the development and implementation of policy; the appointment of a specialist adviser and the allocation of responsibility for policy to senior managers; and an audit and analysis of the

characteristics of the workforce. Each of the dimensions of policy are discussed in the next chapter.

# CHAPTER 4

## A MEASURE OF POLICY IMPLEMENTATION IN THE NHS

This chapter is concerned with the third objective of the thesis, namely, an evaluation of the progress made by the NHS as a whole in implementing equal employment-opportunities policies. The dimensions of policy were specified in chapter three, and this chapter now provides a measurement of their implementation. The data for the measurement were collected by a mail survey - conducted for the thesis - between September 1990 and January 1991. Earlier research had already measured the extent of policy implementation in the NHS but the research data have been limited in scope by a focus on Health Authorities in London only, and policies solely on the basis of ethnicity (LACRC 1985, GLARE 1987), and also by a focus on single policy issues, namely sexual harassment (RCN 1989) and equal opportunities training (NHSTA 1989). More extensive research was undertaken by the Equal Opportunities Commission in April 1990 in a mail survey which covered all Health Authorities in the NHS (excluding Northern Ireland), but the research was limited to policy implementation on the basis of sex and marital status only (EOC 1991). In the light of the limited scope of the earlier research the mail survey was undertaken to collect a more comprehensive set of data for the measurement of policy implementation. Accordingly, the scope of the mail survey was more extensive than the earlier research. The mail questionnaire (appendix 3) enquired about policies which embraced 'race', sex, and disability, and the survey covered all Health Authorities in England and Wales, and Health Boards in Scotland and Northern Ireland - achieving an

87% response - or responses from 201 of the 232 Health Authorities and Boards in the NHS at the time of the survey. Even with this broader scope, however, the data produced are still incomplete as the survey did not investigate policy provisions concerning religion, sexual orientation, and persons with HIV and AIDS, which have been incorporated by some Health Authorities into their equal employment-opportunities policies. Whilst an investigation of some of those additional policy provisions is pertinent to an analysis of racism and patriarchy at work it was obvious when designing the mail survey - from some of the fieldwork undertaken for the thesis - that they had been incorporated into the policies of only a few Health Authorities, therefore, the survey concentrated on the main policy provisions which concerned 'race', sex, and disability.

Before discussing the survey findings a summary is given of the process used to operationalize the abstract concept of an equal employment-opportunities policy into indicators - or variables - that could be measured empirically by the mail survey. In the presentation of the survey findings policy implementation in Northern Ireland is discussed separately - because of a different legislative context - from the rest of the NHS. Attention is given firstly to the responses of the 197 - out of 228 - Health Authorities in England and Wales and Health Boards in Scotland that returned questionnaires for the survey, and then to the 4 Health and Social Services Boards in Northern Ireland - all of whom returned questionnaires. Following the presentation of the survey findings the extent of policy implementation in the NHS is summarised by reference to a measure employed by the Commission for Racial Equality (CRE 1989). On the basis of that measure it is concluded that there has been a very uneven development of equal employment-opportunities policies across the NHS, and there is considerable scope for further policy initiatives by many Health Authorities. To determine the extent of the implementation

of equal employment-opportunities policies in the NHS it was necessary to convert - or operationalize - the concept of a policy into indicators - or variables that could be measured empirically. The process of operationalization used for the mail survey consisted of four steps by which the abstract concept of an equal employment-opportunities policy was converted into concrete indicators, and the process was derived from a number of models of operationalization (Lazarsfeld 1977, de Vaus 1990, Bryman & Cramer 1990). The first step in the process consisted of a vague abstract image which simply incorporated the notion of a policy designed to achieve equal opportunities at work. The next step involved the specification of dimensions of the initial image - or concept - by reference to academic literature concerning equal employment-opportunities and to policy prescriptions made by the Commission for Racial Equality (CRE), the Equal Opportunities Commission (EOC), and two organisations set up to establish expertise on equal employment-opportunities in the NHS - the King's Fund Equal Opportunities Task Force, and the National Steering Group for Women in the NHS. Reference was also made to the policies established by the two case-study Health Authorities. Three dimensions of policy have been discussed in chapter three: measures for the organisation of policy; anti-discrimination measures; and positive action. The discussion of the survey findings presented in this chapter is structured around the three dimensions. The indicators of each dimension are discussed in detail in the chapter, and below they are firstly presented in outline. A graphical summary of the dimensions and indicators is also presented in figure 4.

**Indicators of the organisation of policy**

* a written policy document which has been approved by the Health Authority

* a programme of action and a timetable for implementing the policy

* the establishment of working parties or committees to oversee the development and implementation of policy

* the appointment of a specialist adviser and the allocation of responsibility for policy to senior managers

* an audit and analysis of the characteristics of the workforce

**Indicators of anti-discrimination measures**

* a review of the recruitment and selection process for employment, promotion, training and re-deployment, involving the establishment of person specifications for vacancies and the maintenance and analysis of records concerning recruitment and selection decisions.

* monitoring and analysis of the characteristics of applicants for employment, promotion and training

* the establishment of measures concerning the prevention and management of harassment

* the provision of recruitment and selection training

* the provision of equal opportunities training

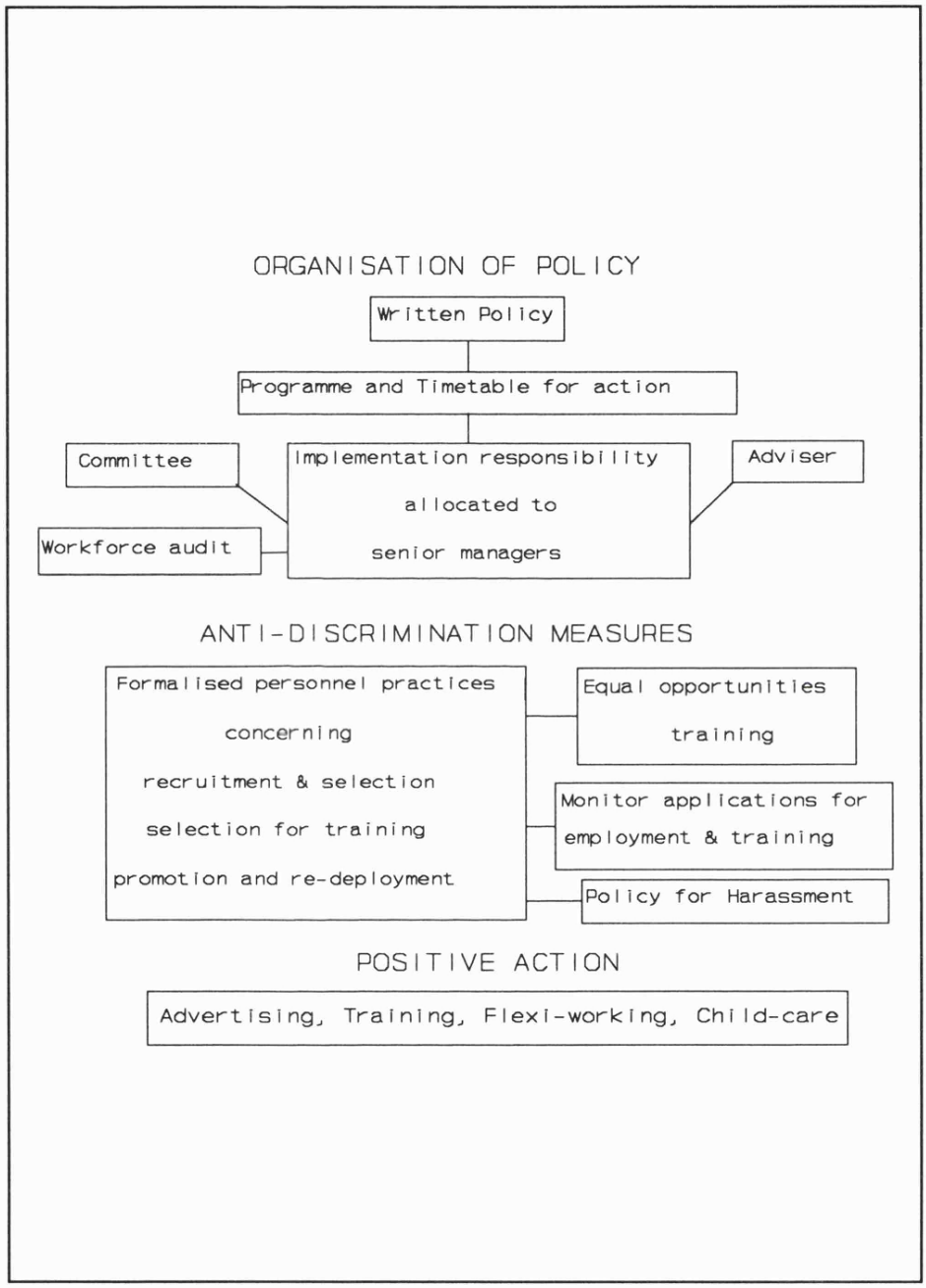
**Indicators of positive action**

The majority of policy prescriptions and subsequent policy initiatives have concentrated - on the basis of earlier research before the mail survey (LACRC 1985, GLARE 1987) and the experience of the case-study Health Authorities - on the first two dimensions of policy, and positive action measures have been relatively under-developed. There is, therefore, a corresponding imbalance in the indicators used for the mail survey as they are chiefly concerned with the first two policy dimensions - this appeared to be justified on

the basis of the earlier survey findings, and the constraints upon the scope of a mail survey. Authorities were simply asked - with regards to positive action - whether they had actually taken any positive action measures, and - if they had - to specify the nature of the measures.

The final stage in the conversion of the concept of an equal employment-opportunities policy - relevant to describing the extent of policy implementation - concerns the amalgamation of the indicators into indices. The indices used in this chapter are based on a measure formulated by the Commission for Racial Equality (CRE 1989) which focuses on five aspects of policy implementation. Whilst the CRE's measure concentrates on the primary aspects of an equal employment-opportunities policy it does, however, provide a rather generous evaluation of progress by measuring policy implementation at a very elementary level. Therefore, a more rigorous measure is used - in concluding the chapter - to evaluate the achievement of the NHS - although it is still based upon the five policy stages singled out by the CRE.

**Figure 4: Dimensions of an equal employment-opportunities policy**



## Organisation of policy

The most obvious starting point for working towards equality of opportunity in an organisation is the establishment of a written equal employment-opportunities policy which has been approved by the Health Authority. Indeed, this is seen to be absolutely essential (NHSTA 1989: 15). The survey revealed that most (87%) - or 171 of the 197 - Health Authorities in England and Wales and Health Boards in Scotland that returned questionnaires for the survey had established a policy. In addition, of the 26 Authorities that did not have a policy, 7 had a draft policy which they expected to be approved before the end of 1990, and a further 5 Authorities expected to have draft policies approved in 1991. But there were still some Authorities that had yet to take the first step. Seven Authorities stated that they did not even have a draft policy and despite the numerous prescriptions for equal employment-opportunities policies in the NHS two Authorities did not appear to see the necessity of establishing a policy. One Authority simply replied that "There is a nationally agreed policy under Whitley. We have no local policy", and the other reported that "Equal opportunities policy currently included in our Employment Policy which covers other areas as well."

Whilst the great majority of Health Authorities had written equal employment-opportunities policies, earlier research had found that some policies were little more than statements of good intent (LACRC 1985: 27). The extent to which the policies of respondent Authorities were more than this could not be
determined directly from the survey as Authorities were not asked to provide a copy of their policy because it was felt that a request for policy documents would have reduced the number of responses by creating more work for potential

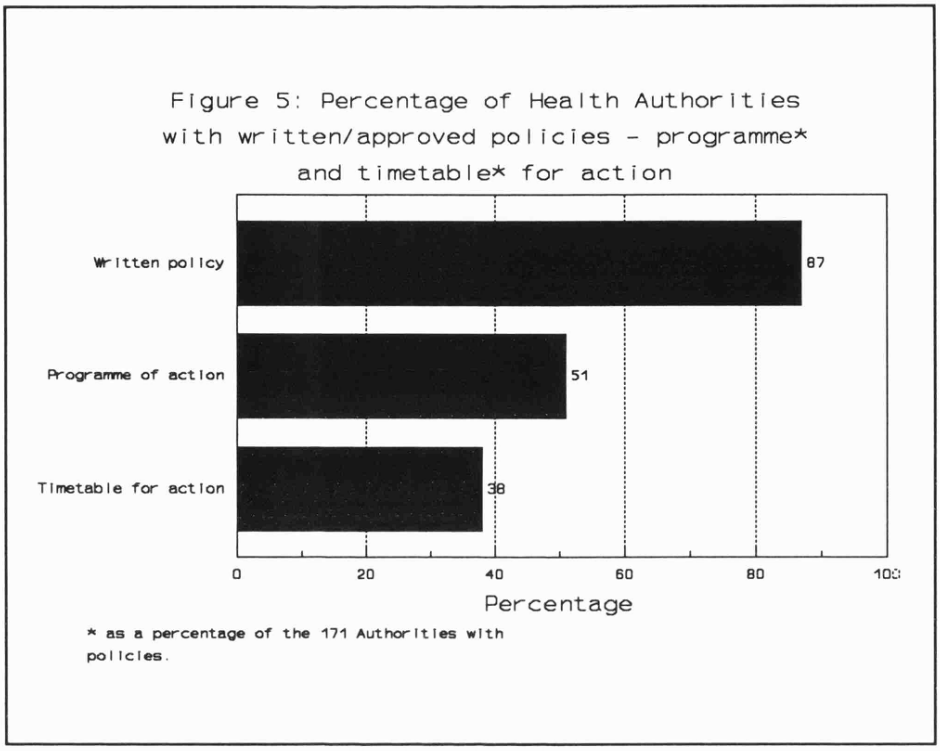



Figure 5: Percentage of Health Authorities with written/approved policies - programme* and timetable* for action

respondents. However, when a policy is followed by a programme of action and a timetable for implementing the programme there is a good indication that it involves an active commitment to equal opportunities rather than simply good intentions. The findings from the mail survey confirm this in relation to the progress made in implementing policies. For instance, positive action measures had been implemented by approximately four times as many Health Authorities with a timetabled programme of action for their policy than those without such a programme. As shown in figure 5, however, just over half - 51% - of the Health Authorities with a written equal employment-opportunities policy had a written programme of action for implementing their policy. Even fewer Authorities with policies had a timetable for implementing a programme of action. Therefore, it appeared to be questionable for approximately half of the Health Authorities with written equal employment-opportunities policies whether their policies were little more than statements of good intent.

It is recommended in the report *No alibi, no excuse* (GLARE 1987) that the effective organisation and direction of an equal employment-opportunities policy requires the combination of three elements:

* the designation of overall responsibility to senior management
* an effective mechanism for monitoring policy progress
* access to expert advice

Accordingly, the mail survey enquired about these three aspects of the organisation of policy. Health Authorities were asked - for the first aspect - whether the development of equal employment-opportunities had been included in the review objectives of the General Manager, Director of Personnel, Unit General Managers, and Unit Personnel Managers. The findings are produced in table 15. In the majority of Authorities with policies, equal opportunities had been included in the review objectives of the Director of Personnel for the Authority, but that responsibility had only filtered down to Unit Personnel Managers in just over half of the Authorities. The development of equal opportunities had been included in the review objectives of the General Manager and Unit General Managers in less than one-third of Authorities. The importance of designating responsibility for policy to senior managers is evident from a further finding of the survey. Where the development of equal employment-opportunities had been included in the review objectives of senior managers Authorities had made greater progress in policy implementation - such as implementing positive action measures - in comparison to those Authorities where responsibility had not been similarly designated.

**Table 14. Responsibility for policy development amongst senior managers.**

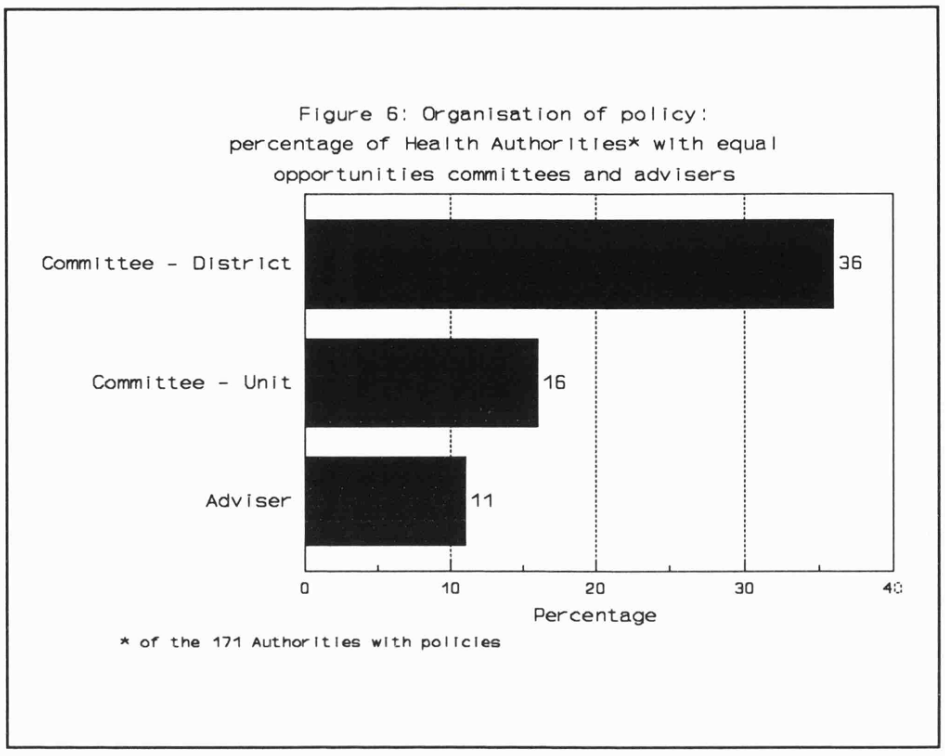
Question 14. Is the development of equal opportunities in employment...a review objective for any of the following ?:

Column percentages

| | Yes % | No % | NI % | DK % | NA % |
|---|---|---|---|---|---|
| Director of Personnel | 69 | 19 | 10 | 2 | - |
| Unit Personnel Managers | 51 | 19 | 19 | 3 | 8 |
| General Manager | 28 | 34 | 36 | 2 | - |
| Unit General Managers | 21 | 34 | 35 | 3 | 7 |

Base (N) = 167
NI= No information provided, DK = Don't know, NA = Not applicable

The second element recommended - in the report *No alibi, no excuse* - for the effective organisation of policy is a mechanism for monitoring policy progress. An equal employment-opportunities working party or committee provides such a mechanism and it can also provide the impetus for the establishment and implementation of policy (KFEOTF 1989a: 8). Despite these potential benefits, however, the mail survey found that equal employment-opportunities committees had only been established in 36% of Health Authorities with policies, and even fewer Health Authorities - 16% - had established committees at unit/provider level.




The third recommended element of policy organisation - ready access to expert advice - is likely to be provided more effectively by a specialist adviser than by someone with responsibilities for equal opportunities added to another job (KFEOTF 1988: 14). However, only a small proportion - 11% - of Health Authorities with policies had appointed a specialist adviser for equal employment-opportunities. Using the implementation of positive action measures again as an indicator of policy progress it is notable from the findings of the mail survey that more progress had been made both by Health Authorities with equal employment-opportunities committees (24%:9%) and specialist advisers (42%:11%) than those without - confirming the findings from earlier research.

## Anti-discrimination measures

### 1. Recruitment and selection: the core of policy

The recruitment and selection process provides the core focus of an equal employment-opportunities policy as the greatest potential for discrimination to occur in an organisation is during the recruitment and selection of new employees, the promotion of existing employees, the selection of employees for training courses, and the re-deployment of employees. Informal recruitment practices - such as word of mouth recruitment - are regarded as poor personnel practice as they potentially discriminate against groups that are under-represented amongst a workforce (CRE 1984b). Although earlier research had revealed their use in the NHS it was anticipated in designing the mail survey that Health Authorities would be unlikely to report that they still used informal methods. Therefore, the survey concentrated on the selection process. An important element in attempting to achieve equality of opportunity in selection is a review of the selection procedures and practices, and selection criteria, with the aim of removing the potential for discrimination (CRE 1984a: 9, GLARE 1987: 23). It was, therefore, encouraging that 91% of Health Authorities with policies reported that they had reviewed their recruitment and selection process as part of their equal employment-opportunities policy and even a majority - 58% - without a policy reported that they had reviewed their recruitment and selection process. In comparison to earlier research - for London at least - significant progress appeared to have been made on this important aspect of policy (cf. LACRC 1985: 30, GLARE 1987: 23-24). However, the findings were less encouraging when selection practices were examined in more detail. For instance, the use of person specifications for job vacancies - applied equally to all candidates - reduces subjectivity and provides clear criteria for selection. Requirements concerning - for example -

experience, educational qualifications and abilities, should match the job requirements as stated in the job description without any surplus requirements that could form the basis of indirect discrimination under the Sex Discrimination and Race Relations Acts (KFEOTF 1987: 9-12). Naturally, they should not contain any requirements that amount to direct discrimination. The objective - which is fundamental to an equal employment-opportunities policy - is that all job applicants should be considered solely on merit in relation to their ability to do the job. However, despite the value of person specifications less than a third - 32% - of Health Authorities with equal employment-opportunities policies reported that person specifications were always drawn up for vacancies for employment.

Other selection practices also aim to reduce subjectivity and promote consistency in selection decisions. For example it is recommended that shortlisting and interviewing should be carried out by the same panel of more than one person with representation as much as possible from the Personnel Department, and only those trained in the appropriate skills should be involved (KFEOTF 1987: 9-12). However, only a minority of Health Authorities - 32% - with equal employment-opportunities policies required mandatory attendance on a recruitment and selection course for all staff involved in the appointment of new employees.

It is further recommended that records should be made of all shortlisting and interview decisions. They can provide both a potential check on the selection process and documentation in the event of allegations of discrimination. However, less than half - 42% - of the Health Authorities with equal employment opportunities policies reported that records were always made of shortlisting decisions for job applicants. Slightly more - 46% - reported that records were always made of appointment decisions. But not all of the

Authorities that kept records actually scrutinised them as only 56% reported that their shortlisting records had at some time been analyzed for equal opportunities purposes. Fewer - 53% - reported that their appointment records had been analyzed.

Attendance on training courses enhances the promotion prospects of staff, therefore an aim of an equal employment-opportunities policy should naturally be to ensure that discrimination does not occur in access or selection to courses. However, some black and

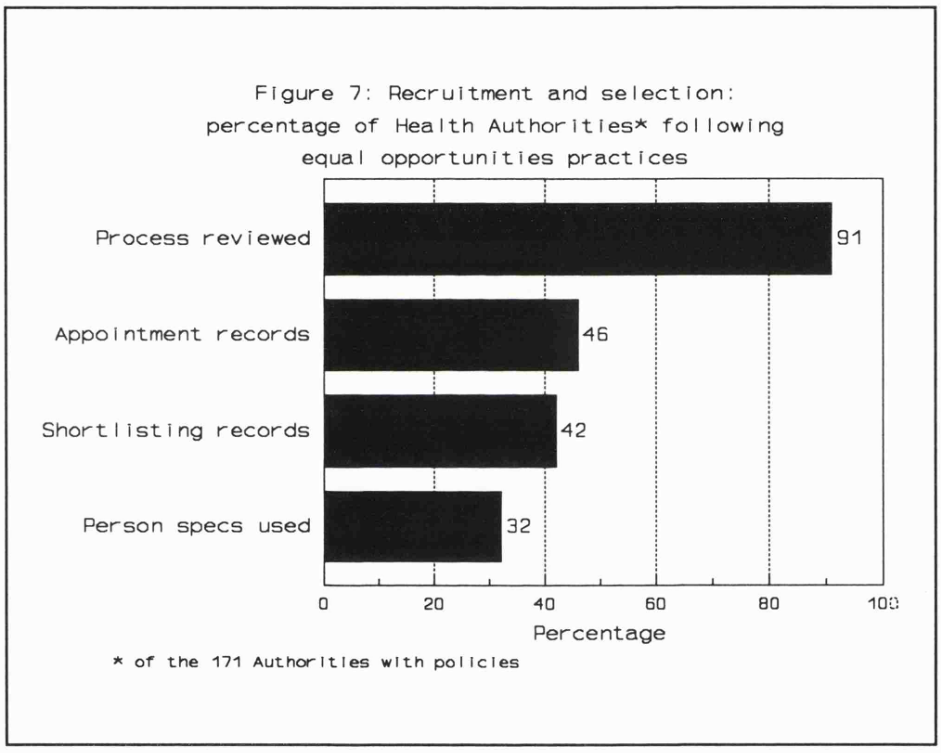


Figure 7: Recruitment and selection: percentage of Health Authorities* following equal opportunities practices

minority ethnic staff have expressed their dissatisfaction in complaints - for example - that they have received less encouragement than white colleagues to apply for training opportunities (CRE 1988b). The King's Fund Equal Opportunities Task Force has linked this disadvantage to the under-representation of black and minority ethnic staff in senior positions which has been indicated by the workforce audits of a number of Health

Authorities (KFEOTF 1990: 22). The Task Force has recommended that advice and encouragement should be provided equally to all staff (perhaps through periodic counselling) about training opportunities in relation to career development. In addition, training opportunities - including those provided by outside agencies - should be widely advertised so that all staff are fully informed about them. Staff should also be fully informed about the appropriate application procedures, and the procedures for selection for training should mirror the procedures recommended for the selection of new employees and the promotion of existing staff. Despite these recommendations a minority of Health Authorities - 42% - reported that they had made a review - as part of their equal employment-opportunities policy - of their process for selecting staff for management or other training provided or funded by the Authority, and only 6% of Authorities with policies reported that attendance on a recruitment and selection course was mandatory for all staff involved in the selection of employees for training courses.

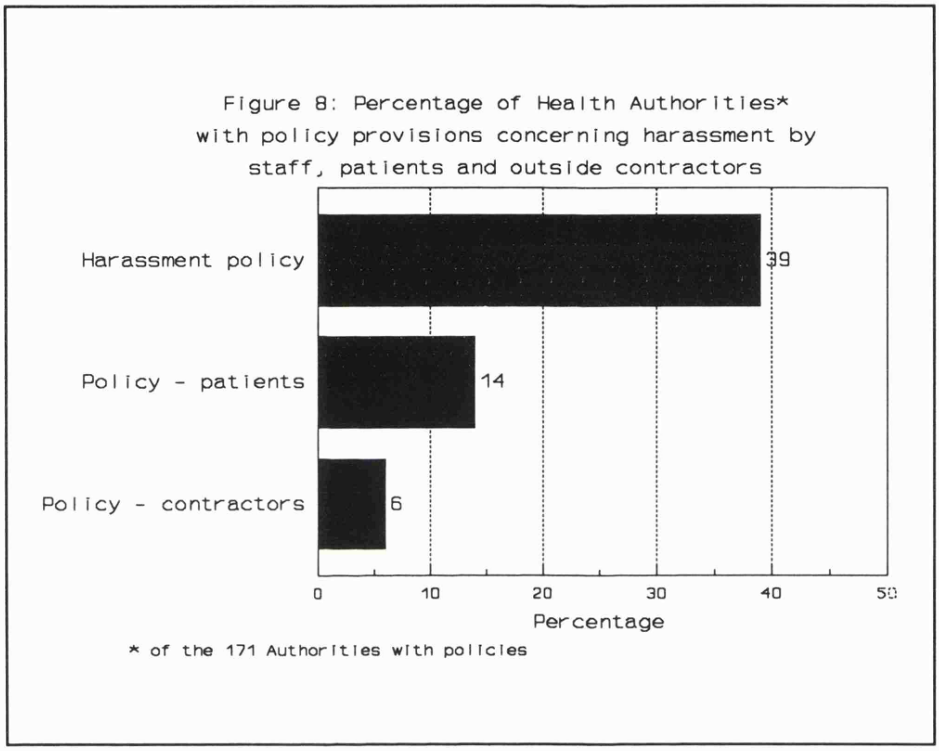
2. Policy provisions for harassment

Harassment - as discussed in chapter one - is a particularly severe form of discrimination and therefore needs to be clearly addressed as part of an employer's equal employment-opportunities policy. Accordingly, the King's Fund Equal Opportunities Task Force has recommended that:-

> Health authorities to be equal opportunities employers should take all reasonable steps to provide a working environment for their staff free from racial abuse and harassment. (KFEOTF 1990: 24)

The steps recommended by the Task Force include the specific provision in the staff discipline and grievance procedures for instances of discrimination, harassment and abuse, and the establishment of procedures to deal with the harassment of staff by patients and visitors. In the latter case it is suggested that action should be taken by a senior member

of staff to advise the patients or visitors of the unacceptable nature of their behaviour, and all patients should be advised in patient information leaflets or posters about the Health Authority's policy on harassment. In addition it is recommended that policy provisions are established concerning harassment of staff employed by outside contractors.




In the light of these recommendations it was notable that only 39% of Health Authorities with equal employment-opportunities policies reported in the survey that they had specifically included provisions concerning racial and sexual harassment in their staff discipline procedure. Only 14% of Health Authorities with policies reported that they had an established procedure which dealt with racial and sexual abuse and harassment by patients and visitors. In addition, only 6% of Health Authorities with policies reported that they had an established procedure concerning harassment of Health Authority employees

by outside contractors.

The low level of activity by Health Authorities on harassment revealed by the mail survey indicated that little progress had been made in comparison to the findings of earlier research. In November 1988 the Royal College of Nursing (RCN) sent a questionnaire to Directors of Personnel in NHS Districts, Boards and Special Hospitals, to determine the extent of policy implementation on sexual harassment. A 63% response was achieved (144 questionnaires returned out of 229 sent out). The majority of respondents - 72% - reported that they had no policy at all concerning sexual harassment. Amongst those that did make some policy provision 12% reported that they had a specific policy concerning sexual harassment and a further 16% included sexual harassment in the equal opportunities policy. In response to a question concerning procedures for dealing with cases of sexual harassment most - 78% - reported that they would use the disciplinary or grievance procedure, 7% reported that they had a District procedure or an adaptation of the disciplinary/grievance procedure for dealing with sexual harassment, and 15% reported that they had no procedure (RCN 1989).

3. Equal opportunities training

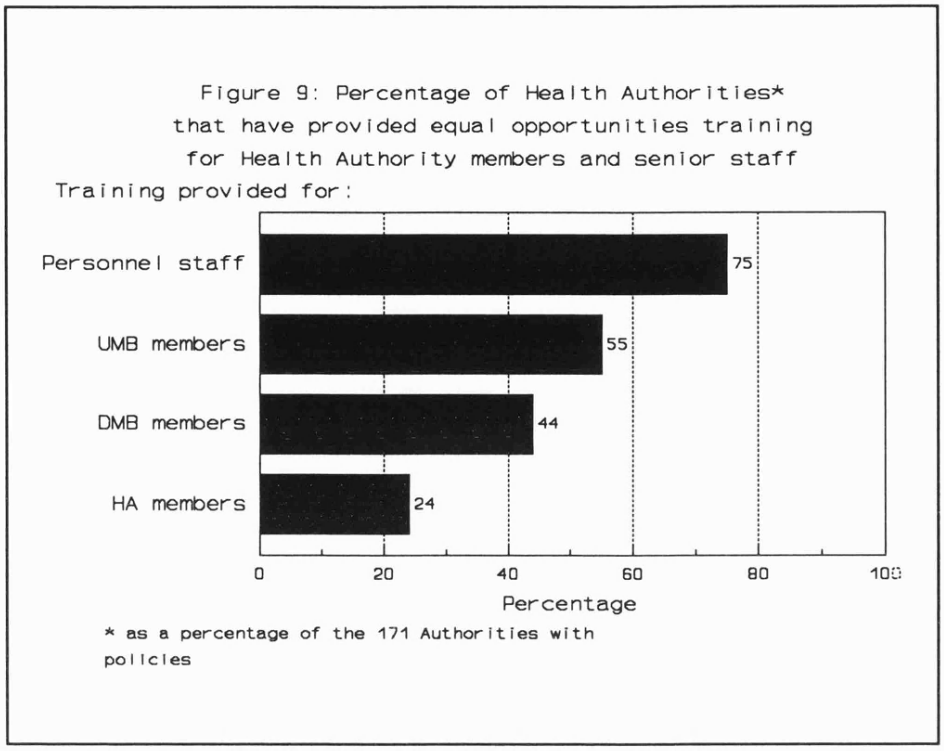
Employees involved in the recruitment and selection process occupy a central role in relation to the provision of equal opportunities at work. Accordingly, the King's Fund Equal Opportunities Task Force has recommended that everybody involved in the recruitment and selection of staff should receive recruitment and selection training within six months of their appointment, or within two years of the adoption of an equal employment-opportunities policy (KFEOTF 1987: 9). Because of the significance of their role it is arguable that all staff involved in the recruitment and selection process should receive mandatory training. However, the mail survey revealed that mandatory training

was required by only 32% of Health Authorities with an equal employment-opportunities policy.

The Task Force has also recommended that the training should explore the effects of assumptions and prejudices on selection decisions; the nature of discrimination; and the possible misunderstandings that might occur when interviewing candidates from a different cultural background (KFEOTF 1987: 9-10); and it should also inform employees of their own liability under the relevant legislation and the Health Authority's own equal employment-opportunities policy. In addition, it has been recommended that Health Authority members and senior officers should receive equal opportunities training to develop understanding of their role in the Authority's policy, and this is particularly important - it has been argued - to develop a serious commitment to equal opportunities within an organisation (GLARE 1987: 35).

Because of the limited scope of the mail survey, it was not possible to enquire about all of these aspects of training, however, it was determined that whilst the majority of Health Authorities with policies - 83% - reported that their management training included an equal opportunities element only a small minority of Health Authorities with policies - 24% - had provided equal opportunities training for Health Authority members; 44% had provided equal opportunities training for their Management Board members; and 55% of Health Authorities had provided equal opportunities training for their Unit Management Board members - where applicable. The majority of Health Authorities with policies reported that they had provided equal opportunities training for personnel staff.

Equal opportunities training is also appropriate for other staff - in addition to senior managers and those involved in recruitment and selection - as in some instances they can occupy significant 'gatekeeping' roles to employment as demonstrated by the




Commission for Racial Equality's formal investigation of St.Chad's Hospital (CRE 1984b). The Commission concluded that discrimination had occurred against black applicants for domestic work. Recruitment depended upon casual enquiries which were dealt with in the first instance by telephonists or receptionists who were instructed by one manager - it was alleged - to inform black enquirers that there were no vacancies. Although the use of such informal recruitment methods is now clearly regarded as poor personnel practice, casual enquiries are still made about employment. For instance, in one of the case-study Health Authorities (East Thames) I was present when a telephone enquiry about employment was received by the Equal Opportunities Adviser - having been relayed by the switch-board operator. Therefore, staff who deal with such enquiries - in the first instance - need to be informed about the Health Authority's equal employment-opportunities policy. It was therefore encouraging that just over two-thirds - 67% - of

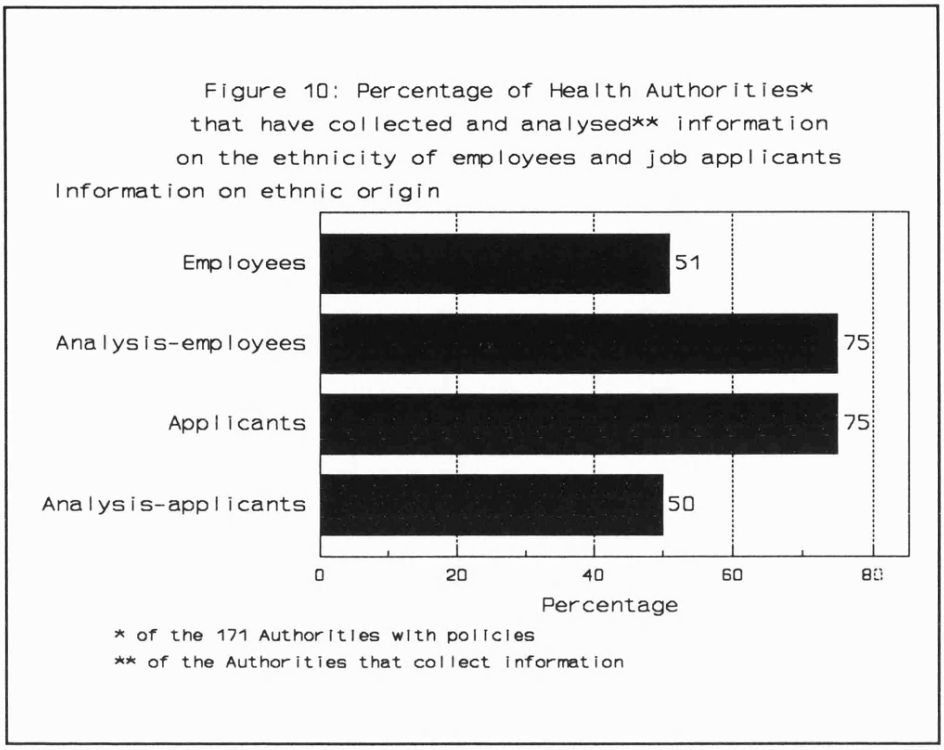
Health Authorities with policies reported in the mail survey that they included an equal opportunities component in their induction training.

### 4. Monitoring the characteristics of the workforce and job applicants

Procedures for monitoring the characteristics of a workforce and job applicants have been regarded as essential elements of an equal employment-opportunities policy and are recommended in the codes of practice of both the Commission for Racial Equality (CRE 1984a: 18-20) and the Equal Opportunities Commission (EOC 1985: 14-15). Guidelines produced for employers have principally concerned 'ethnic monitoring' (cf. CRE 1978, CRE 1980, KFEOTF 1989b) but the same process applies when monitoring on the basis of other characteristics such as sex, marital status and disability. In those guidelines, the two procedures - workforce monitoring and job applicant monitoring - are usually discussed together. In chapter seven, however, it is argued that the procedures contain different potential. An audit of the workforce concerning the distribution of employees according to their characteristics will indicate any under - or over - representation of particular groups of employees - eg. women and black employees - and will therefore provide information for organising other aspects of policy. For instance, if the under-representation of a particular group is found in an area of work in comparison to their representation in the workforce as a whole then other measures - such as applicant monitoring - could be applied to determine the explanations. In addition, positive action measures - to be discussed in the next section of the chapter - depend upon the information provided by a workforce audit. A succession of audits can also be used to determine - in the context of inequities in the distribution of particular groups across a workforce - whether an equal employment-opportunities policy has produced any changes in the distribution of employees. Applicant monitoring, in contrast, may indicate prima

facie evidence of discrimination in a particular area of work - which would require further investigation - when certain groups of job applicants are less successful than others. The monitoring can provide - as will be argued in chapter seven - a powerful deterrent to discrimination by holding managers accountable for their selection decisions. When employers are taken to industrial tribunals - with regard to allegations of discrimination - they may be required to provide evidence that they have implemented monitoring systems.

The two procedures - workforce monitoring/audit and applicant monitoring - can be divided into two operational stages. The first stage concerns the collection of the required information. In the case of the workforce audit this concerns the distribution of employees across grades and occupational groups according to their characteristics. For the applicant monitoring it concerns information about the outcome of shortlisting and appointment decisions with regard to the characteristics of applicants for employment and promotion. Information about the sex of employees is usually available from personnel records, and accordingly, 94% of Health Authorities with equal employment-opportunities policies reported in the mail survey that they have information available concerning the number and distribution of men and women in the workforce. Information about the sex of applicants for employment has traditionally been collected on application forms and 80% of Health Authorities reported that they collected information about the sex of applicants for employment. Fewer Authorities had collected information on ethnicity. Slightly over half - 51% - of Health Authorities with policies reported that they had made an audit of their workforce concerning the ethnic origin of employees, and 75% of Health Authorities with policies reported that they collect information about the ethnic origin of applicants for employment.




The second stage of the audit and monitoring procedures concerns the analysis of the information collected. However, the mail survey indicated that not all Health Authorities had made an analysis and more Authorities had analyzed information concerning their workforce than information concerning job applicants. Amongst Authorities with policies, 75% of Authorities that had data available concerning the ethnic origin of employees reported that they had analyzed the data, whereas only 50% regularly analyzed information collected about the ethnicity of job applicants. Similarly, 70% of the Authorities that had data available on the distribution of their workforce by sex had analyzed the information, and only 53% regularly analyzed information collected about the sex of job applicants.

## Positive action

Information about the characteristics of a workforce and job applicants is a prerequisite for positive action measures permissible under the Race Relations and Sex Discrimination Acts. The Race Relations Act enables the encouragement of job applications from members of particular 'racial' groups when there are either no persons of the group employed in a particular area of work at an establishment, or when the proportion of the group employed is 'small' in comparison to their proportion amongst all those employed at the establishment or amongst the population of the areas from which an employer normally recruits its workforce (Race Relations Act 1976: sec.37-38). Under the same conditions, special training can be provided for members of particular 'racial' groups to help them acquire the skills for particular work.

As discussed in chapter three, preferential treatment, or positive discrimination in the actual selection for work is not permissible according to the Acts, and therefore all candidates must be considered on the basis of merit. The only exception to this, in accordance with section 5(2) of the Race Relations Act is where a person's 'racial' origin is a genuine occupational qualification for a job. The only circumstances in which this is likely to arise for Health Authorities is where "the holder of the job provides persons of that racial group with personal services promoting their welfare, and those services can most effectively be provided by a person of that racial group." (Race Relations Act 1976: sec. 5(2)(d)).

Despite encouragement for employers to implement positive action measures - as noted in chapter three - slow progress appears to have been made in the NHS. By 1985 only four London Districts had made positive action provisions (LACRC 1985: 29), increasing to five by 1987 (GLARE 1987: 25). The mail survey revealed that by January

1991, only 19 - or 11% - of the Authorities with equal employment-opportunities policies that responded to the survey had implemented positive action measures. The most frequently mentioned positive action initiatives concerned statements of encouragement in job advertisements and recruitment aimed at local communities. There was clearly some confusion about this aspect of policy as measures reported by four additional Authorities did not constitute positive action. For example, one Health Authority included an "equal opportunities statement of intent" under positive action measures !

The relevance of an equal opportunities policy to the employment of people with disabilities appears to have been recognised in principle by most Health Authorities as nearly all - 93% - of the Authorities that returned questionnaires for the mail survey - and indicated that they have an equal employment-opportunities policy - reported that their policies covered staff groups on the basis of disability. Most of the elements of policy discussed to this point apply equally to people with disabilities as they do to others. In addition to those elements, employers are obliged by statute to take further measures. For example, under the 1944 Disabled Persons (Employment) Act, employers with twenty or more workers have a duty to employ a quota of registered disabled people, and to maintain a record of the number employed. Although the National Health Service is not bound by the Act, Health Authorities were strongly advised some years ago by the Department of Health that the 3% quota should be regarded as a minimum to be exceeded (U.K. 1977).

Although policy provisions for people with disabilities are not directly related to an analysis of racism and patriarchy at work, they are included in this section on indicators of positive action because they provide an additional indication of the extent to which Health Authorities have progressed beyond policy measures aimed at just

preventing discrimination. Health Authorities were therefore asked in the mail survey about the availability of information concerning employees who are registered disabled and measures taken to increase the recruitment of people with disabilities. Most - 91% - of Health Authorities with equal employment-opportunities policies reported that they had available information about the number and distribution of employees who were registered disabled, as did most - 88% - Authorities without policies. However, only just half - 49% - of Health Authorities with equal employment-opportunities policies reported that they had taken measures to increase the employment of people with disabilities. The proportion was even lower - 31% - for Authorities without policies.

Health Authorities reporting that they had taken measures to increase the recruitment of people with disabilities were asked in the survey to provide some detail about the measures. The largest group of responses - by the Authorities with equal employment-opportunities policies - referred to contact with agencies external to the Health Authority. Accordingly, 22% of Authorities specifically mentioned contact with Disablement Resettlement Officers or the Disability Advisory Service. Most of the Authorities that referred to these agencies provided little detail, simply stating for example; "All vacancies notified to job centre/DRO" and "Liaison with DRO". A small number of Health Authorities indicated a more active relationship with the agencies, as for example, one Authority reported the "Secondment of local manager of Disabled Advisory Services to Hospital". A few Authorities reported a lack of success with the agencies with regards to the recruitment of people with disabilities, as one Authority reported that "We liaise with the local Disablement Resettlement Officers - who are not too helpful !", and another reported that they have "links with local DRO, but minimal response in terms of potential employees".

Contacts with other agencies were reported by 10% of Authorities with equal employment-opportunities policies. The detail of the responses again varied from the very general, such as "We have discussed the matter with representatives of a number of agencies representing disabled workers" to more active involvement, for example, in the case of one Authority which reported that they had established "involvement with local authority 'Disabled Person Employee Resource Bank' - data bank of vacancies matched to potential applicants". A small number of Health Authorities - 13% - with equal employment-opportunities policies reported that they had provided guidance or training for managers or other staff related to the employment of people with disabilities. The guidance ranged from the general raising of "awareness" mentioned most often amongst the responses to the more specific provision of "management guide and training to recruiting people with disabilities". It was apparent for one Authority that whilst some training had been provided, it occurred some years ago, as it was simply reported that there were "presentations given some years ago by Disablement Resettlement Officer to those responsible for staff recruitment".

A few Health Authorities reported some particularly active measures. Amongst them, three Authorities reported that they guaranteed either shortlisting or an interview to job applicants with disabilities, and a further three Authorities reported that they had established a steering group or a working group concerning the employment of people with disabilities. In addition, one of those Authorities also reported that they have appointed a "disability officer". However, the particularly active Authorities are only a small minority in the NHS, and - as indicated by the survey findings - approximately half of all the Health Authorities do not take any measures at all to increase the recruitment of people with disabilities.

## Northern Ireland

Before proceeding to the conclusions of the chapter the achievement of the four Health and Social Services Boards in Northern Ireland - with regards to the implementation of equal employment-opportunities policies - is discussed separately here as the legislative context of policy for the Boards differs in comparison to the rest of the NHS. The difference concerns the legislation affecting discrimination on the basis of 'race', and discrimination on the grounds of religious belief or political opinion, for the 1976 Race Relations Act does not apply to Northern Ireland (Race Relations Act 1976: sec.80(2)), but - as established by the Fair Employment (Northern Ireland) Act 1976 - employers are prohibited from discriminating on the grounds of religion or political opinion (secs.16-18). In addition, the Boards in Northern Ireland are affected by requirements stipulated in the 1989 Fair Employment (Northern Ireland) Act. In particular, they are required to prepare an annual monitoring return for the Fair Employment Commission concerning the composition of job applicants with reference to membership of the Protestant or Catholic communities; undertake a review - every three years - of the distribution of employees across the workforce on the basis of whether they belong to those communities (sec.31(1)); and review their employment practices - again every three years - concerning recruitment and training for employment, and the training and promotion of existing employees. Each of these requirements have to be met otherwise an employer is committing an offence under the Act.

The statutory requirements have therefore provided a potential stimulus for the Northern Ireland Boards - which has not been provided in the same way for the rest of the NHS - to establish particular elements of an equal employment-opportunities policy. That stimulus has possibly affected the progress of policy, as - for some of the aspects

of policy that are comparable with the rest of the NHS - the Boards in Northern Ireland appear to have made more progress. For example, each of the four Boards had a written policy, although it was notable that only two of the Boards had a programme and timetable of action for implementing the policy; all of the Boards had appointed an equal opportunities adviser; and the development of equal opportunities in employment had been included in the review objectives of senior managers to a greater extent than the rest of the NHS; greater provision also appears to have been made for equal opportunities training. In contrast, however, less progress appears to have been made on the critical element of policy - the recruitment and selection process. For example, whilst three of the four Boards reported that they had reviewed their recruitment and selection process for employment - as required under the Fair Employment Act - and the other reported that it was going to do so shortly, none of the Boards required mandatory attendance on a recruitment and selection course for all staff either involved in the selection of new employees or the selection of existing employees for training courses.

Because of the different legislative context to policy, it is only possible to compare the survey findings concerning policy initiatives for specific groups of the workforce - between Northern Ireland and the rest of the NHS - on the basis of sex and disability. Very few Health Authorities outside of Northern Ireland reported that their policy covered staff groups on the basis of religion, and it was notable that none of the Boards in Northern Ireland covered staff groups on the basis of 'race' as part of their policy. With regards to policy concerning people with disabilities, there appeared to be little difference between the achievement of the Boards in Northern Ireland and the rest of the NHS. More progress appears to have been made, however, with policy provisions on the basis of sex. For example, each of the four Boards reported that they had analyzed information

available concerning the number and distribution of men and women in the workforce; each Board reported that they regularly analyzed information collected about the sex of applicants for employment; and greater attention also appears to have been given to sexual harassment as three of the four Boards, for example, reported that they have an established procedure concerning sexual abuse and harassment of staff by patients and visitors.

Whilst only a few elements of an equal employment opportunities policy have been discussed here with regards to Northern Ireland, the survey findings indicate that for the implementation of many of the elements the achievement of the four Health and Social Services Boards as a group had been greater than the rest of the NHS as a whole. That greater achievement did not apply, however, to - arguably - the most important aspect of policy - the recruitment and selection process. It also did not apply to policy provisions on the basis of 'race', and - on the basis of the survey findings - 'race' does not seem to have been an issue with regards to the development of equal employment opportunities policies in Northern Ireland.

**Some more equal than others**

In its report on the implementation of equal employment-opportunities policies concerning sex and marital status the Equal Opportunities Commission concluded that the NHS is not implementing policies effectively (EOC 1991). This conclusion follows the observation made by the King's Fund Equal Opportunities Task Force in its final report to the Department of Health (KFOETF 1991: 3) that although most Health Authorities had adopted an equal employment opportunities policy on the basis of 'race' few had implemented many of the measures to make their policies effective. The data presented in this chapter supports these conclusions and a summary of the findings is presented here

which includes an analysis of the comparative policy progress of the regions. The summary excludes the four Health and Social Services Boards in Northern Ireland which - because of the different legislative context - have already been discussed separately in the chapter.

Prior to summarizing the survey findings, a point should be made about their potential validity. In an attempt to determine the accuracy - or validity - of responses, a test was established as part of the survey. Between August and December 1990, requests for application forms were made in reply to job vacancies advertised in the *Nursing Times* and the *Health Service Journal.* Application forms were acquired for one post in 84% - or 163 - of the Health Authorities that returned questionnaires. It was possible to determine from the application forms whether Authorities monitored the ethnicity of job applicants, and this was compared to each Authority's response to a question on the survey questionnaire about whether such information was collected. The outcome qualifies the confidence in the survey findings as only 66% of the Authorities that reported that they collect information about job applicants included monitoring questions with their application forms. Therefore, some Authorities either did not provide accurate responses on this question, or their job application systems were not functioning efficiently. The latter is certainly a possibility, as in one of the case-study Health Authorities - East Thames - it was discovered that for one sector of the workforce job application forms were not accompanied by monitoring forms, even though the monitoring system had been established for a number of years. However, it was not possible to determine how much of the disparity between the survey findings and the application forms was due to inefficiency rather than inaccurate replies. Therefore some caution is necessary in interpreting the survey findings, and a 66% level of confidence would perhaps provide the

lowest estimate of their validity. The survey, therefore, perhaps over-estimates the progress made by the NHS.

To summarize the survey findings, then - in relation to the achievement of the NHS in implementing equal employment-opportunities policies - a process is used here based on a measure formulated by the Commission for Racial Equality (CRE 1989). It measures the achievement of employers against five indicators of policy development, and although the CRE's measure concerned policies on the basis of 'race', it applies equally to policies on the basis of other characteristics such as sex and disability. The five indicators of policy consist of:-

* a written equal employment-opportunities policy
* the issuing of guidelines for good practice in recruitment and selection
* the collection of information about the characteristics of job applicants and employees
* the analysis of the information collected
* positive action provisions

Whilst the CRE's measure focuses on the primary elements of an equal employment-opportunities policy a drawback is that it provides a generous evaluation of progress as it measures policy implementation at a very elementary level. Therefore a more rigorous measure is used here to evaluate the achievement of the NHS - although it is still based on the five policy measures singled out by the CRE. The measure does not prescribe a set order for policy implementation although some of the policy measures inherently follow others.

1. Written policy - at first sight, the mail survey appears to indicate that considerable progress had been made in the NHS as a whole - in comparison to earlier findings for

London (LACRC 1985, GLARE 1987) as 87% of the Health Authorities that returned questionnaires had a written policy. However, the establishment of a written policy alone seems to be a rather generous measure of achievement as it is questionable whether the written policies of many Authorities were simply more than statements of good intent. For instance, only 33% of Health Authorities that responded to the survey had a timetabled programme of action for implementing their policy. Therefore, in using this more rigorous measure of policy implementation:

*** Only a third - 33% - of Health Authorities had achieved the first measure.**

2. Guidelines for good practice in recruitment and selection- considerable progress also appeared to have been made - again at first sight - on the second measure of policy as 79% of Health Authorities reported that they had reviewed their recruitment and selection process as part of an equal opportunities policy. However - as recruitment and selection provides the core of policy - additional aspects of policy are used here. For instance, the use of person specifications for all vacancies and the maintenance and analysis of records concerning all shortlisting and appointment decisions are essential elements of policy aimed at achieving equality of opportunity. By using the implementation of all these aspects of policy to represent the second measure of policy implementation:

*** Only 12% of Health Authorities had achieved the second measure.**

3. Collection of information about the characteristics of job applicants and employees - In the same way as any other employer Health Authorities collect information about the sex of job applicants and employees as part of the application and appointment process. Therefore, information on the basis of 'race' is solely used here for this stage of policy as it indicates that additional effort had been made as part of an equal employment-opportunities policy. Accordingly:

*** 40% of Health Authorities had achieved the third measure of policy.**

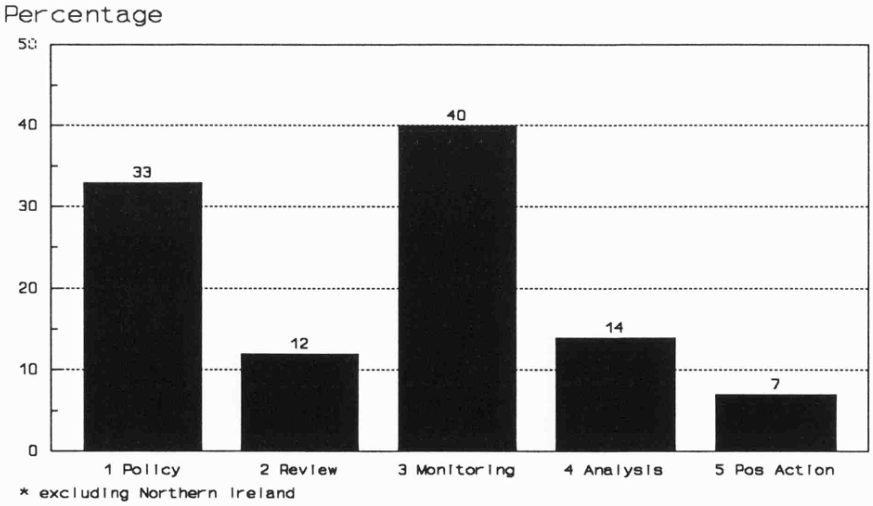
4. Analysis of information collected about the characteristics of job applicants and employees - The analysis of information concerning the sex of job applicants and the number and distribution of men and women in the workforce is included here - in addition to information on 'race' - to represent the fourth measure of policy implementation. Accordingly:

*** Only 14% of Health Authorities had achieved the fourth measure.**

5. Positive action provisions - This stage is described by the CRE as the establishment of "remedial objectives", which - on the basis of examples provided - chiefly consist of positive action provisions. The implementation of provisions to increase the recruitment of people with disabilities is additionally included here. On the basis of the implementation of both of these measures:

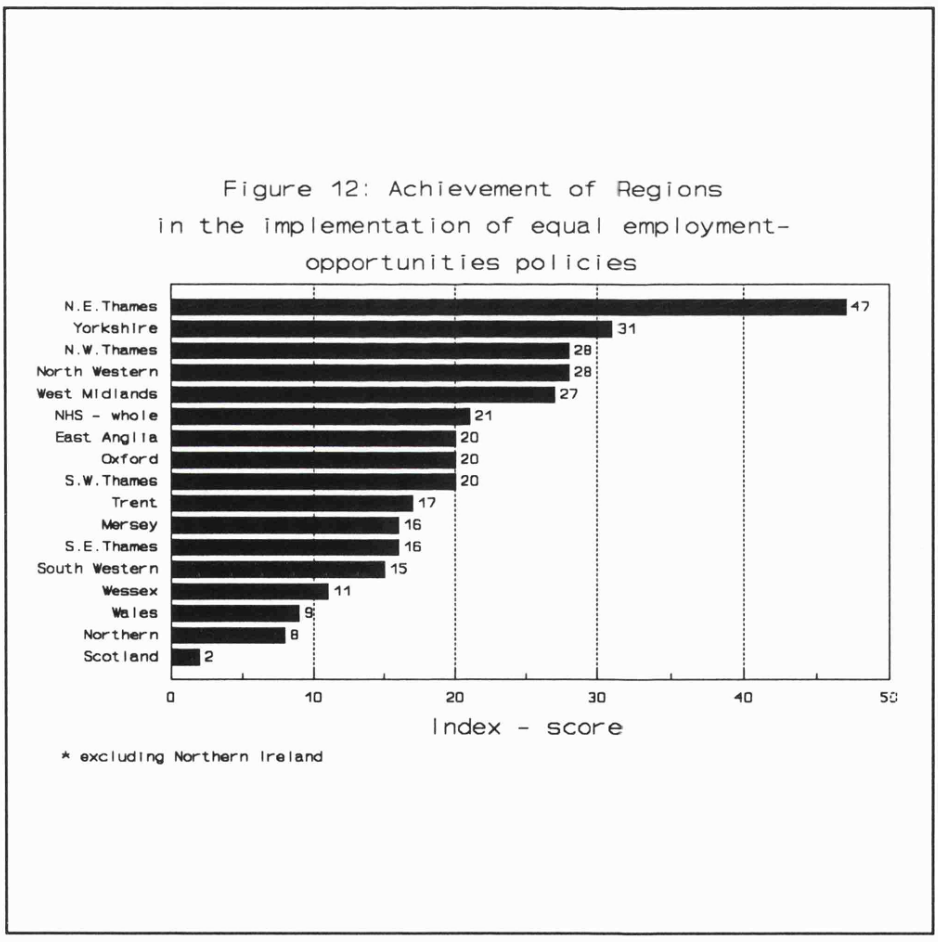
*** Only 7% of Health Authorities had achieved the fifth measure.**

Figure 11: Percentage of Health Authorities* achieving each of the five measures of policy implementation



When the achievement of individual regions is examined it is obvious that there had been a very uneven development of policy across the NHS. To enable a comparison between regions an index of achievement has been calculated for each region by: calculating the percentage of Authorities within each region - that returned questionnaires - at each of the five measures of policy achievement; adding the percentages together, and then dividing the total by five.

The maximum possible score for the index is 100 - which would indicate that all of the Health Authorities that returned questionnaires in a particular region had achieved each of the five measures of policy. The scores for each region are shown in figure 12.



The score for the whole of the NHS was 21. Five Regions - North East Thames, Yorkshire, North West Thames, North Western, and West Midlands, were well above this score and consequently well ahead of the other regions. It is obvious then - in conclusion - that the NHS as whole has much to achieve in the implementation of equal employment-opportunities policies. It is also obvious that some Authorities have a long way to go to catch up with the others.

# CHAPTER 5

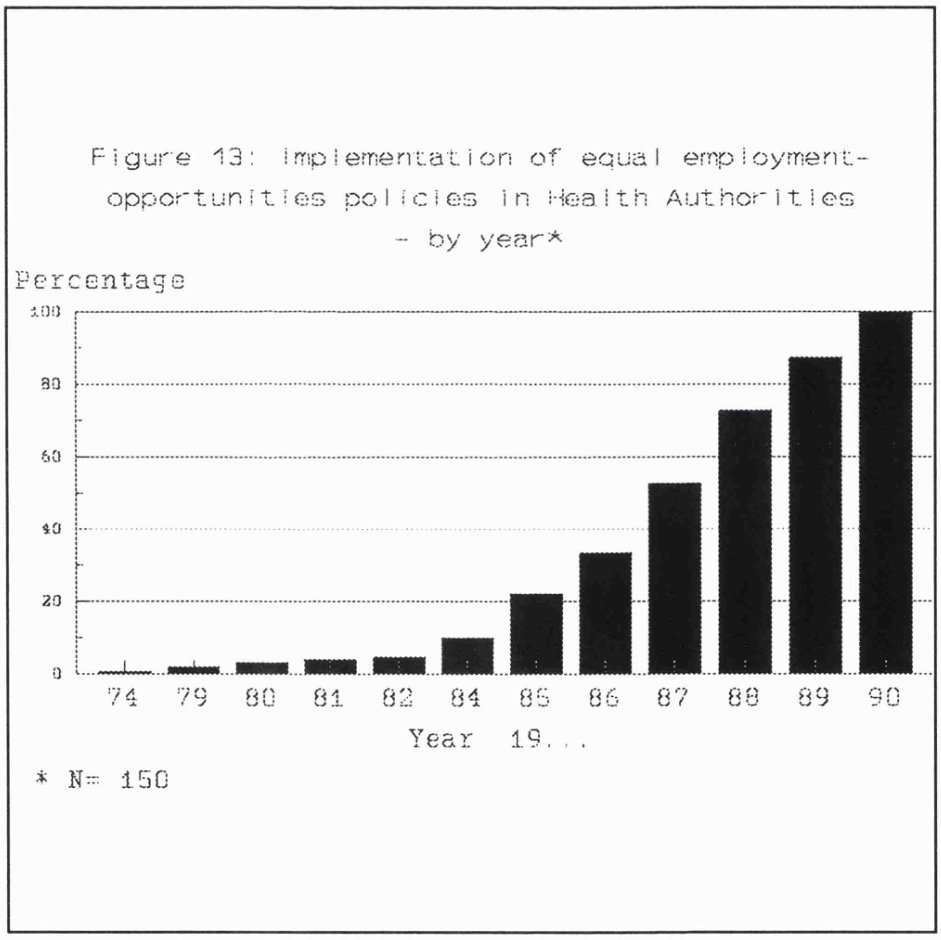
## ORGANISING POLICY IMPLEMENTATION IN THE NHS

This chapter focuses on the 'institutional' dimension of racism and patriarchy at work at the macro level by presenting an analysis of the organisation of equal employment-opportunities policy for the NHS as a whole. A number of weaknesses in the organisation of policy are identified, and it will be argued that the weaknesses have constituted significant impediments to the implementation of equal employment-opportunities policies at work. In focusing on the macro level the analysis is concerned with policy development beyond the activities of individual Health Authorities, although the macro policy process is explicitly concerned with affecting activity at the micro level. The analysis focuses chiefly on the Department of Health's role in the implementation policy, although inputs to the macro policy process from other institutions such the Commission for Racial Equality and the Equal Opportunities Commission are also considered. The chapter is structured on the basis of a chronological analysis of the policy process which is divided into three phases in relation to equal employment-opportunities policies in the NHS. The first phase covers the period from the inception of the NHS in 1948 to 1983, and although it is a lengthy period, equal employment-opportunities policy development only began to occur in the late 1970s. The passing of the 1976 Race Relations Act stimulated early policy activity. That activity was limited to the issuing of a circular by the Department of Health and Social Security (DHSS) - now called the Department of Health - to draw the attention of Health Authorities to their responsibilities

under the Race Relations Act. It will be observed, however, that the circular appears to have had little impact as only a few Health Authorities established policies during the period. The production of a *Code of Practice* for employment by the Commission for Racial Equality in 1984 marks the beginning of the next phase in the policy process. This phase 1984 - 1987 was characterised by emergent pressure on the DHSS to encourage Health Authorities to implement policies. At the time the DHSS seemingly perceived that there was inadequate expertise in the NHS to implement equal employment-opportunities policies and they therefore responded to the growing pressure by establishing two institutions to generate the required expertise - the King's Fund Equal Opportunities Task Force, and the National Steering Group for Women in the NHS. The third phase covers the period between 1988 and the time of writing - 1992, and it has been characterised by a greater intensity of the inputs into the policy process. A significant event in the macro policy process was the introduction of equal employment-opportunities into the Department of Health's annual review process for Regional Health Authorities. This appeared to provide a considerable stimulus, and for the first time made Regional Health Authorities accountable for the implementation of policy.

Data collected from the survey of Health Authorities - reported in chapter four - have contributed to the chronological analysis of the policy process in this chapter. Authorities that had established equal employment-opportunities policies were asked on the survey questionnaire to indicate the year in which the policy had been formally approved by the Health Authority, and 150 - or 88% - of the 171 respondent Authorities (excluding Northern Ireland) that had established policies provided the requested information. A graphical summary of the findings is presented in figure 13, which provides a cumulative count by year of the Health Authorities that have implemented

policies. The lack of activity characterising the first phase of the policy process is evident from the small number of Authorities that had established their policies before 1984. Only 5% of the Authorities had established approved policies by 1982 and no policies were formally approved in 1983. A slightly greater rate of activity marked the third phase of the policy process as the remaining 50% of respondent Authorities - that provided information about the year in which their policies had been approved - had




established them between 1988 and 1990. Whilst the data presented in figure 13 provide

a useful illustration of the chronology of the policy process they must, however, be interpreted with some caution. On the basis of replies given on some of the questionnaires returned by respondents it was realised that the reliability of the question which asked for the year in which the policy was formally approved might be uncertain. The question asked: "In which year was it (the policy) formally approved by the Health Authority ?" (Appendix 3, question 3). A small number of the replies were very precise as they provided both the month and year - and in two instances even the exact date - of policy approval, but the majority of replies simply provided - as requested - the year in which the policy had been approved. In contrast, two of the replies were very imprecise as they just stated, for example, "mid 1980s", and consequently they were not included in the data. The replies which challenged the reliability of the question indicated that the respondent Authority had introduced more than one policy and the current policy was a revision of an earlier version. For instance, one Authority replied: "Originally 1986 Revised 1989". Another respondent stated: "1990 - 2 other policies existed before this". These replies suggested the possibility that other respondent Authorities might have been referring to a current revised policy and consequently the data collected by the question concerning year of policy approval might not provide an accurate reflection of the chronology of policy implementation. To compound this difficulty even further there is also a possibility that some of the persons who completed the questionnaires might have relied solely on their memories for the year of policy approval - or even made a guess - without reference to policy documents. Hence the validity of the information would be eroded even further.

In the light of these potential problems an attempt has been made to check the validity of the information provided against other relevant published data in the two

reports on policy implementation in London; *In a critical condition* (LACRC 1985) and *No alibi, no excuse* (GLARE 1987). These two reports are the only published sources of data pertinent to the question under discussion and they only concern the London Health Authorities. It was possible to compare the information contained in the reports against replies to the mail survey for twenty-one London District Health Authorities. Data were not available for the remaining ten London Authorities - at the time of the survey - either because they were not contained in the reports or because the Authorities had not responded with this information to the mail survey.

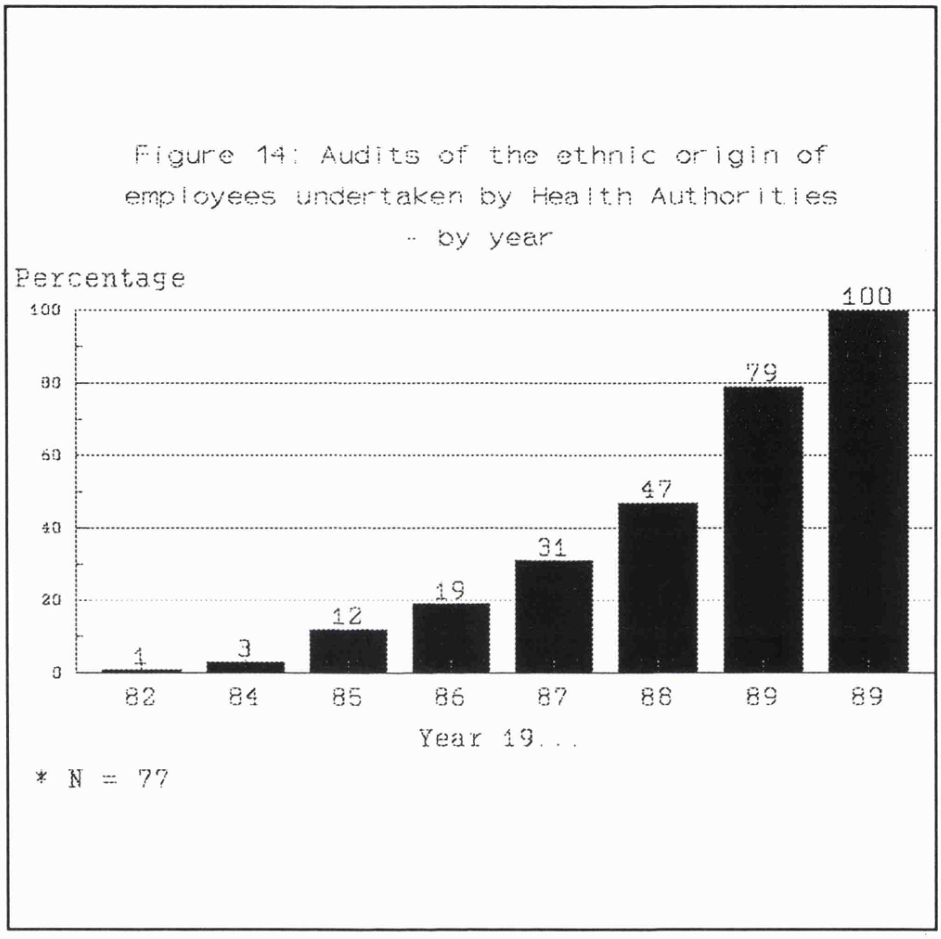
The test group of twenty-one Authorities is divided into two sub-groups. The first sub-group contains eleven Authorities for which information on date of policy approval is available from both of the test sources - the published data and the mail survey. For just under two-thirds - or 7 - of the eleven Authorities there was agreement between the two sources on date of policy approval. The policies of the remaining four Authorities had been approved earlier - on the basis of the published data - than the year indicated on the survey questionnaire. The largest difference was eight years, and for the others it was four, three, and one year respectively. The other sub-group contains ten Authorities for which an exact year of policy approval is not available from the published sources, although it is possible to determine whether their policies had been approved before or after the end of 1985. Three Authorities - on the basis of the published sources - had their policies approved in the earlier period but the replies to the mail survey for two of the Authorities indicated that approval was given after 1985. For six of the remaining seven Authorities there was agreement between the published data and the mail survey data that their policies had been approved after 1985.

In drawing conclusions from the validity test, data from the published sources

corresponded to the mail survey data in thirteen - or 62% - of the test group of twenty-one Authorities. It seems reasonable to suggest, therefore, that the data presented in figure 13 provide a strong indication but not an accurate reflection of the chronology of the policy process, and specifically, early policy achievement is under-represented. But an observation which may increase the confidence in the data presented in figure 13 is that the mail survey indicated that the four Thames Regions which contain the London District Health Authorities are more advanced as a group in terms of policy implementation than the other Regions as a group (see figure 12 page 155) who are, therefore, perhaps less likely to have made revisions to their policies.

Additional data collected by the mail survey enhance the interpretation of the chronology of the policy process and may also increase confidence in the data presented in figure 13. Specifically, Authorities were asked to indicate on the questionnaire whether they had "made an audit of the workforce concerning the ethnic origin of employees" (Appendix 3, question 30), and - if they had - "In what year was this first done ?" (Appendix 3, question 31). By enquiring about the "first" occasion on which an audit had been undertaken one of the problems of validity raised in the discussion above is avoided. On the basis of the survey findings presented in the last chapter - and as will also be discussed in chapter seven - it appears that for many Health Authorities where an audit has been undertaken it has occurred at an early stage of policy implementation. Therefore, data on the chronology of workforce audits provide a useful indication of the chronology of policy implementation as a whole. Eighty-seven - or 51% of the 171 Authorities with equal employment-opportunities policies that responded to the survey - indicated that they had made an audit of the ethnic origins of their workforce. Ten of the eighty-seven Authorities failed to provide the information concerning the year in which the audit was

first undertaken. The data for the remaining seventy-seven Authorities are presented in figure 14 which provides a cumulative count of workforce audits conducted by the Health Authorities.




It can be observed from figure 14 that the data appear to validate the chronological division of the policy process into the three phases specified above. Only one Authority that provided the requested information had conducted an audit of their workforce before 1984, thereby confirming the impression of very little activity by Health Authorities during the first phase of the policy process. Policy implementation began to gather

momentum - on the basis of the workforce audits - during the second phase of the policy process - 1984 to 1987. A much grater rate of policy implementation can be noted for the third phase of the policy process as 69% of Health Authorities that had undertaken a workforce audit - by the time of the mail survey - did so between 1988 and 1990.

**Three phases of policy implementation**

To set the context for the policy analysis of the first period, a brief overview is presented here of the experience of migrant labour in the NHS, and it will be argued that it has been characterised by aspects of racism and patriarchy at work. Black migrant workers - and especially black women - have made a significant contribution in the shape of their labour power to the British National Health Service since its foundation. The NHS has in the past actively recruited overseas labour - particularly for the nursing and ancillary sectors - due to periods of a shortfall of indigenous British workers prepared to work in the Health Service. The shortfall has been due chiefly to the low wages paid to Health Service workers and the subsequent competition from the private sector which has offered more attractive pay and conditions (Pearson 1987: 25). The consequent employment of migrant labour from less developed countries has enabled wages to be maintained at their low level. This has been functional for capital in respect of minimizing the drain on its resources into the Health Service which provides an important service to capital in the reproduction of labour power. If labour costs are kept to a minimum then the drain on resources is also minimized (Doyal et al 1979: 68). This process has required a source of labour which would be receptive to low-paid servile work, and Ramdin (1987: 310) - for instance - has argued in the case of nursing that black women have been especially suited to a servile role in the nursing labour force for not only has nursing traditionally been the function of women in their domestic labour of caring for men and

their children but black women in particular have been associated with service work during slavery and colonialism. Similarly, the Black Women's Group observed that:

> The relationship between black women and nursing, wet nursing or dry nursing, of other people's children and other people's husbands and wives, dates from before any National Health Service. Whether working in hospitals as auxillaries, SENs or SRNs, in the head of the black nurse from the Caribbean is the echo of slavery: in the head of the Asian nurse is the servitude to Sahib and Memsahib. (Black Women's Group 1974: 226).

The experience of black migrant workers in the NHS has been marked by a subordination that is characteristic of racism and patriarchy at work. In the case of nurses, for instance, anecdotal evidence suggests that having been recruited to low-paid work that could not attract an adequate supply of indigenous British labour many black migrant women were subject to exclusionary processes which maintained them in their positions of disadvantage. Their experience has therefore been characterised by exploitation rather than equity with their white colleagues (Alibhai 1988: 26). Three exclusionary processes which maintained the exploitation can be distinguished. The first concerns the channelling of the nurses by deception to the bottom of the nursing hierarchy where they served as cheap labour (Black Women's Group 1974: 226, Ramdin 1987: 310). One of the ways in which this operated is that some potential migrants were promised entry to professional nurse training - SRN - but once they arrived in Britain that promise was broken as they were employed as auxillary nurses without any guarantees of access to training. An example of a more insidious variation of this form of exploitation has been provided by Torkington (1987) in the account of one nurse who reported that the matron of the hospital in which she was working even contrived to keep her there as a nursing auxillary by sabotaging her applications to other hospitals for SRN training (Torkington 1987: 27).

The second process of exploitation involved a channelling of black migrant nurses into the lower grade pupil nurse training for the SEN qualification which limited career

prospects to the lowest levels of the nursing hierarchy. It appears that some of the migrant women were channelled into SEN training unwittingly (Torkington 1987: 27) through the attraction of a shorter training course in comparison to SRN training (Black Women's Group 1974: 227) and many did not know that two tiers of training existed (Pearson 1987: 25-26, Baxter 1988: 25). Others who did not have the educational qualifications required for entry to SRN training appear not to have been given the same opportunity as white British women to sit an entry test instead (Hicks 1982: 789). For many of the migrant women SEN training was unrecognised in their countries of origin and it was therefore worthless if they wanted to return. Some of the nurses have reported that they felt isolated when they realised their dilemma as they got little support from their schools of nursing and colleagues in trying to alter their career path (Baxter 1988: 26). One black nurse recalled that the pupil nurses - who in the hospital in which she worked appeared to be mostly black - were treated as "just a pair of hands" in that they were given the unpleasant jobs on the ward whilst actual training in nursing procedures was given to the mostly white student nurses (Hicks 1982: 789). In short, it has been argued that on the ward floor, black women serviced the patients, the professional nurses (SRNs) and the doctors (Black Women's Group 1974: 227).

The third aspect of exploitation appears to have involved the channelling of black migrant nurses into the less popular specialities and less prestigious nursing schools, and it was even argued in 1982 that this practice was still continuing (Hicks 1982: 790). The exclusionary processes described in chapter one inhibited their escape into higher status, more highly paid, and more desirable areas of work. In summary, anecdotal evidence suggests that many black migrant women in the NHS were subject to exploitation as they were purposely employed as cheap labour through being channelled into the lowest levels

of the nursing hierarchy with the least status, least pay, and most menial tasks. However - as will be observed shortly - the presence of large numbers of black employees in the NHS appears to have been interpreted by the Department of Health as an indication of the provision of equality of opportunity at work.

As already stated, the first significant event in the equal opportunities policy process at the macro-level for the NHS appears to have been the issuing of a circular (U.K 1978) to Regional Health Authorities, Area Health Authorities, and Boards of Governors. The circular has been described as "one of the few positive and imaginative responses made by Government to the passing of the Race Relations Act." (LACRC 1985: 8). It contained summaries of the definitions of racial discrimination according to the Act, and it indicated circumstances of unlawful discrimination in; recruitment for employment; the employment of contract workers, such as agency nurses; and the advertising of vacancies for employment. Examples were also provided of what were stated in the circular to be more subtle and sometimes unconscious practices of discrimination arising from assumptions about the characteristics of individuals from various minority groups.

The circular contained a number of recommendations for policy implementation. For example, Health Authorities were advised to review their employment practices concerning the selection, training, promotion and transfer of staff, to ensure that they are free from direct and indirect discrimination. Similarly, they were also advised to review their criteria for recruitment and job specifications to ensure that they do not contain elements of indirect discrimination. Authorities were advised to attempt to achieve more than just bare compliance with the Race Relations Act, and it was recommended that:

> employment policies and practices should therefore include effective procedures to ensure equality of opportunity for members of minority groups. This can best be achieved by developing a policy which is clearly stated, known to all employees, and has and is seen to have the backing of

> senior management, is effectively supervised, provides a periodic feedback of information to senior management, and is seen to work in practice. (U.K. 1978 para 14)

The circular also drew attention to the provisions of the 1976 Race Relations Act concerning the exceptions for genuine occupational qualifications (1976 Race Relations Act: section 5), and it suggested that:

> Authorities may wish to take advantage of this provision in some cases where there are particular problems relating to the language or cultural background of clients of the health services, for example in the health education or health visiting field. (U.K. 1978 para 15)

Attention was also drawn to the positive action provisions of the Act concerning access to training for employment (1976 Race Relations Act: sections 37 & 38).

Despite the recommendations contained in the circular, it appears to have had little impact on the course of policy implementation as evident from the chronological analysis discussed above and also from the accounts of some of the research respondents. The observations of one of the respondents (R2) provides some insight into what might have happened to the circular in many Health Authorities, as they reported that in the Authority in which they were employed - when the circular was issued - it was simply "filed away" and forgotten about. Historically, the recommendations contained in circulars issued by the centre have been for guidance only and are not mandatory and the issuing of circulars has generally been regarded as an ineffective means of developing policy at local level (Mc.Naught 1988: 71) and having little impact (Brown 1962: 371-74, Stewart & Sleeman 1967, Ham 1981: 184, Klein 1983: 51).

The London Association of Community Relations Councils argued in their 1985 report *In a critical condition* - that some of the responsibility for the lack of action on the part of Health Authorities in response to the circular rested with the Department of Health and Social Security. The report argued that it:

> appears to have done nothing to follow up the circular; it has never asked authorities to what extent they have acted on the advice given, and it has never issued any further advice on equal opportunities. (LACRC 1985: 8).

The question of why the Department did not apparently follow up the circular and monitor the response of Health Authorities was also raised by the House of Commons Home Affairs Committee in 1981, and it is instructive to read the exchange on this question between the committee chairman and the Under Secretary for Social Services - Mr. Scott Whyte:

> (Chairman) So far as promotion of equal opportunities is concerned, back in October 1978 following the 1976 Race Relations Act, the Department issued guidance to the health authorities and others, I think, urging the need for positive equal opportunities policies. Has there been any follow up to that ? Have you monitored the extent to which Area Health Authorities and others have been pursuing those equal employment policies ?
>
> (Mr. Scott Whyte) No, we have not done this, partly because the extent of our monitoring the activities of both health and local authorities is something which we have been reducing, but also because those policies laid down in the Race Relations Act were really full legal obligations on employing authorities. They were not policies being recommended to them by the Government. The Act, of course, contains its own system of enforcement of the obligations which does not involve any participation by the Secretary of State so there is not really a case - it would seem a work of supererogation - for us to monitor the extent to which authorities are conforming with the law.
>
> (Chairman) It is not clear to me why you issue guidance, if that is the case, but you do.
>
> (Mr.Scott Whyte) It is normal practice to draw the attention of health and local authorities to any changes in the law which affect their operations. At the time when an Act is passed or regulations are made, we draw the local authorities' attention to this new feature of the landscape that they have got to work in. (U.K. 1981b: p195)

Even if the circular was simply drawing the attention of Health Authorities to the requirements of the Race Relations Act - and in contradiction of Mr. Scott Whyte's evidence it went much further than that and was clearly a work of "supererogation" - it

appears pertinent to ask why the Department did not take a more active role in ensuring the provision of equal opportunities ? One possible answer is that it did not consider that employment discrimination seriously affected the NHS, and this certainly appears to have been the Department's view in the mid 1970s according to its submission to the 1975 Select Committee on Race Relations and Immigration in which it stated that:

> Although the Department is not complaisant, the policy that all eligible persons shall have equal opportunities for employment and advancement would seem to be working adequately in the NHS, if measured by the low volume of complaints. It appears that over the period of the last seven years that all of the cases investigated by the Race Relations Panel of the GWC (and some of these were reviewed independently by the RR Board) only in one of these was the complaint upheld.
>
> It is, we feel, universally recognised that the NHS would have had the most serious staffing difficulties many years ago at all levels and in all professions if it had not an employment policy towards staff that disregarded race, colour, ethnic or national origins. (U.K 1975b: 191)

It is curious, however, why the Department had failed to recognise that employment discrimination was not a problem in the NHS. Admittedly, the anecdotal evidence of the experiences of migrant nurses discussed in the introduction to this chapter and the evidence of exclusionary processes facing black workers and women in the NHS did not begin to emerge until the 1980s. However, some earlier indications of discrimination had been made apparent. For instance, in the case of migrant nurses, in the Newsletter of the Institute of Race Relations in 1968 Gish (1968) observed that "Commonwealth" nurses were under-represented amongst senior nursing staff despite the fact that as a group they had been working in the NHS long enough to achieve a greater representation amongst senior nurses than was apparent. In suggesting the indication of racism at work Gish observed that:

> The other suggestion offered (privately) as to the lack of promotion, in the case of West Indians in particular, was that they are "too slow, less qualified and less able to take charge." There would appear to be no need

> to discuss this view except to note that if such bias is widespread in the nursing profession it would go far in explaining the lack of promotion for overseas-born nurses. (Gish 1968: 458).

The Department's recognition of discrimination at work in the NHS might have begun to evolve shortly after it provided the above submission to the Select Committee, as in 1976 in the Quarterly Journal of the Employment Section of the Community Relations Commission it was commented that:

> Black workers, irrespective of occupational status, find their job experience in the NHS structured by institutional racialism - this is the over-view which we gain when the fragments of information are pieced together. Remarkably, it is acquiring a consensual position among the administrative elites (in the DHSS, the GMS, the medical schools...). The real debate begins when we ask: what is to be done? (Grainger 1976: 12)

If a consensual position had emerged as was suggested, it was not followed up by any action - apart from issuing the circular - to encourage Health Authorities to promote equality of opportunity at work, and this was despite further indications of discrimination - against overseas doctors - produced by the Policy Studies Institute in 1980 (Smith 1980). The inactivity of the Department was summed up by the House of Commons Home Affairs Committee in 1981:

> The Department of Health and Social Security apparently have neither Minister nor staff with a particular responsibility for combating racial disadvantage...//...There is little or no evidence that the Department are aware of the implications for their areas of responsibility of the wide range of racial disadvantage. Local authority social services departments and local health authorities are perforce aware of such matters and have taken a variety of administrative steps towards dealing with them. The department have not, and would not appear to have taken the lead in advising authorities on good policy and practice. (U.K. 1981b :xxi).

Despite the Select Committee's belief that local Health Authorities had taken "a variety of administrative steps" to combat racial disadvantage the mail survey findings reported above, and the LACRC research on the implementation of equal employment opportunities policies in London, indicate on the contrary that such action had only been taken by a few

Health Authorities.

The failure of the Department to take the lead on the implementation of policies in the NHS which aim to promote equality of opportunity also needs to be considered in the context of the prevailing management style in the NHS in the late 1970s and early 1980s which was characterised by - as one of my respondents (R4) described it - a "hands-off" approach between management at the centre and local management in Health Authorities. The respondent's further comments encapsulate the weaknesses of both the issuing of circulars per se - as discussed above - and the issuing of circulars in the context of a management style characterised by a "hands-off" approach:

> the 1978 Circular. That was simply telling Authorities what was in the Race Relations Act and advising them as to how they should deal with it, and that was the style then. We launched our guidance on the waters and watched with interest to see what happened to it, but we didn't actively pursue it...and it was only really post the Griffiths Report with the establishment of the Management Board that we got into the style of pursuing things with a formal review process to do it in.
>
> In the early eighties it was always a very much hands-off approach, in the early years of the present Government, it was cut down the Civil Service, reduce the functions, get as much out of the Department as much as you can, and there was no sense in which the Management Executive were managing the Health Service. It might've on occasion been doing a political, or managerial, or administrative lead on particular topics...but they were very highly selective, and there was nothing like the present review process...and the whole thing by present day standards was very ad hoc and messy, and it was just a matter of raising things at periodical meetings with the chief officers of the Authorities. In so far as it did have meetings with the individual Authorities, it was more likely to be about their capital programme than the broad spectrum of developments. (R4)

Even though the implication of the prevailing management style of the Department of Health was that its influence on the implementation of equal employment-opportunities policies by Health Authorities was restricted to the level of exhortation it could have still been possible for the Department - and in a broader sense the Civil Service as a whole - to lead by example through its own employment practices. The significance of the

Government's role in this respect was emphasized during this period by Ollerearnshaw (1983) who argued that:

> Although government may stress the importance of equal opportunity in its public statements and ministerial speeches, its own practices and policies will inevitably stand as a major example from which other employers, large and small, will take their lead. In discussion with private employers, for example, CRE staff have often been told "the Civil Service doesn't have an equal opportunity policy or carry out comprehensive monitoring. Why should we ?" (Ollerearnshaw 1983: 160)

Yet it has been argued that progress by the Civil Service during this early period was slow (Ollerearnshaw 1983: 158). Accordingly, one civil servant in the Department of Health interviewed for the thesis questioned the commitment and progress of the Civil Service in implementing its own equal employment opportunities policy (R2).

In summary, the period before 1984 - and in focusing particularly on the years 1978 to 1983 - was characterised by a marked inactivity of the Department of Health and Social Security in relation to the implementation of equal employment-opportunities policies in the NHS. During the period riots occurred in 1980 and 1981 in urban areas with significant proportions of minority ethnic communities which produced a variety of social policy responses. For instance, they stimulated a re-emergence of interest by central government in using the Urban Programme to benefit disadvantaged minority ethnic communities, and a significant increase in the funding of the Programme was provided. One of the more overt responses was the unprecedented acquisition by Michael Heseltine - the Secretary of State for the Environment - of special responsibility for Merseyside (Young 1983: 291-2). In the context of the occurrence of the riots and the subsequent policy responses by central government, one of the objectives of the analysis for the thesis was to consider the impact of the riots in relation to the development and implementation of equal employment opportunities policies in the NHS. In relation to health service

provision one of the respondents from the Department suggested (R2) that the riots may have been partly influential in the greater funding provided for the *Asian Mother and Baby Campaign* in comparison to the earlier *Stop Rickets Campaign.* But it appears - on the basis of the account from the other respondent in the Department - that the impact of the riots on the Department itself in relation to employment issues was limited:

> Indirectly in the sense that there's been considerable national concern about ethnic minority issues from a variety of perspectives, but, and I've no doubt that all those events served to heighten awareness, but I couldn't say that it had any direct influence, any influence greater than that. (R4)

In comparison to the limited impact upon the centre, the riots appear to have made a greater impact upon some Health Authorities, particularly those in which the riots actually occurred. For instance, Mc.Naught observed in his study of West Lambeth Health Authority that the Brixton riots added a greater impetus to emergent policies concerning both equal employment opportunities and services sensitive to the needs of minority ethnic groups (Mc.Naught 1988: 115-6), and the publication of the Scarman report appears to have been influential in the decision of the District Management Team in 1982 to proceed with an audit of the ethnic composition of the workforce proposed by the District Personnel Officer. This reversed an earlier rejection of the proposal (Mc.Naught 1988: 93). Whilst it is apparent then that the riots did have some impact on the course of policy development it appears to have been considerably limited - as indicated by the small number of Health Authorities that established policies between 1980 and 1983.

The publication in 1984 of the Commission for Racial Equality's *Code of Practice* (CRE 1984a) - containing recommendations for the implementation of dimensions of equal employment-opportunities policies - marks the beginning of the second phase of the macro policy process for equal employment-opportunities in the National Health Service. That phase was characterised by a considerable increase in policy activity compared to

the first phase. The CRE followed up publication of the *Code of Practice* with an approach to the Department of Health. According to one of the civil servants in the Department interviewed for the thesis:

> the CRE approached us at that time and said "isn't it about time you updated your circular", which was the 1978 circular ? (R4)

The publication of the Code of Practice and the approach by the CRE occurred in the context of a change in management style in the NHS which meant that the Department would take a more directive role:

> We'd just got the Griffiths Report - which was in October 1983 - and we were beginning to consider how to re-build the system so that the centre was managerial rather than administrative, if I can use that over-simplifying distinction. We didn't actually go much on issuing circulars, and we thought then that what was needed was some kind of body which would help to drive the thing. (R4)

The need for a "body" to lead the development of equal employment-opportunities policies appeared to be justified by the Department of Health on the grounds of a lack of appropriate expertise within the Health Service, for as one respondent reported:

> The Department's feeling was that what was needed was the injection of some expertise into Health Authorities, because they felt that the reason that Health Authorities were not proceeding as quickly as other sectors was a need for expertise. (R1)

This view corresponded with the account of one of the respondents - quoted above - from the Department of Health:

> this was a subject on which frankly very little had been done other than to try and protect...other than Authorities trying to protect themselves from legal action...and not always successfully at that, and there was very little expertise out there. So the first task that was set to was to make it easier for them. If we'd said to every Authority "Prepare an equal opportunities policy" they'd have to start from scratch...somebody in a personnel department somewhere was familiar with the legislation and could advise people on it...but there weren't people out there who had written policies...or very few of them...or had any experience of developing and running a pro-active policy. (R4)

The Department's perceived need to establish a body of expertise coincided with an emerging interest in equal opportunities by the King Edward's Hospital Fund for London (King's Fund), and the eventual outcome - after approximately eighteen months of negotiations - was the establishment of an Equal Opportunities Task Force in May 1986 under the auspices of the King's Fund. One respondent described this convergence of interests:

> They (the Department of Health) felt that it wasn't appropriate to have a unit within the Department, that what was appropriate was a unit placed somewhere outside, and the King's Fund was the obvious institution to approach to ask to take on a Task Force, so they approached the King's Fund. This tied in with...ideas which the Chief Executive of the King's Fund had at the time that he would like to extend what the King's Fund was doing in the equal opportunities field. (R1)

It appears, however, that the CRE - which originally stimulated the activity by the Department - had reservations about the establishment of the Task Force, and as the same respondent explained:

> their reservations were that they felt that the initiative that was required was for the Department nationally to in some way direct Health Authorities to implement the Code of Practice. I think what they were suggesting was another circular to Health Authorities, which at the time the CRE felt would be the answer. (R1)

Despite the CRE's apparent reservations, however, they subsequently accepted representation amongst the membership of the Task Force. In addition to the CRE's pressure on the Department, the Equal Opportunities Commission also began to apply some pressure:

> So we launched the Task Force, then there was a certain amount of disquiet around from the Equal Opportunities Commission and from (within the Department) that we weren't addressing equal opportunity issues for women. (R4)

It was decided that two organisations should be established to develop the expertise for equal employment-opportunities policy separately on the basis of 'race' and sex. In

negotiations between the Department of Health and the King's Fund:

> the case was argued there for looking at equal opportunities in employment right across the board. One of the reasons that we decided against that was because it would have left out the service link for ethnic minorities. But another strong reason is that any single body looking at that whole area which is in any way representative becomes gigantic and very readily descends into a "talk shop". The way to overcome that is to appoint a small group of individuals for their expertise. (R4)

A key reason behind the establishment of separate organisations appears to have been a desire to establish the "confidence" of representatives from minority ethnic groups:

> The problem that we had there was that we couldn't have people readily available from within the health service or close to the health service who would actually have the confidence of all the groups, and a good deal of the purpose of the Task Force and the National steering group has been to build confidence. And we felt that it was necessary if the ethnic minorities themselves were to believe that what was being done was seriously directed towards their interests to have a body which had a substantial ethnic minority membership on it, and which was, as it were, dedicated to their interests. They would have suspected if we'd set up a body to look right across the board that it would focus primarily on gender issues. (R4)

Therefore, in addition to the King's Fund Equal Opportunities Task Force, the National Steering Group for Women was established in December 1986. Both organisations produced written policy guidance - cited in the thesis - which was disseminated to Health Authorities. In addition, the aim of the Task force was to:

> try to encourage role models - to help those Authorities that were most advanced to continue to advance, so that their examples could be used by other Health Authorities. (The Task Force has) also tried to help equal opportunities advisers, because it has seen that as one other way that equal opportunities development was going to come about. (R1)

In short, the second phase of the macro policy process for equal employment-opportunities in the NHS was characterised by a recognition by the Department of Health that expertise needed to be generated to achieve the implementation of policy across the NHS, and the subsequent establishment of that expertise.

The third phase of the equal employment-opportunities policy process for the NHS

began in 1988 with the introduction of equal opportunities into the annual review process. The annual Ministerial review of Health Regions - and in turn the review of Districts by Regions - was established in 1982 (Allsop 1984, Levitt and Wall 1984). The review was strengthened by the introduction of a system of performance reviews of Regions by the NHS Management Board (now called the NHS Management Executive) in 1986 (Mills 1987). The strengthened annual review process provided a potential mechanism for the accountability of Regions and subsequently Districts in the implementation of equal employment-opportunities policies. By 1988, sufficient equal opportunities expertise appears to have been generated for the NHS for policy implementation to be included in the review process:

> The timing was calculated in relation to the progress which the Task Force and the National Steering Group had made...1988 was the right timing in terms of there being enough material now available for Authorities being able to pick that up and turn it into working policies relatively painlessly..../...there were a number of Districts who had made progress from whom you could network and there was varying levels of interest and expertise in regions, and more so in Districts - and that's still the case - but there were enough people ready to go, and there was enough material ready for them to build on. (R4)

In this third phase of policy implementation two additional significant countervailing processes occurred in relation to the implementation of equal employment-opportunities policies in the NHS. One process was the 1991 re-organisation of the NHS which devolved accountability away from the centre - the Department of Health - to health service employers. The re-organisation potentially weakens central control on the implementation of policy, although this is a matter of speculation until the effects of the re-organisation can be evaluated. The second process involved a growing recognition of a potential labour shortage facing the NHS. That recognition - as will be discussed in chapter six - appears to have provided a significant stimulus for policy implementation.

## Organisational barriers at the macro level

A number of organisational barriers - at the macro policy level - to the implementation of equal employment-opportunities policies have been identified in this chapter. In the late 1970s and early 1980s the Department of Health failed to provide a lead to the NHS in the implementation of policy. Part of the failure rested in the prevailing management style at the time which according to one respondent (R4) was "administrative" rather than "managerial". There was also seemingly a belief that because significant numbers of black workers were employed by the NHS discrimination was not a problem. When the need for measures to provide equality of opportunity at work began to be recognised, it was apparent that there was a lack of expertise necessary for effective policy implementation. The lack of expertise provided a further significant barrier to the formulation and implementation of equal employment-opportunities policies. In the late 1980s, when more effective managerial mechanisms had been established, and when the necessary expertise had been generated, the rate of policy implementation increased. Others factors, though, such as the potential labour shortage facing the NHS - as will be discussed in chapter six - provided an additional powerful stimulus behind policy implementation. In essence, the barriers to policy implementation have provided a significant component of the 'institutional' dimension of racism and patriarchy at work by inhibiting the implementation of measures aimed at challenging inequalities between black and white workers, and women and men at work, and the exclusionary processes which reproduce and maintain the inequalities. The barriers have therefore been integral elements of racism and patriarchy - conceived as 'systems of dominance.'

# CHAPTER 6

## THE UTILITY OF EQUAL EMPLOYMENT-OPPORTUNITIES

This is the second of the two chapters which analyze the macro policy process concerning the implementation of equal-employment opportunities policies in the NHS. The chapter focuses primarily on the policy process in the late 1980s and early 1990s, a period which has been characterised by considerable macro level activity in comparison to earlier years. Whereas chapter five focused on the organisational aspects of the macro policy process and the potential organisational barriers in the 1990s, this chapter focuses on the stimulae to policy implementation. It will be observed that whilst moral considerations provide the philosophical basis - and the heart - of equal employment-opportunities policies, the chief stimulae for implementation have been utilitarian considerations. The main considerations have been the need to recruit, retain, and make the most efficient use of labour, in the context of a potential shortage in the labour supply; and the need to make the provision of health services more sensitive to minority ethnic communities in the context of criticism of service provision. These utilitarian justifications - although primarily the former - have figured prominently in the exhortations for policy implementation by Ministers leading the Department of Health - and other participants in the policy process - and the moral argument has barely been raised. For instance, on the occasion of the launch of the "model" equal employment-opportunities policy for the NHS by the King's Fund Equal Opportunities Task Force - a body established to develop equal opportunities expertise for the NHS - the Minister for Health - Tony Newton - encouraged

"Chairmen" (sic) of Regional, District, and Special Health Authorities to "make constructive use of the Task Force's proposals in shaping their employment policies" for as he stated:

> The Government is firmly committed to ensuring that the NHS should offer, and be seen to offer, genuine equality of opportunity both in its recruitment and training policies, and in the career prospects it provides. This is not only important in itself; it is likely to contribute to achieving the parallel objective of making sure that the NHS services properly reflect the needs of all sections of the community. It is increasingly clear, too, that the staffing requirements of the service demand that no potential source of recruitment, or of developing to the full the skills we need, should be neglected or under-used. (Newton 1987).

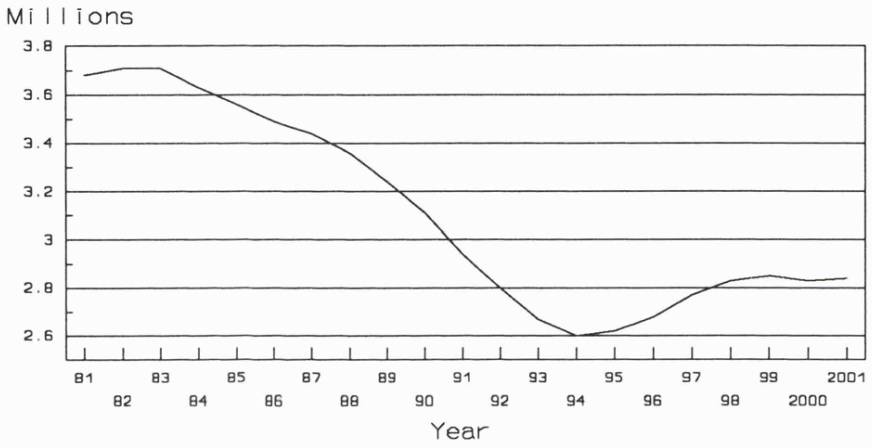
It will be further proposed that when morality is the sole reason for the implementation of an equal employment-opportunities policy a significant barrier exists which is rooted in the 'paradox of equal opportunities', that is, the more an equal employment-opportunities policy is needed to combat racism and patriarchy at work, the less likely it is to be implemented, unless it can be opportunistically attached to other policy imperatives.

**Recruitment, retention, and the efficient use of labour**

The NHS is facing what has been frequently called the "demographic time-bomb" (cf. U.K. 1988a). Due to a decline in the birth-rate in the 1960s and 1970s there has been a fall since the early 1980s in the number of young people in the labour market whilst the population as a whole has continued to grow. As the NHS has traditionally recruited a substantial proportion of its workforce from amongst school-leavers it has been facing a growing shortage in the supply of labour. In the case of nurses, for instance - constituting approximately half of the NHS labour force - new recruits have normally been drawn from school-leavers - primarily female - with qualifications ranging between 5 GCE 'O' levels and 2 'A' levels or equivalent (Conroy & Stidston 1988: 4). But this potential pool

of labour has been declining and will continue to decline in the early 1990s, as indicated in figure 15 which illustrates the demographic 'dip' characterising the number of young people in Britain.

Figure 15: Estimates and projections of the resident population of Great Britain aged 16-19 for the years 1981-2001




Adapted from:
Employment Department April 1992, table 2.

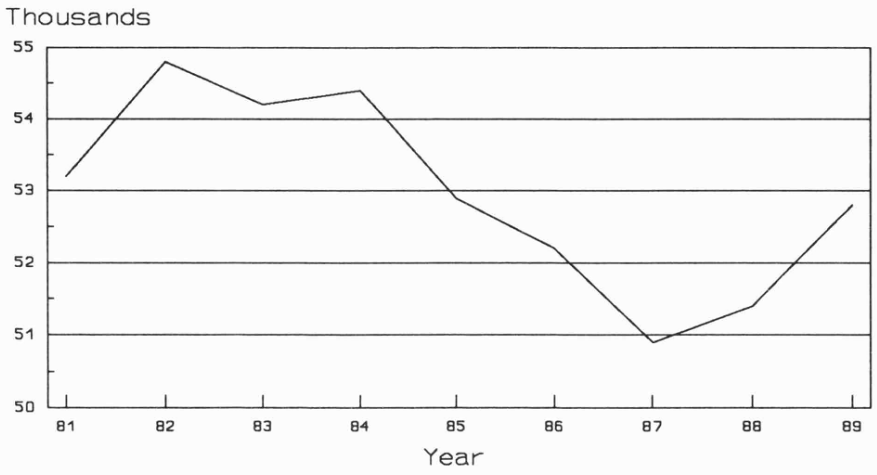
Between 1982 - when there was a peak in the supply of 16-19 year-olds (3,712,000) - and the projected trough in supply in 1994 (2,602,000), the number of both male and female 16-19 year-olds - and therefore potential young workers - would have fallen by approximately 30% (29.90%) (U.K. 1992: 176-177). The reduction is fractionally larger for females - 30.14% - which is significant in the case of nursing for instance, as approximately 90% of the nursing workforce are female. The number of female school-

leavers with five 'O' levels to 2 'A' levels is projected to have declined to a lesser extent during this period (22% between 1983 and 1993) but the difference is eroded by the higher proportion predicted to enter further education (Conroy & Stidston 1988: 5). The number of 16-19 year-old males and females is projected to increase slowly from 1995, although by the year 2001 their number is only projected to have reached approximately 77% (76.62%) of their 1982 level, and slightly less - 76.38% - in the case of females.

The fall in the supply of potential labour has been matched during the 1980s by a fall in the annual number of trainee nurses as illustrated - in the case of student nurses - in figure 16. The number of student nurses declined from their peak in 1984 (54,418) to a low in 1987 (50,875), and then began to rise again. The rise was primarily due to the increasing number of male student nurses whose total increased by nearly 33% (32.61%) between 1984 and 1989 (5,646 to 7,487) whilst the number of female student nurses declined by 7% (7.01%) during the same period (48,772 to 45,354). The number of trainee nurses overall though - when taking the lower training grade of pupil nurse into account - has fallen considerably during the 1980s.

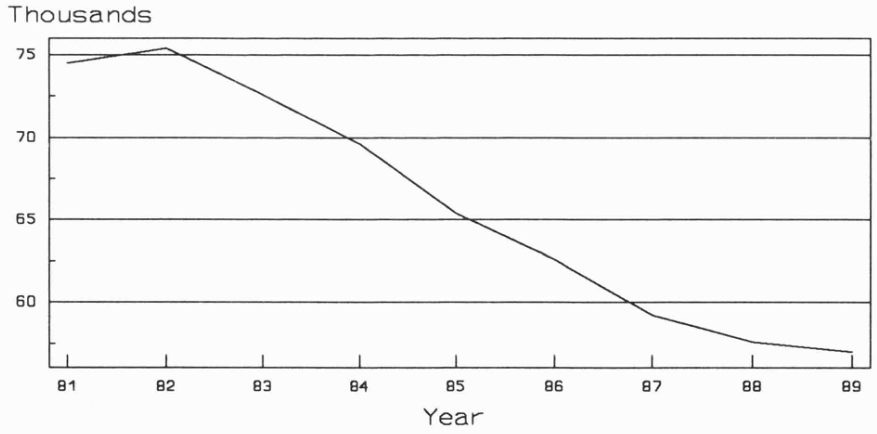
The number of pupil nurses fell by 80% (80.34%) between 1981 and 1989 (21,254 to 4,179) as a consequence of the phasing out of two-tier nurse training. The rise in the number of student nurses in the late 1980s did not compensate for the decline in the number of pupil nurses, and as illustrated in figure 17 there was a consistent annual fall between 1982 and 1989 in the total number of trainee nurses, falling by 24% (24.38%) in total (75,402 to 57,020).

Figure 16: Number of student nurses
England 1981-89




Sources:
Department of Health 1988: Table 3.7
Department of Health 1991: Table 3.18

Figure 17: Number of trainee nurses
(student and pupil nurses)
England 1981-89



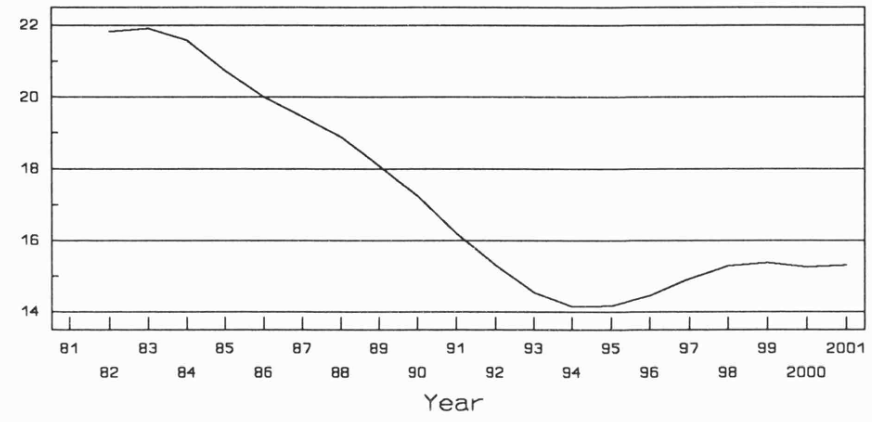

Sources:
Department of Health 1988: Table 3.7
Department of Health 1991: Table 3.18

The decline in the supply of potential new recruits to the nursing labour force has co-existed with a growing demand for NHS services. For instance, between 1982 and 1994 - the peak and the trough respectively in the number of 16-19 year-olds - the number of 65 year-olds and over is projected to increase by nearly 8% (7.67%). This group of the population makes the greatest demand - in comparison to younger age groups - on the National Health Service (cf. Breeze, Trevor & Wilmot 1991: 120). The shortfall in the potential supply of young new nursing recruits in relation to the increasing demand for their labour eases from 1995 following the projected growth in the number of 16-19 year-olds which outstrips the continued growth in the number of 65 year-olds and over. For instance, the number of 16-19 year-old females is projected to increase by 8.91% between 1995 and 2001 compared to a 0.82% increase in the number of 65 year-olds and over during the same period. But the number of 16-19 year-old females as a proportion of the number of 65 year-olds and over - both males and females - in 2001 will still be well below the 1982 level when there was a peak in the number of 16-19 year-olds. In 2001 the proportion will be only 15.30% compared to 21.83% in 1982. The worst point in the shortfall of potential young nursing recruits in relation to the demand for health services from 65 year-olds and over will occur in 1994 when the number of 16-19 year-old females as a proportion of the number of 65 year-olds and over will be at its lowest in the 1982-2001 period at 14.16% - as illustrated in figure 18. Therefore, the "demographic time-bomb" is set to explode in 1994.

The potential staffing crisis facing the NHS as a consequence of demographic changes has been worsened by a growing demand from the service sector as a whole which competes for the same pool of young female labour. The strength of competition is indicated by the growth of service sector employment which increased by over 17%

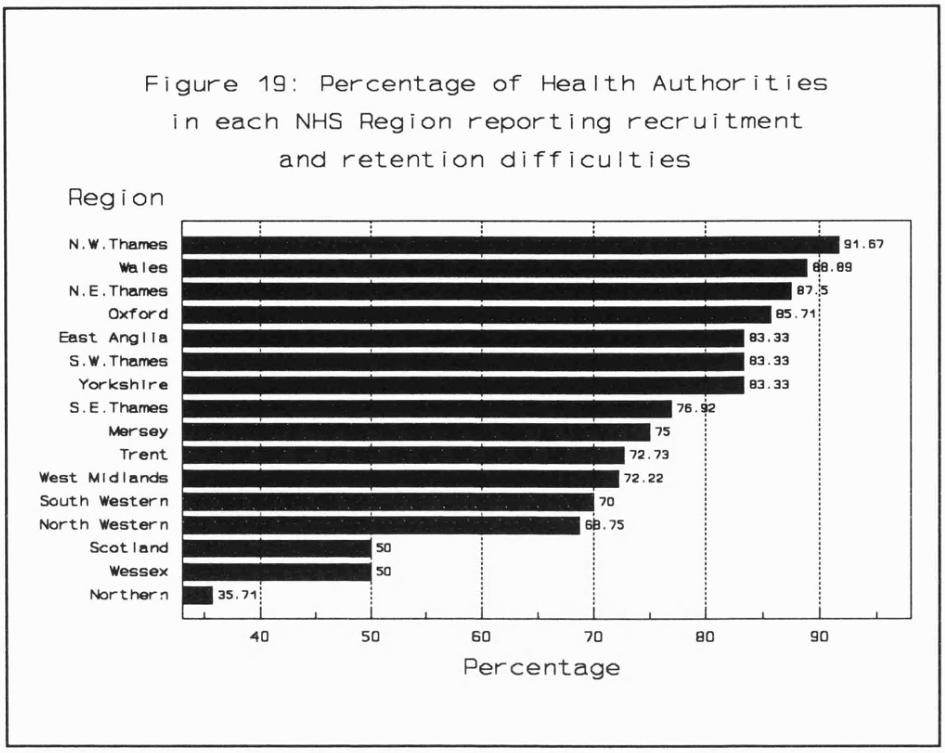
(17.82%) between 1981 and 1990, compared to a decline by a similar proportion (17.21%) in the numbers employed in the manufacturing sector (U.K. 1992a: 75).

Figure 18: The number of 16-19 year-old females as a proportion of 65 year-olds and over in the resident population of Great Britain 1981-2001




Source:
Employment Department April 1992: Table 2.

The mail survey conducted for the thesis - as reported in chapter four - provides an indication of the extent of the labour supply difficulties facing the NHS at the time the survey was conducted - September 1990 to January 1991. All respondents - except for Regional Health Authorities - were asked on the survey questionnaire whether they were experiencing recruitment and retention difficulties for particular groups of staff (Question 22). Nearly 73% of Authorities reported that they were experiencing such difficulties. The percentage of respondent Authorities in each Region - and Boards in Scotland - that were experiencing recruitment and retention difficulties is illustrated in figure 19.




Authorities experiencing recruitment and retention difficulties were asked on the mail survey questionnaire to provide details. Difficulties were subsequently reported for a wide range of staff groups by 118 of the 134 Authorities experiencing recruitment and retention difficulties. The nine most frequently mentioned groups are indicated in table 15. Overall, nurses were the most frequently mentioned group, and amongst them, psychiatric, mental handicap and theatre nurses were the most frequently mentioned specialities.

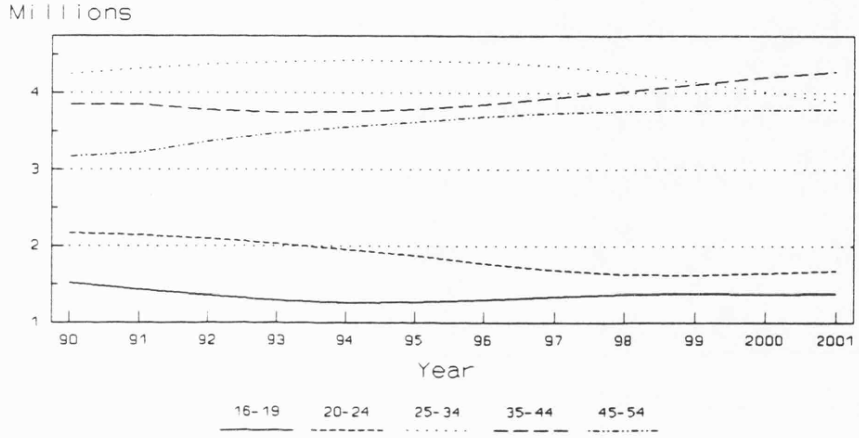
In summary, the NHS has been facing since 1983 a growing shortfall in its supply of new labour relative to the increasing demand on its services. In demographic terms the largest disjunction between supply and demand is projected to occur in 1994, and although it will then begin to decline the potential supply of new nursing recruits relative to the demand for their labour in the 1990s will be well below the level of the 1980s.

| Table 15: Seven occupational groups most frequently mentioned by Authorities experiencing recruitment and retention difficulties | |
|---|---|
| Occupational group | Number of Authorities reporting difficulties |
| Nurses | 56 |
| Occupational Therapists | 32 |
| Secretarial | 28 |
| Finance/Accountancy | 26 |
| Physiotherapists | 20 |
| Speech Therapists | 14 |
| Administrative and Clerical | 14 |

To maintain its supply of labour relative to the demand for its services the NHS has to recruit from additional sources, as is the case for all employers that have normally recruited a large proportion of new workers from amongst school-leavers. Accordingly, the need for alternative supplies of labour was emphasised by the Department of Employment in 1988 in its White Paper *Employment for the 1990s* (U.K. 1988a). It specified four potential sources; "women", "ethnic minorities", "unemployed people", and "older workers" (U.K. 1988a: 8-9). As a group, women provide a massive potential supply of labour for the 1990s as their economic activity rate - although growing fast - remains lower than the rate for males. The labour force as a whole is projected to have increased by 0.8 million between 1989 and 2001, and 90% of the projected increase consists of women workers (Spence 1990: 186). The increase in women workers will have to be drawn from the older age groups for whilst the number of 16-19 year-olds is declining the number of women in the 35-44 year-old age group is projected to increase by 30.55% between 1981 and 2001, and the number of women in the 45-54 year old age group is also projected to rise by 23.45%. Additionally, when the number of 16-19 year-olds

reaches its 'trough' in 1994, the number of 20-24 year-olds is projected to have reached its peak level. The increase in the number of older women compared to the decline in the number of younger women is illustrated in figure 20.

Figure 20: Estimates and projections of the female resident population of Great Britain by age for the years 1990-2001




Adapted from
Employment Department April 1992, table 2

It could be expected that employers which aim to increase their labour supply by recruiting women from the older age groups would need to make provisions for flexible working (Guy & Gould 1989) - as described in chapter three - to reduce the barriers to working for women with children. For instance, in the late 1980s a higher proportion of women over the age of thirty worked part-time compared to full-time, and the presence of dependent children is a significant factor associated with part-time working (cf. Breeze, Trevor & Wilmot 1991: 58). The minority ethnic groups in Britain will also potentially provide an increasingly significant source of labour in the 1990s, as their age profile is

younger in comparison to the 'white' population. For instance, on average for the years 1987-89 over one-third (34%) of the "ethnic minorities" as a whole were aged under sixteen years compared to under one-fifth (19%) of the white population, and whilst the "ethnic minority" groups accounted for 4.7% of the population overall, they accounted for nearly twice the proportion (8.03%) of under sixteen year-olds (U.K. 1991b: 25). Hence they will provide a growing pool of young potential workers.

Many individuals, though, who constitute the potential sources of labour supply have faced barriers to their participation - in terms of both quantity and quality - in the labour market. In the case of the NHS some of the barriers affecting women and members of black minority ethnic groups were illustrated in the discussion in chapter one of the exclusionary processes characteristic of the politics of racism and patriarchy at work. One way of increasing the recruitment of individuals from those groups, therefore, is for employers to remove the barriers to their participation. Accordingly - with regards to barriers of 'discrimination' - the Secretary of State for Employment in 1988 - Norman Fowler - recommended in the preface to the Employment Department's White Paper *Employment for the 1990s* that:

> We must prevent discrimination in recruitment and employment on grounds of race, sex, disability or age, which hinders the best use of the country's human resources at a time when the population of working age is hardly growing. (U.K. 1988a: 4).

In the case of "ethnic minorities" specifically, the White Paper argued that:

> Discrimination against ethnic minorities by employers is not only unlawful but it is also against their own commercial interests to cut themselves off from a source of skilled or potentially skilled labour. (U.K. 1988a: 8-9).

Measures to prevent discrimination are only one aspect of an equal employment-opportunities policy - as discussed in chapter three. Other policy measures concerned with flexible working and support for working parents, for instance, would additionally remove

some of the barriers inhibiting the labour market participation of women in particular. Accordingly, the White Paper, also argued that employers:

> will need women employees, and must recognise both their career ambitions and domestic responsibilities. This will involve broadening company training policies, much more flexibility of work and hours and job-sharing, to facilitate the employment of women with families and help adapt to their needs. (U.K. 1988a: 8).

In short, the White Paper explicitly established a connection between the provision of equal employment-opportunities and the recruitment of labour in the context of a shortfall of traditional sources of recruitment. The same connection was consistently made for the NHS by politicians leading the Department of Health in the late 1980s and early 1990s. For instance, the Minister of Health in May 1989 - David Mellor - on the launch of a "Management Guide" to the implementation of equal employment-opportunities policies in the NHS (NHS Training Authority 1989) explicitly drew the connection between equal employment-opportunities policies and maintaining the supply of labour by warning Health Authorities which failed to provide equality of opportunity for female and minority ethnic staff that they faced a "staffing crisis of unprecedented proportions." He stated that:

> Equal opportunities is not just about social justice - important though that is. As every good employer well knows, equal opportunities has a more practical dimension, namely securing a future workforce in terms of numbers and quality and making the best use of our most valuable resource - our staff...//...As a labour-intensive organisation, the looming shortage of staff - especially skilled - must surely be one of the greatest challenges confronting the NHS over the next decade...//...equal opportunity must be addressed as part of mainstream management practice to ensure the NHS attracts and keeps the staff it needs to meet the demand placed upon it...//...Unless that is done quickly the service could find itself confronting a staffing crisis of unprecedented proportions. That is why in the short time still available managers must give this matter their full and urgent attention. (U.K. Department of Health 89/190).

Nearly three years later, the then Minister for Health - Virginia Bottomley - stated

publicly in promoting the equal opportunities initiatives of the "Opportunity 2000" campaign in the NHS that it was 'not a philanthropic exercise...but enlightened self-interest' (Bottomley 1992). The Department of Health launched a number of major equal employment-opportunities initiatives for women in the NHS in 1991 and 1992, and they were promoted primarily both on the grounds of recruitment and retention of female labour, and an efficiency argument concerning the most cost-effective use of labour. For instance, at the launch of the "Women in the NHS" initiative in June 1991 (U.K. Department of Health H91/278) Virginia Bottomley argued that:

> The NHS employs more people and more women in particular than any other organisation in Europe. As demographic changes intensify competition for the best school-leavers, the NHS must be in the forefront. It must become a by-word for good 'women friendly' employment practices. (U.K. Department of Health H91/285).

Similarly, in October - shortly before the establishment of the NHS "Women's Unit" in November 1991 (U.K. Department of Health H91/520) - the Health Minister again argued that:

> Equal opportunities is not just about social justice - important though that is. As every good employer knows, equal opportunities has a more practical dimension. It is about securing the right number of qualified staff to meet future needs. It is about making the best possible use of our most valuable resource - our workforce. (Department of Health H91/495).

The contribution made by equal employment-opportunities policies to the efficient use of human resources was emphasised by Duncan Nichol - the Chief Executive of the NHS - in the NHS Management Executive's "Good practice handbook" for "Women in the NHS" - launched in October 1991 (U.K. Department of Health H91/495) - who stated that:

> The NHS employs more than a million people. Over 75 per cent of these are women. Managers have a clear business responsibility to ensure that they make the best possible use of these valuable people. The Health Service simply cannot afford to lose these skilled and expensively trained staff. It ought to be leading the way in implementing employment and career progression policies which are not only compatible with the

> particular needs of women staff, but which also make sound business sense. This is a necessity if we are to continue to recruit and retain the services of good quality staff. that is why we at the centre are committed to a policy of improving opportunities for women across all disciplines and at all levels. (U.K. 1991c).

In short, the provision of equal employment-opportunities results in the most efficient use of human resources. In theory, an equal employment-opportunities policy ensures - by equalizing opportunities for competition, and appointment on the basis of merit, that the best - or the most competent - person is appointed for a job. The human aspect of the productivity of the job is therefore maximised, and the productivity of the organisation as whole is also maximised as it will consist of an aggregate of the most competent individuals. On the other hand, if the most able individuals are excluded from jobs due to prejudice or other processes of exclusion as discussed in chapter one then the productivity of particular jobs and the organisation as a whole will be reduced. It clearly makes good business sense therefore (Confederation of British Industry 1981: 308), or in the case of public services the best - or most efficient - use of human resources to appoint the most competent person for the job. Whilst this 'efficiency principle' has been a central justification expressed in exhortations for policy implementation at the macro-level, it has also been echoed at the micro-level. For instance, one personnel specialist in East Thames Health Authority stated - when interviewed - that:

> I actually equate equal opportunities with good management practice, and I believe that good managers will actually be equal opportunity managers...//...You're going to discriminate, but on reasonable, justifiable grounds ie. it's the best person, or the person for that particular need at that particular time. That's good management practice. (R44)

Such a justification would also appear to appeal to the instinctual priorities of managers which was illustrated by another personnel specialist who reported that they "sold" the equal employment-opportunities policy on the basis of "good management practice" as

"most managers would agree with this" (R42).

The equal opportunities policy process - at the macro level - for the NHS in the late 1980s and early 1990s has been characterised by a consensus amongst the key players in the process in relation to the stimulus for policy implementation. The consensus has been remarkable as some of the organisations involved bring competing interests to the policy process. Groups established to develop equal opportunities expertise for the NHS - the National Steering Group for Women in the NHS and the King's Fund Equal Opportunities Task Force - the Equal Opportunities Commission, the training arm of the NHS Management Executive - the NHS Training Authority (latterly the NHS Training Directorate) - and the trades unions have all argued that the implementation of equal employment-opportunities policies by Health Authorities is essential - in the context of the labour supply crisis - to retain existing staff and attract additional sources of workers. For instance, in its guide for the implementation of equal employment-opportunities policy in the NHS the National Steering Group argued that:

> The NHS has to adapt its policies if it is to cope with the changing labour market. It has to make itself more attractive as an employer in order to attract the maximum number of recruits; it has to broaden its pool of potential recruits by employing mature women, more men and more members of the black and ethnic minority communities. It will need to retain the services of existing staff by reducing wastage and attracting back those who have left. (National Steering Group for Women in the NHS 1989: 7).

The National Steering Group also argued that:

> Our recommendations have to be taken seriously if for no other reason than to see the NHS staffed in the 1990s. (National Steering Group for Women in the NHS 1989: 1).

Similarly, the National Health Service Training Authority in its "Management Guide" to the implementation of equal employment-opportunities policies observed that;

> The impact on the NHS, both in terms of skill shortage and skill mix, will be dire, unless immediate action is taken to address the issues. Equal opportunity can no longer be seen as something only to be attempted in the name of social justice. It must be addressed as part of mainstream management practice, designed to ensure that people with potential are attracted into and retained within the service, irrespective of their background. (NHS Training Authority 1989: 9).

Likewise, in the preface to the "Management Guide" the Chair of the NHS Training Authority made it clear that:

> Equal opportunities is thus much more than natural justice, it is a practical imperative to assist managers in resolving staffing issues and improving service delivery. (NHS Training Authority 1989: 3).

A focus on the labour and skills shortage has also significantly been at the centre of the Equal Opportunities Commission's strategic plan for the 1990s, and their strategy of intervention in the NHS in particular. In specifying their strategy for the 1990s the Commission hailed a new era in their approach to equal opportunities by planning a shift in strategy from moral exhortation for policy implementation to a more persuasive approach by profiling the potential contribution of women in the labour market in the context of the projected shortage of young workers. In their strategy document *From Policy To Practice* the Commission announced:

> Our strategy focuses more directly and with greater priority on the task of making fully available to society the skills which women can provide. We shall change from being an organisation largely engaged in securing equal rights for women into a body which can also play a major role in achieving central national economic objectives through the implementation of effective equal opportunities practice. (EOC 1988)

In emphasising the connection between equal employment opportunities and the supply of labour, the Commission observed that:

> Far-sighted employers, who already see the advantage of good equal opportunities practice, will continue to respond to encouragement and advice about ways of attracting and retaining skilled and experienced employees. (EOC 1988: 1).

The tenor of the Commission's strategy document is that the "demographic time-bomb" has provided the most expeditious moment for persuading employers and policy-makers to establish equal employment-opportunities practices and improve the material position of women in the labour market. The new strategy of the Equal Opportunities Commission for the 1990s coincided from 1990 with the Commission's strategic focus on the NHS. That focus was part of a continuing strategy of concentrating their efforts on one distinct area of employment after another, and prior to the NHS employment in police forces in Britain had been targeted for attention. The interest in the NHS appeared to have emerged ( in addition to the obvious consequences of the demographic timebomb because the NHS is such a large employer of women) from the involvement of the Chair of the EOC in 1988 - Baroness Platt of Writtle - in meetings with senior Health Service managers via the Royal Institute of Public Administration where she learnt about the slow progress of equal opportunities policy implementation in the NHS. Although there was no regular formal liaison between the EOC and the Department of Health Baroness Platt subsequently approached the then Health Minister Barney Hayhoe to push for top level commitment to policy implementation by the Department. It appears that there was some surprise in the Commission at the apparent "hands-off" approach to equal opportunities in Health Authorities by the Department of Health, and according to the EOC's Director of Development Patrick Walker - in his speech at a King's Fund seminar in May 1990 - the Commission was attempting to take a "strong line" with Ministers with the "intention to keep up pressure from the top downwards on the whole issue of equal opportunities." In keeping with the EOC's strategy for the 1990s their approach to the NHS was to focus on the potential labour and skills shortage and the subsequent contribution that could be made by women. One influential aspect of the EOC's focus on the NHS - in relation to

the course of the macro policy process - was a survey and subsequent report published in August 1991 of the extent of equal employment-opportunities policy implementation by Health Authorities across the NHS, which demonstrated that the NHS as a whole had still much to achieve (EOC 1991). According to one respondent from the Department of Health (R8) the Department wanted to be seen to "do something" before the survey findings were made public, and the Personnel Directorate of the NHS Management Executive commissioned the Office for Public Management to produce a report which detailed the experience of women workers in the NHS, initiatives taken, and a strategy to improve the position of women overall (Goss & Brown 1991).

The apparent value of an equal employment-opportunities policy in relation to the recruitment, retention, and the most efficient use of labour, has also been a prominent argument behind policy exhortation from the NHS staff-side organisations. The National Union of Public Employees (NUPE) - for instance - in its submissions to the Nursing Staff, Midwives and Health Visitors Pay Review Body (cf. NUPE 1989, 1990) has argued - as well as emphasising the importance of pay to the recruitment and retention of staff - in the case of women workers that:

> the NHS must attract experienced nursing staff back to the service and recruit women returning to work after bringing up children. But competition for women, particularly women returners, will grow fiercer through the 1990s, as industry and commerce also look to recruit from these labour sources. Those employers who can offer women career development opportunities, and a flexible pattern of work to fit in with their domestic commitments, will be the most successful in the competition for employees. (NUPE 1990: 3-4).

In the case of black minority ethnic nurses NUPE has also argued that:

> The NHS will also need to tap into non-traditional recruitment markets. This means reversing the growing shortage of black and ethnic minority nurses, by checking their departure from the NHS, attracting back those who have left, and encouraging more young black people into nursing. (NUPE 1991: 4).

There has also been a consensus between the union and NHS management with regards to the 'efficiency principle' behind equal employment-opportunities policies as the union argued that:

> Sex and race discrimination represent an inefficient use of resources, because the skills and expertise of many nurses are not being fully utilised...Improving equality of opportunity in the NHS is a sound investment. (NUPE 1991: 5).

To summarise the potential labour supply benefits of equal employment-opportunities policies, the supply of labour will increase as a policy can in theory remove discriminatory barriers facing particular groups through the formalisation of the recruitment and selection process, and remove barriers inhibiting the labour-force participation of women with children through the provision of flexible working arrangements and child-care support, thereby making employment accessible to an under-employed pool of labour. The implementation of an equal employment-opportunities policy may also promote the favourable image to potential employees that employment conditions within the organisation are "fair and equitable" (NHS Training Authority 1989: 10), and thereby the organisation may appear more attractive to women and minority ethnic applicants (National Steering Group for Women in the NHS 1989: 7) when compared to other organisations without policies. Such attractive employment conditions may also improve the retention of employees. An equal employment-opportunities policy also ensures in theory that the best use is made of an organisation's human resources in that individuals do not face barriers to contributing their full potential, and thereby the most efficient and cost-effective use is made of employees.

## Recruiting black health workers

There has been an additional - and prominent - utility argument used during the late 1980s to justify the implementation of equal employment-opportunities policies in the NHS. The argument has concerned improvements to health service delivery to black minority ethnic communities by increasing the responsiveness of services through the recruitment of health workers from the communities concerned. Accordingly, the implementation of equal-employment opportunities policies has been regarded as a significant measure for the recruitment of black minority ethnic health workers. Such an outcome would represent an important utility of equal employment-opportunities policy, as health care provision by the NHS to black minority ethnic groups has been strongly criticised. In relation to health care in the 1970s, Brent Community Health Council (CHC) argued - for instance - that the culture and specific needs of black people had neither been acknowledged nor catered for by the NHS. It argued that black patients had been treated with "contempt" as there had been little recognition and special provision for different dietary needs, few provisions had been made for interpreters for Asian patients for instance, who also "found themselves ridiculed when their way of naming led to confusions in their records." (Brent CHC 1981: 8). From an even more controversial perspective the NHS was - according to Brent CHC - involved in the State's efforts to control the number of black people in Britain through the promotion of contraception in the context of State sponsored fears about Britain being swamped by people from alien cultures - in other words fears characteristic of the "new racism" as discussed in the introduction to the thesis. Brent CHC claimed that "More leaflets have been produced in Asian languages on birth control than any other topic". Additionally, some black women reportedly felt that they had been offered abortions and sterilisations more readily and

more frequently when compared to white women, and it was also alleged that the controversial - and now banned - contraceptive injection - depo-provera - was similarly offered more readily to black women (Brent CHC 1981: 21-22).

In relation to the response of the NHS to the health-care needs of black minority ethnic communities in the 1970s, most of the energy - according to Brent CHC - was expended on health education programmes aimed at the Asian community, thereby focusing on the community itself rather than improvements in health services. In addition, the professional training of health workers and the material on which the training was based was allegedly permeated by distortions and negative representations of black people (Brent CHC 1981: 13 & 14). The provision of health services for black minority ethnic communities in the 1980s has also been strongly criticised. With regard to psychiatric services in particular concerns have been expressed about the possibility of misdiagnosis arising from the cultural gap between many psychiatrists and black clients (CRE 1991a: 8-9). It has been additionally argued that black cultures have been regarded as pathological, as the source of psychological problems (Black Health Workers and Patients Group 1983: 54), and there has allegedly been a lack of understanding of the role of racism in the aetiology of mental illness as, at best, health services have been slow to respond and, at worst, the psychological impact of racism has not been sufficiently recognised (Burke 1984 :1, Health & Race 1986: 1). Mc.Naught (1984: 24-27, 1988: 58-59) has presented a synopsis of additional alleged 'discrimination' faced by black people at the hands of health service professionals. In relation to nursing care it has been alleged that black patients have been treated in an "offhand" manner; subjected to derogatory comments; and administered unnecessary medication. With regards to medical treatment, it has been alleged that diagnosis has sometimes failed to account for cultural

aspects of illness; black patients have been offered little or no explanation about their conditions; they have often been assumed to be hypochondriacal; and treatment has been both delayed and inappropriately administered without necessary consent. McNaught observed that:

> Many of these problems are not specific to ethnic minorities. The NHS has a poor track record for 'user friendliness'. As such what distinguishes poor treatment for minorities is that they seem to receive it as a result of their racial, cultural or ethnic origin, as opposed to their other personal characteristics. (Mc.Naught 1988: 58-59).

In addition to these criticisms the National Association for Health Authorities in 1988 argued that few Health Authorities had provision for the needs of minority ethnic groups in their planning and delivery of service (National Association of Health Authorities 1988: 8).

In the light of the criticisms of the NHS with regard to the provision of health services for black minority ethnic groups there appears to be an obvious need in relation to improving understanding and sensitivity for a strong representation of health workers from those groups. That need provided a central justification for the implementation of equal employment-opportunities policies for a number of managers interviewed in the two case-study Health Authorities. For instance, a personnel specialist interviewed in East Thames District stated that:

> how can you provide for the local community a service that relates to that community if you are not employing staff that reflect the community to start with. The extreme is to say that you have a 50% black - 50% white community, and you have 100% white labour force. It's got to have implications at the very basic most simple level for black people who are coming to be treated there. Why aren't they being treated by black people ? It would be the same if it was all blacks being employed. (R43)

Similarly, when asked how they justify the implementation of an equal employment-opportunities policy, another personnel specialist in the District stated:

> I feel that we have a responsibility to ourselves to do as much as we can to make sure that we make service delivery and our staff that give that delivery a very equal service and that we try and mirror the needs of patients and clients by providing them with the service they want and making that accessible to them as much as we make them part of the service. (The Health Authority) should employ where it can a firm proportion of local people because I think that local people will have skills, will have an understanding of the people they're dealing with. (R39)

One of the line managers interviewed felt so strongly about the value of employing staff from minority ethnic groups in relation to service provision, that they were prepared to discriminate illegally in their favour:

> I would positively discriminate to try and get into the service people from minority groups...//...for instance, this week I was telephoned by a woman who was an Indian (health worker) who was not fully qualified to work here, and wants a job to work for six months, and then to take further qualifying exams in this country...I've encouraged her to apply, and I'm sure she will, and if at the point of interviewing, I was interviewing her alongside an English speaking person, I would positively discriminate in her favour because I am so anxious to up the minority representation in my staff group, and similarly I would for people from the background of many of the people that we serve round here. (R54)

Another line manager justified the recruitment of minority ethnic health-care workers in clearly instrumental terms in relation to the performance of his department:

> I think it's absolutely crucial, even if we didn't believe in it (equal opportunities) from a proper and professional and personal point of view, for very practical reasons, of getting the job done, job done more efficiently, safely and quickly and conveniently, one must be able to communicate and understand the patients and clients. So even if we were prejudiced, or some of us were, if we didn't have that it would be a major inconvenience to our job. (R64)

The need to employ health workers from black minority ethnic communities - to increase the sensitivity of services to those communities - has also been increasingly recognised by the NHS management. Barriers to communication - both linguistic and cultural - between members of Asian communities and health service workers were highlighted in the early 1980s during the *Stop Rickets Campaign* funded by the Department of Health

and Social Security and targeted on the Asian communities in Britain. The aim of the campaign was to reduce the incidence of rickets amongst those communities through a health education programme aimed at increasing the intake of vitamin D. It was apparent to campaign workers that many individuals in those communities lacked a clear understanding of the extent of NHS services available to them, and similarly the work of many Health Service professionals was hindered by their lack of understanding of Asian cultures. It was recognised that the employment of health workers with appropriate language skills would improve the delivery and access to health care and it was recommended - in the campaign report - that effort should be made - with regard to the recruitment and training of Health Service professionals - to increase the numbers of health visitors, school nurses and midwives who could speak Asian languages (Save the Children Fund 1983: 14-19). The recruitment of health workers from the Asian communities - and hence sharing the same language and cultural background - was a central element of a further campaign - the *Asian Mother and Baby Campaign* - organised and funded by the Department of Health and Social Security in the mid 1980s. The origins of that campaign lay in the apparent gap between need and service provision indicated by the earlier *Stop Rickets Campaign.* The *Asian Mother and Baby Campaign* recognised that "racial stereotyping" by health service professionals in addition to cultural and language differences between potential user and service provider resulted not only in inappropriate service provision, but also discouraged the use of services (U.K. 1987: 12). The employment of eighty "link-workers" initially funded for two years by the Department of Health and Social Security as part of the campaign was intended to improve communication and understanding between Health Authorities and Asian communities thereby improving the health care of those communities.

In addition to the employment of specialist workers, it has been proposed by politicians leading the Department of Health - and others with potential policy-making influence - that the implementation of equal employment opportunities in general will lead to improved and more sensitive provision of health services to black minority ethnic communities. For instance, in opening a "Management Seminar" on "Ethnic Minority Health" in 1987 organised by the Department of Health and Social Security, the Minister for Health - Tony Newton - after stating the "Government's" commitment to equal employment-opportunities in the NHS, claimed that:

> We are committed as deeply to equal opportunities in service delivery. The two are obviously closely linked. No-one would wish to move to a situation where patients were treated only by staff of their own ethnic group. But an NHS which has developed an equal opportunities policy in employment is likely to be - and to be seen to be - more ready to promote equal access to services. And an NHS where there is a better ethnic mix across the hierarchy will be better equipped to identify and remove obstacles to equal access. (U.K. 1988b: 2).

Similarly, in introducing its' "model" equal opportunities policy the King's Fund Equal Opportunities Task Force asserted that:

> We believe that by ensuring equal opportunities in employment for ethnic minorities, authorities will be better placed to improve the delivery of service to minority racial groups. We believe also that the Health Service must benefit from using to the full all the potential talent and experience available from the whole community. (KFEOTF 1987: 3).

The National Association of Health Authorities also clearly drew the connection between equal employment-opportunities and improvements in health-care delivery by arguing in 1988 that:

> real improvements in service provision for black and minority ethnic groups in the NHS can only be successful if parallel measures are taken on equal opportunities in employment.
>
> An effective way of making health services responsive to the needs of a multi-racial and multi-cultural population is to ensure that members of minority ethnic groups are employed at all levels in the health service and thus involved automatically in the planning, management and delivery

of those services. (National Association of Health Authorities 1988: 10).

In summary, the essence of the connection between equal employment-opportunities policies and improvements in the delivery of health care to black minority ethnic groups is that through the removal of barriers to the employment of individuals from minority ethnic groups their representation in the workforce will increase and health services for their particular communities will consequently improve because of the increased understanding their presence brings of the needs of their communities.

**Morality: a barrier to equal employment-opportunities**

In the preceding analysis of exhortations for the implementation of equal employment-opportunities policies in the NHS in the late 1980s and early 1990s moral considerations have not been mentioned. This is because they have barely been in evidence. This conclusion was supported by one of the informants (R2) from the Department of Health who greeted my question about the possibility of a moral influence with cynical laughter. Indeed there was a general consensus amongst my informants that moral considerations have played little part in the policy process. At first sight, this might appear to be a curious phenomenon, particularly in the context of the discussion of the moral foundation of policy in chapter three in which it was argued that the principle of equal opportunities is rooted in notions of social justice. Yet the arguments for the eradication of discrimination against women and black workers in the NHS, and the removal of barriers to participation in paid-work - affecting women in particular - have not been concerned with social justice - or, in other words, concerned with the just treatment of individuals - they have been concerned with recruitment, retention, efficiency, in short a "sound investment" and "good business sense". Whilst it might be argued that the maintenance of an adequate labour-supply to meet the demand for health-care services,

and the most efficient - or cost-effective - use of that labour, are ultimately concerned with social justice in the shape of meeting needs through the provision of health-care, they have nothing to do with the intrinsic morality behind the principle of equal opportunities. The irony, in the case of the NHS, therefore, is that an essentially moral policy has been promoted on 'immoral' grounds.

The use of 'immoral' arguments for the implementation of equal employment-opportunities policy in the NHS suggests an inherent paradoxical barrier to policy implementation. That is, appeals to morality alone are not enough. A number of my informants for the research had already drawn that conclusion themselves. For instance, one respondent (R7) suggested to me that evidence of discrimination and disadvantage affecting women at work would have little impact on the practices of many health service managers as they would rationalise the differential structural distribution of male and female workers by explanations characteristic of patriarchal common sense - as discussed in chapter one. The same could probably be said about the potential impact upon managers of evidence of 'race' discrimination and disadvantage. A further respondent - from the Department of Health - suggested that it is a question of "power relations" and argued that "You cannot expect powerful men in an organisation to give up power just on a moral argument." (R8). In short, the more entrenched are racism and patriarchy at work, the less likely it is to be implemented. The moral arguments - according to another respondent (R9) - appeal to the "idealists" who are the "innovators" in relation to equal employment-opportunities policy. But the "innovators" cannot secure the commitment of others by employing solely moral arguments. According to one respondent they have to use a language that others will listen to. Accordingly, in the case of the Equal Opportunities Commission, the strategy of promoting policy implementation on the

grounds that it is necessary to attract and make the best use of the health service labour force in the presence of a shortage of labour and skills, appears to have been an attempt to use a language that Health Service managers will both understand and listen to. The strategy was a response to the feedback from some Health Service managers to the EOC that the commitment of managers in general was more likely to be secured by a 'business' argument - by appealing to their "pragmatic instincts" (R5) - rather than a moral argument. In this context, the demographic dip provided a "sweet gift" (R7) to the EOC in their pursuit of equal opportunities. As Patrick Walker - the EOC's Director of Development - stated at a King's Fund seminar in May 1990:

> People tell us one way of getting through to managers is to talk about skill shortages, but as far as we are concerned we are talking about equal opportunities.

This would seem to be a perfectly rational and effective strategy, as what better time - another respondent (R2) in the Department of Health suggested - to push for equal opportunities policy when there is a labour shortage ? Likewise a further respondent in the Department of Health reported that:

> The moral issue is still rather a minority support amongst Health Service people, but there is a strong recognition - and quite a lot of people probably wouldn't be giving the thing priority on moral grounds - that we do need to tackle it on recruitment, retention, and best use of skills grounds...So we began with a social approach to it if you like, and that's gradually moved over time to there being a very strong recruitment, retention etc, basis to it, and frankly that's getting more done than any amount of preaching. (R4)

The need for this deliberate pragmatic strategy had already been recognised by the National Steering Group for Women in the NHS in the late 1980s, as in introducing its guide to the implementation of equal employment-opportunities policies in the NHS, the Chair of the Steering Group - Victor Flintham - reported that:

> The Group started work in earnest in 1986 and from the beginning adopted

> a pragmatic, rather than a philosophical, approach to its work. It seemed to us that appeals for positive action from the NHS management would only succeed if we focused on managerial needs and concerns. (National Steering Group for Women in the NHS 1989: 1).

There appears then to have been a conscious strategy to promote the implementation of equal employment-opportunities policies in the NHS by the use of utilitarian - or 'immoral' - arguments, primarily, as discussed in the analysis, in relation to the recruitment, retention and most efficient use of labour, and the effective provision of health services to black minority ethnic communities. For some participants in the policy process - such as the EOC - the strategy appears to have been expeditious when recognising the limitations of moral exhortation, although morality implicitly remained the primary concern. The analysis of policy exhortation in the NHS appears to indicate therefore that the implementation of equal employment-opportunities policies is an opportunistic process utilising policy imperatives that are divorced from the moral concerns behind the principle of equal opportunities. When morality is the sole stimulus, therefore, a significant barrier faces policy implementation. That barrier is rooted in the paradox of equal opportunities, that is, in the context of racism and patriarchy at work, the more a policy is needed on moral grounds, the less likely it is to be implemented, unless 'immoral' arguments can be brought into play.

# CHAPTER 7

## MONITORING FOR EQUAL OPPORTUNITY

The introduction to the thesis specifies the dimensions of the concepts of racism and patriarchy used in the thesis. They are conceptualised as interacting systems of dominance which have both a structural and a political character - as illustrated in chapters one and two - producing a cycle of dominance in which the relative political impotence of black and women workers enables the functioning of processes which reproduce structural and political inequality across the workforce. Some of those processes - as demonstrated in chapter one - are mechanisms of inclusion and exclusion which have an ideological basis. Other processes, in contrast, have no ideological basis at all yet they also make a significant contribution to the systems of dominance. This chapter focuses on those processes at the micro level. The non-ideological processes singled out for attention perpetuate and sustain the structural and political character of racism and patriarchy at work by inhibiting measures designed to challenge the systems of dominance. They are themselves, therefore, integral aspects of the systems of dominance at work. Specifically, the chapter focuses on processes at work which have interfered with the establishment of a job applicant monitoring system in both the case-study Health Authorities - although as the system was far more advanced in East Thames there is a bias in the material presented towards that Authority.

One of the chief objectives of an applicant monitoring system is to present a deterrent to the mechanisms of inclusion and exclusion which reproduce and sustain the systems of dominance. In chapters three and four - in the discussion of the dimensions of an equal employment-opportunities policy - it was argued that the main pre-condition for the continued operation of racism and patriarchy at work is the lack of accountability - and the informality - affecting the decisions made by line managers in the selection and promotion of staff. It was further argued that the statistical monitoring of the outcome of those decisions provides a significant instrument for making managers more accountable. The chapter presents an analysis of the experience of both case-study Districts in establishing and implementing such a monitoring system. At the outset, however, it should be noted that despite good intentions neither District had succeeded in establishing an effective system and they had therefore failed to establish significant measures which would inhibit racism and patriarchy at work.

The dimensions of an ideal applicant monitoring system and the theory behind its effectiveness shall be discussed first by drawing on the policy objectives of East Thames District Health Authority. An analysis will then be made of the reasons behind the failure to implement effective systems in both Districts. The material subjected to analysis is derived from three sources; observations made whilst present in the organisations and attending meetings in the Districts; interviews with personnel specialists; and policy documents and records of the Equal Opportunities Committee meetings in East Thames District. From the analysis of this material it will be argued that the successful

implementation of an applicant monitoring system depends upon the interaction - primarily - of three elements. These are; the **cooperation** of job applicants and personnel staff; the availability of the necessary **expertise and resources** for the operation of the system; and the **commitment of policy makers** to the full implementation of the monitoring system. The failure of any of these elements will result in the failure to implement the monitoring system as a whole, and it will be observed that each of the elements did indeed fail in both of the case-study Districts.

### The ideal job applicant monitoring system

The phrase 'job applicant monitoring system' is used here to refer to the statistical monitoring of the outcome of decisions concerning the selection and promotion of employees on the basis of sex and ethnic origin. It is necessary to make this definition clear at the outset as in common sense interpretations of equal employment-opportunities policies and in the literature containing policy prescriptions such a system is commonly connected to the process of making an audit of a workforce under the one title of "monitoring". However, both in practice and in objective, job applicant monitoring and a workforce audit are quite separate activities - as will be made clear in the discussion to follow - although the difference has not been emphasised in policy prescriptions (cf. CRE 1980: 2, KFEOTF 1989b: 6).

The principles of a workforce audit will be discussed further below and attention is solely given at this point to an applicant monitoring system. The objective of such a system is to make a comparison between the collective experiences of different groups of

job applicants (eg. female and male, black and white) to determine whether one group is more successful in attaining employment than another. If differences are discovered then the next step would be to evaluate whether or not they can be supported by differences in the characteristics of job applicants in relation to job requirements. That step would involve an analysis of records made of the selection decisions for each applicant for the jobs in question. Therefore - to return to the statistical monitoring - it will not in itself indicate whether discrimination has occurred, but it will provide prima facie evidence of discrimination which can then be subject to further scrutiny. (The function of applicant monitoring was spelt out by the Court of Appeal in their judgement in the case of the West Midlands Passenger Transport Executive versus Singh (18.3.1988). The Court ruled that: "Statistical evidence may establish a discernible pattern in the treatment of a particular group: if that pattern demonstrates a regular failure of members of the group to obtain promotion to particular jobs and to under-representation in such jobs, it may give rise to an inference of discrimination against the group." (EOR 1988: 36).)

According to one personnel specialist I interviewed, the process of applicant monitoring makes managers more accountable for their decisions:

> It depends upon how we actually use the data, let's say that we might have a feeling that there is a potential for discrimination in a particular hospital or a section, and we might produce information that can never prove it, but might indicate that there is perhaps a tendency, and we will then say to the manager "interesting to see that you've had X applications from Y ethnic origin, could you justify why you...aren't taking anybody from that category on ?" So it's making people more accountable, making managers more accountable for their decisions. (R43).

It follows, therefore, that the potential benefit of job applicant monitoring is not only that

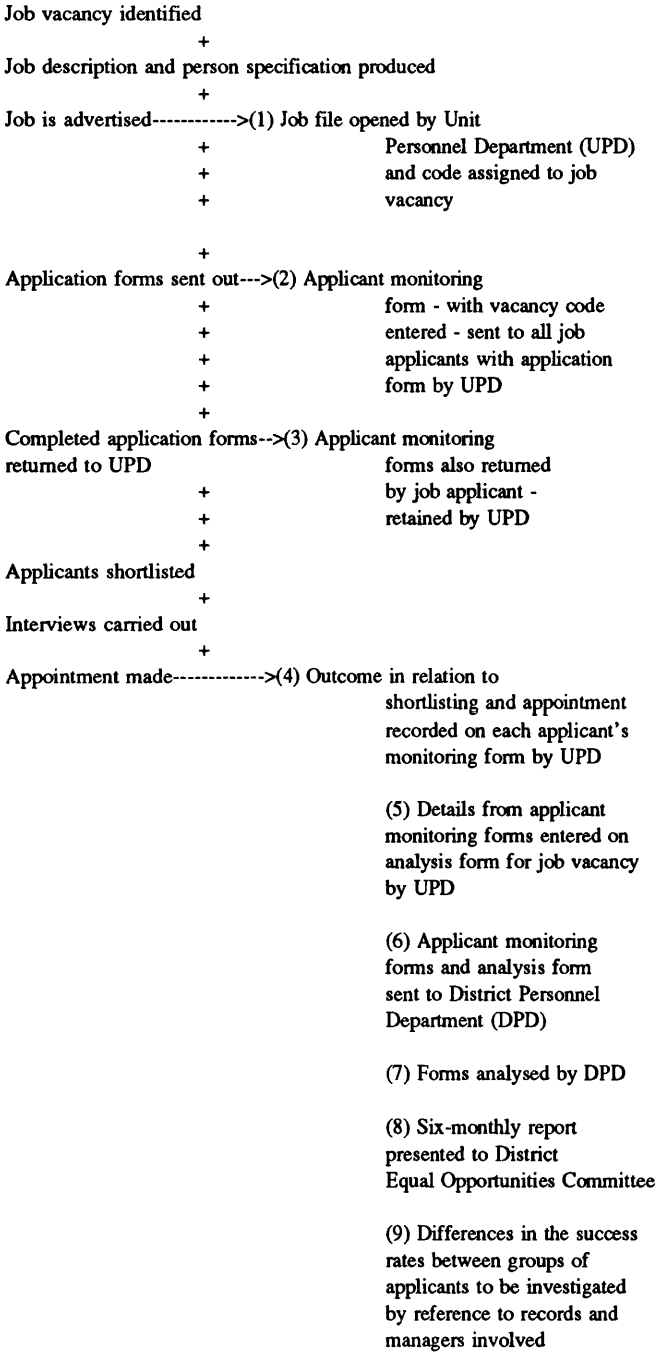
it indicates where discrimination might be at work but perhaps more importantly it will also serve as a deterrent to discrimination as managers will be aware that they might have to account for their selection decisions. The benefits are dependent - of course - upon the effective operation of the monitoring system.

A summary of the principles of the system proposed in East Thames District is presented in figure 21. It is adapted from an organisational chart produced by the District personnel department (DPD). When the fieldwork began in East Thames District (January 1990) their existing equal opportunities monitoring system had been in operation since April 1988. The data necessary for the statistical monitoring of selection decisions were requested from all job applicants on an applicant monitoring form which is sent with job application forms to all prospective applicants responding to advertised vacancies for employment. The monitoring form requested details of the applicant's ethnic origin, marital status, sex, age, any registered disability, and the source by which the applicant found out about the vacancy. The form was a revision of an earlier version which only requested details of ethnic origin. An appeal is made on the form for the applicant to provide the information requested, and the appeal alludes to the accountability value of applicant monitoring by suggesting that the information will help the Health Authority achieve its aim of ensuring that no job applicant receives less favourable treatment than others. Applicants are requested to complete and return the monitoring form along with the job application form to the Unit personnel department (UPD) for the unit in which the vacancy occurred. The intention was that the monitoring forms would not be seen by any

person involved in the shortlisting or the selection of applicants for the particular job in question. (There appears to be a difference of opinion amongst policy prescriptions concerning the accessibility of the monitoring information in the selection process. In contrast to the practice in East Thames District the Commission for Racial Equality recommends that the ethnic monitoring question is grouped together with other questions about personal characteristics on the job application form, but separate from the questions concerning employment characteristics. The CRE argues that "There is no evidence that the inclusion of ethnic data on the form encourages prejudiced managers to reject people on racial grounds, while it is probably the case that this method results in a higher response rate from applicants." (CRE 1991b: 22). The CRE observes that employers prefer to include the ethnic monitoring question on the application form because - amongst a number of reasons - a separate monitoring form involves extra administration and an implication that "line managers are not to be trusted". However, the CRE's assertions appear to be speculative as there is no research evidence available to test the hypotheses).

Upon the appointment of a candidate - in East Thames District - the monitoring forms were collated and sent to the District personnel department along with another form completed by the UPD which served as a summary for the analysis of the characteristics of applicants in relation to shortlisting and appointments. The forms were then to be analysed by the DPD and six-monthly reports of the findings presented to the District Equal Opportunities Committee. Any observed differences in the success rates between groups of applicants would then be pursued with the line managers involved.

**Figure 21: Job applicant monitoring procedure**
**East Thames Health Authority**



In practice, however, the applicant monitoring system never actually operated as intended. Whilst the issuing, return and processing of the monitoring forms proceeded largely as planned up to and including stage 6 in figure 21, the forms had never been analysed and consequently no reports on the monitoring had been produced for the Equal Opportunities Committee. The completed forms - along with the analysis sheets - had simply been stored away without further scrutiny in a locked cupboard in the District personnel department. Therefore, at the beginning of the fieldwork in East Thames Health Authority recruitment monitoring forms with information provided by job applicants from almost the two previous years were stored away in the cupboard. The reasons for the failure of the system will now be considered.

**Cooperation of job applicants and personnel staff**

The effective operation of an applicant monitoring system depends in the first instance upon the cooperation of job applicants to supply the information required by the completion and return of the monitoring forms along with their job application forms. In the experience of East Thames District this did not present any difficulties as there was a high level of cooperation from job applicants. As part of my research agreement for access to the District the researcher assisted in the analysis of a small sample of the returned forms which was linked to a larger exercise of an audit of the whole workforce. Information for a sample of 36 appointments was selected for the analysis although - for reasons which will be explained shortly - it was only possible to analyze the data for 22 appointments. Out of 90 applicants for the 22 appointments in total, 88 (or 98%) returned

their monitoring forms. Whilst there was hardly any problem with their return, 36 (or 41%) of the forms were incomplete, but the majority of forms did contain the information on the key variables of sex (97%) and ethnic origin (99%). Cooperation with the system appeared to begin to breakdown, however, with the processing of the forms in the unit personnel departments. As indicated in the outline of the monitoring system above the role of the personnel departments in the District was to record which applicants - according to their characteristics - had been successful at the stages of shortlisting and appointment. It was only possible to analyze the 22 appointments, however, as this information was not provided by the unit personnel departments for the remaining 14 appointments. There was, therefore, a serious failure at this early stage of the system. But with hindsight this hardly seems surprising. As the monitoring forms were simply locked in a cupboard in the District personnel department apparently without further scrutiny it appears that the unit personnel departments were never asked to account for their omissions. In turn, there was therefore little incentive for them to meticulously pursue their role in the applicant monitoring system. This was not the only failure at this early stage of the system, as it also came to light as a consequence of the sample analysis that in one hospital in the District - in the case of nursing vacancies - the monitoring forms were not even being sent out to prospective applicants with the job application forms. (It is possible that this particular failure in the applicant monitoring system has also affected other Health Authorities as it was observed in the presentation of the mail survey findings in chapter four that only two-thirds of the Authorities that reported that they monitor the ethnicity

of job applicants included ethnic monitoring forms in their job application packs sent to prospective applicants. The remaining one-third of Authorities had either provided incorrect information concerning the establishment of a monitoring system or alternatively their systems were not fully operational across the organisation.)

In conclusion, it appears reasonable to speculate that these failures at the early stage of the applicant monitoring system would have been checked if the subsequent stages of the system had been fully implemented. It will now be argued, however, that in the case of East Thames District there appeared to be a lack of commitment to implementing the system.

### Commitment and the Equal Opportunities Committee

Both of the case-study Districts had established Equal Opportunities Committees, and in theory such committees can play a significant strategic role in the implementation of policy. For instance, an Equal Opportunities Committee can undertake a developmental role by providing the stimulus for the formulation and implementation of policy; it can provide a monitoring function by overseeing and subsequently ensuring the implementation of policy; and it can provide the mechanism to involve individuals with the relevant expertise and responsibilities in the equal opportunities policy process (cf. KFEOTF 1989a: 7-8). In short, an Equal Opportunities Committee potentially provides a significant element of the 'commitment' required for the implementation of policy and in chapter four it was observed - from the mail survey findings - that 36% of Health Authorities in the NHS with equal employment opportunities policies had established a

committee.

In East Thames District the author attended the bi-monthly meetings of the Equal Opportunities Committee over an eighteen-month period between approximately February 1990 and October 1991 and I was also allowed access to the minutes of previous meetings dating back to the first meeting in November 1987. On the basis of observations made during attendance at the meetings and from the scrutiny of the minutes the analysis concluded that with regards to the implementation of the applicant monitoring system the Committee failed to exercise any impact over the implementation of policy. It is not being argued here that the Committee failed to make any impact on the implementation of other aspects of the equal employment-opportunities policy, but it does seem fair to single out its role in the failure of the monitoring system as such a system is arguably one of the most important elements of policy. A number of reasons for the failure of the Committee will now be suggested.

One of the most significant reasons concerns the lack of expertise amongst Committee members with regards to the implementation of equal employment-opportunities policies. This should not be interpreted as calling into question the integrity of the Committee members but instead should be regarded both as an inevitable aspect of the 'functional specificity' of their professional roles and the underdeveloped state of equal employment-opportunities policies in the NHS and amongst employers in general. In essence, as the implementation of equal employment-opportunities policies has been a relatively recent phenomenon in the NHS few of the Committee members had been

involved overtly in the implementation of policy as part of their professional activities. Responsibility for the establishment of equal employment-opportunities policies appears to be firmly located within the personnel function in the NHS and other organisations, but again because the policies are a recent development few personnel specialists appear to have extensive experience of implementing the many dimensions of a policy. This lack of expertise was evident in the early activities of the Equal Opportunities Committee in East Thames District. For instance - in returning to the establishment and implementation of the applicant monitoring system - the Committee appeared to have got overwhelmed by the difficulties of identifying the appropriate resources for the operation of the system. For instance, the minutes of the first Committee meeting record:

> After general discussion it was agreed that the resource implications must be a prior consideration in this and all measures aimed at facilitating equal opportunities in employment. In particular it was suggested...that an effective monitoring system might require at least one dedicated employee to operate and maintain the system together with new or enhanced computer support facilities.

The meeting concluded that Committee members would forward comments on the proposed system to the personnel specialist coordinating the establishment of the monitoring system, and the proposed arrangements would be considered further at the next meeting. The minutes of that meeting in January 1988 record that the monitoring arrangements required further attention - in relation to the nature of the information and its use, presentation, and availability - before attention could be given to the development of appropriate computing facilities. With regard to those facilities the minutes of the following meeting in February 1988 record that the existing available computing facilities

needed to be assessed to determine whether they were suitable for the applicant monitoring. The next meeting - in March 1988 - was informed that new micro-computing facilities had been made available in the District personnel department which were capable of processing the monitoring information. The meeting agreed that a report on the findings of the monitoring should be produced every six months. In the event, however, despite the Committee having recognised the need for additional staffing for the monitoring, no extra provisions were made. The micro-computer was also never adapted to analyze the information returned on the monitoring forms. In the minutes of the subsequent Equal Opportunities Committee meetings there is no mention of any discussion of the recruitment and selection monitoring arrangements, and the issue - for the Committee at any rate - appears to have petered out.

One of the reasons for the failure to resolve the resources issue appears to have been an absence of the required expertise - both within the personnel function and amongst the representation of the Equal Opportunities Committee - in relation to the organisation of the monitoring system and particularly in relation to the computing requirements. The result was that the issue appeared to have got lost in the confusion. For instance, one personnel specialist observed:

> it's also like the blind leading the blind to a certain extent. You go there for some sort of, you know, this is our idea, this is what we'd like...and you don't come away with that. So you're actually saying "well I'm not really sure what I'm supposed to be doing now"...and I think that's always been the way really. (R44)

A recognition of the lack of expertise seemed to be implicit to the decision to appoint

an equal opportunities Adviser in September 1989. Nearly two years after the establishment of the applicant monitoring procedure - in March 1990 - one personnel specialist discussed their expectation with me that they were clearly looking to the Adviser to assess the monitoring system and identify the resources required. They stated that they expected the Adviser to:-

> assess as best she can what are the implications of doing monitoring properly, working out what the resource requirements are, developing training programmes, and putting it together in such a way as that there is a realistic prospect of success. (R43)

At the time of writing - Summer 1992 - that expectation had still not been fulfilled and the reasons why this was the case will be returned to shortly.

A further reason for the failure of the Equal Opportunities Committee in East Thames District in relation to the establishment of the applicant monitoring system is rooted in the general lack of authority that the Committee could bring to bear in the policy process. In both of the case study Districts the authority of the Equal Opportunities Committee was limited to an advisory function only. For instance, the sanction of the District Health Authority was required for the general policy initiatives whilst the personnel function exercised authority over the detail of policy and held responsibility in operational terms for policy implementation. Whilst historically the Directors of Personnel in post in both Districts when the fieldwork was first undertaken had been the chief source of equal opportunities policy initiatives in the mid-1980s and were personally responsible for their subsequent implementation, they had withdrawn from their lead role when some of the initiatives began to come to fruition. For example, in West Thames

District the operational responsibility was shared by Personnel Managers and an equal opportunities adviser, all of whom were accountable to the Director of Personnel who in turn reported to the District General Manager and subsequently the Chief Executive following the NHS re-organisation in April 1991. Whilst the Director of Personnel in East Thames District was similarly accountable for the policy, operational responsibility for policy implementation had been wholly delegated by them to the equal opportunities Adviser. The delegation of that responsibility along with the fact that they were appointed on the basis of their specialist knowledge of equal opportunities - and therefore they probably knew more about equal opportunities policies than other managers in the District - meant that the equal opportunities Adviser operated with considerable autonomy in the policy process. Therefore, instead of constituting an accumulation of expertise concerning the implementation of equal opportunities policies the Committee constituted a collection of 'amateurs' faced by the professional 'expert'. Whilst the Committee members were all experienced in their own professional context, they were novices in the field of equal opportunities in comparison to the specialist expertise of the equal opportunities Adviser. Inevitably, the Adviser always dominated the Committee meetings. The Adviser set the agenda and took the minutes and even though a Health Authority member acted as Chair of the meetings the Aviser usually lead the discussion. In effect, they reported on their activities to the Committee but were rarely held to account for them. Whilst the employment of an equal opportunities Adviser and their subsequent membership of the Equal Opportunities Committee naturally introduced a greater degree of expertise into the

Committee the effect was that the Adviser's own agenda and priorities influenced the direction of the equal employment-opportunities policy, and that direction was away from the implementation of an applicant monitoring system. For instance, nearly twelve months after the appointment of the Adviser the expectation of them - referred to above - with regards to the establishment of the monitoring system had not been fulfilled. Although a small sample of the monitoring returns had been analysed, greater priority had been given to completing an audit of the workforce. The audit report was completed by the autumn of 1990, but by March 1991 plans were being prepared - as will be discussed later in the chapter - for a repeat of the workforce audit to coincide with the 1991 census. Hence, nearly three years after the applicant monitoring system was established in the District only a small amount of the information provided by job applicants had been analysed, and the resource requirements for the effective operation of the system had still not yet been identified let alone put in place.

In conclusion, it is significant that earlier research - concerned with London District Health Authorities - found that Equal Opportunities Committees had been established in the Authorities that had made the most progress in implementing their equal employment opportunities policies (GLARE,1987;29) and similarly, the mail survey undertaken for the thesis indicated that positive action measures had been implemented by a higher proportion of Authorities with Committees than those without. However, whilst these findings strongly suggest a causal relationship between the establishment of a Committee and policy progress they do not prove such a relationship and it is equally

possible that the establishment of Committees has instead been an indication of the greater prior commitment that Health Authorities already had to implementing their equal employment-opportunities policies. The competition between these two hypotheses can only be decided by an analysis of the role and work of individual committees. It would detract from the objectives of the chapter to present such an analysis here, but in respect of the implementation of the applicant monitoring system in East Thames District the Committee appears to have had no impact at all.

**Commitment and the priority of the workforce audit**

A further reason behind the lack of commitment to the implementation of an applicant monitoring system in both case-study Districts - as has already been mentioned with regard to the priority of the equal opportunities Adviser in East Thames District - appears to have been the greater priority given to the completion of an audit of the characteristics of the workforce - chiefly on the basis of sex and ethnic origin. The two Districts were not unique in this respect as the mail survey undertaken for the thesis indicated that more Health Authorities have completed an analysis of the characteristics of their workforce than the characteristics of job applicants. Interviews with personnel specialists in the case-study Districts and observations made during the course of the field research suggest that the workforce audit was commonly regarded as serving two functions. Firstly, it was seen as an instrument which might provide prima facie evidence of discrimination and therefore indicate areas of the organisation that need to be targeted for equal opportunities purposes. Secondly, a series of audits is regarded as providing a

potential measure of the success of the policy by revealing changes in the representation of target groups across the workforce.

However, with regards to the first function - the provision of prima facie evidence of discrimination - the logic behind this expectation appears to be confused. There is an assumption that if certain groups of employees - such as female or black staff - are under-represented in particular areas of work in comparison to their representation within the workforce as a whole then discrimination 'might' be occurring which is barring entry for the group in question to that particular area of the organisation. Further investigations would then have to be conducted. For example, the workforce audit completed in East Thames District in 1990 revealed that black nurses were under-represented at senior level in comparison to the previous step in the hierarchy at charge nurse/sister level. Whilst this provided a very strong suggestion of discrimination at work it was notable that such an accusation was never made openly by any of the personnel specialists or members of the Equal Opportunities Committee. It is likely that this was because it could never have been substantiated without further evidence. That evidence could only be provided by an examination of the comparative success rates over time of black and white applicants for vacant senior nurse posts and a subsequent examination of the success rates on the basis of the qualities of individual applicants in relation to the job requirements. In other words, the collection of the additional evidence that would be required is dependent upon the pre-existence of an applicant monitoring system. Indeed, such a system would in itself provide both the prima facie and more conclusive evidence of discrimination without the need -

in the context of the provision of evidence of discrimination - for the completion of a workforce audit. In addition, an applicant monitoring system would potentially expose discrimination in instances where it would not be indicated by the characteristics of the employees actually in post. For instance, it is quite conceivable that even if there was an equitable representation of black and white staff amongst senior nurses discrimination could still be occurring in the selection process and the equitable representation could simply be due to a higher proportion of black applicants. In such an instance, only a recruitment and selection monitoring system would reveal the existence of this type of discrimination. Such a system then is superior to a workforce audit for the exposure of discrimination within an organisation. It is curious, therefore, why the two case-study Districts - and apparently many other Districts as appears to be indicated by the mail survey - have given a greater priority to the completion of a workforce audit than the establishment of a recruitment and selection monitoring system. (One of the reasons might be that recommendations concerning applicant monitoring have been subsumed in recommendations concerning 'monitoring' as a whole which have been biased towards a workforce audit (cf. CRE 1980, KFEOTF 1989b). A recent exception to this trend has been the CRE's publication; *A Measure of Equality: Monitoring and Achieving Racial Equality in Employment.* (CRE 1991b))

The second function of the workforce audit - as perceived by the personnel specialists - provides some of the basis for further speculation about the priority given to a workforce audit. The expectation is that a series of audits will provide a measure of

success of the implementation of the equal employment-opportunities policy. For instance, one personnel specialist suggested that:

> I feel that it's the basis from which we operate in the future in a lot of ways, because I feel that a lot can be said about what's happening, are we doing this, are we doing that, and until you actually do monitoring, and find out what the situation is factually, where staff are, what grades they're in, etc, etc, you haven't got the measurement, and the monitoring is a measurement at the end of the day. (R40)

Whilst the majority of the personnel specialists interviewed in the two case-study Districts similarly regarded the workforce audit as a measure of the success of policy implementation this view was not unanimous. For instance, one personnel specialist stated:

> I have to admit I think it is of limited value...I'm not sure what we're going to be able to give the managers back from it, what value that would be to the managers...I suppose it would be useful if we looked at potential absences on religious holidays and things like that. (R59)

It has been argued that the use of 'monitoring' - or a 'workforce audit' as it has been called in this chapter - to measure the effectiveness of an equal employment-opportunities policy confuses equality of outcome with equality of opportunity. Specifically, Jewson and Mason have argued that "Progress towards greater representativeness has clearly on occasion been taken as an indicator of the provision of equality of opportunity. This is a view which is clearly taken by many of the *participants* in policy making. In other words, it is very easy for equality of outcomes to be regarded as one - or indeed the only - criterion of equality of opportunity." (Jewson & Mason 1984: 125). It is questionable, however, whether "greater representativeness" should be used - in the way that Jewson and Mason appear to use it - as a synonym for equality of

outcome. For instance, whilst there was clearly an expectation amongst the personnel specialists in the two case-study Districts that the equal opportunities policy would lead to a greater representation of black and female staff in senior positions it was never suggested or implied that it would be in proportion to their representation in the occupational groups in question. Therefore, whilst equality of outcome was never explicitly stated as the goal of the policy, a movement *towards* equality of outcome was clearly expected. The basis of this expectation is obvious when the widespread perceptions of the operation of discrimination at work - as discussed in chapter one - are taken into account. Quite simply, if discrimination has been occurring in an organisation there would have been barriers to the progress of particular groups in the occupational hierarchy. Therefore, the introduction of an effective equal employment-opportunities policy would in theory remove barriers to progress and the representation of the groups in question would naturally increase. The rate of that increase would chiefly be dependent upon the rate of staff turnover, however, and it seems reasonable to speculate that if the distribution of staff is the only measure used to evaluate the success of policy implementation then a slow rate of increase of the target groups in senior positions would lead to frustrations with the policy and those responsible for its implementation. Any expectations of an eventual equality of outcome would also be frustrated as women would still be disadvantaged at work in relation to men due to the operation of patriarchy outside of the workplace (as discussed in chapter one) and frustrations in relation to implementation of policy would again be likely (Jewson & Mason 1984: 125). But there are no reasons - in

relation to progress within an occupational group - why black women should be disadvantaged in comparison to white women - and black men in comparison to white men - if the equal employment-opportunities policy is operating as intended apart from possible differences in the age structures of the groups in question.

If a series of audits would indeed serve as a measure of success of the implementation of an equal employment opportunities policy - as expected in the two case-study Districts - then it seems to be reasonable that the completion of an initial audit to provide a baseline against which to compare subsequent audits is given some priority. However, the experience of both case-study Districts was that the completion of the initial audit actually interfered with the outcome of the implementation of the policy elements which were to be measured by a series of audits in the long run. This problem was particularly acute in East Thames District. The District Personnel department did not have any computing resources available for the statistical analysis of the data collected from the workforce audit which meant the analysis was conducted by using a pocket calculator to work on data aggregated at an elementary level from the computerised payroll system. As part of the access agreement for my research in the District the author was employed to assist the equal opportunities Adviser in the analysis of the data. Working from scratch in devising an analytic framework - as there had been no published guidelines for the analysis - and working with the limited resources, the analysis demanded a considerable input in terms of time and effort. The completion of the analysis through to the production of a draft report required the attention of one full day each week over a period of

approximately six months for both myself and the equal opportunities Adviser. This eroded the time that the Officer had available for the development of the applicant monitoring system. The arrangements for the workforce audit were organised differently in West Thames District as the responsibility for the audit was allocated to an individual personnel specialist whilst their colleagues and the equal opportunities Adviser continued with the development of other aspects of the policy. Therefore, the audit did not interfere with the progress of policy implementation to the same extent as in East Thames District, but it did interfere with the establishment of the applicant monitoring system. Chiefly, it was realised rather belatedly that the structure of the forms issued to employees for the return of the information required for the audit was not suitable for the transfer of the information onto the computerised payroll system. This realisation occurred after approximately three thousand employees had returned their completed forms. Throughout my period of research in the District - approximately twelve months - the personnel specialist responsible for the audit deliberated with colleagues and sought advice for a solution to the problem. The author was even invited to submit proposals and attend meetings in the District aimed at resolving the problem. The personnel specialist was also responsible for the establishment of the recruitment and selection monitoring system which was inevitably pushed to one side by the difficulties with the workforce audit.

In summary, the lack of expertise within the personnel function with regards to the collection and analysis of statistical data for a workforce audit and the lack of computing resources for the analysis of the data collected diverted effort away from the

implementation of the equal opportunities policy in both of the case-study Districts. The result was that the establishment of an instrument expected to measure the implementation of policy actually inhibited - particularly with regards to the applicant monitoring system - the implementation of the policy elements it was supposed to measure. There is, however, one advantage that the workforce audit holds over an equal opportunities monitoring system which might explain in part the priority given in both of the case-study Districts to the completion of an audit. The advantage is that the audit raises the profile of the policy amongst employees through the process of collecting the necessary information and the subsequent dissemination of the findings. A danger of carrying out an audit, however, is that the findings may provoke allegations of discrimination when structural inequalities are revealed.

In conclusion, - in returning to the implementation of the applicant monitoring system in the case-study Districts - the lack of expertise within the personnel function regarding the collection and analysis of statistical data for a workforce audit and the lack of computing resources for the analysis of the data collected diverted effort away from the implementation of the equal opportunities policy. The result was that the establishment of an instrument expected to measure the implementation of policy actually inhibited - particularly with regards to applicant monitoring system -the implementation of the policy elements it was supposed to measure.

## Limited resources

A further explanation for the failure of the applicant monitoring system in East Thames District appears to be rooted in the pressure of work encountered by the personnel specialists and the way that they prioritised their work in the context of that pressure. For instance, it was apparent that during the course of the fieldwork in the District the time and effort of the equal opportunities Adviser had become increasingly consumed by work concerning complaints arising from employment practices, due to perhaps, a greater awareness of equal opportunities across the District because of the increasing profile of the policy. The equal opportunities Adviser - as she recognised herself - had been increasingly "reacting" to demands made upon her rather than getting involved in what she described as "developmental" work. Part of this developmental work would have been the identification of the resource requirements for the applicant monitoring system, however - in the face of competition from greater priorities - it was put to one side.

The same process characterizes the history of the applicant monitoring system in general in the District as in the presence of constrained personnel resources other priorities appear to have pushed the establishment of the system off the policy agenda. For instance, one personnel specialist reported that:

> There was no dedicated funding commitment, continuity and determination to get something out of it. It was "if we've got the time", "if we can sort of handle it"...It's resources, staff time, priority at any particular occasion. If they said to us, right, I say they - the powers that be - whoever you consider them to be, within the next three months you've got to get this system up and going and there will be resources, and you do not have to do X,Y and Z other tasks, you do not have to bother with the clinical nurse grading exercise and anything else, it can be done. But I think it inevitably

> falls in to being judged in relation to other priorities and how I and other people actually allocate resources and people's time. (R43).

Without the provision of additional resources the extra work involved in analyzing the monitoring information returned by job applicants had to be fitted in around existing responsibilities. As one personnel specialist reported:

> It was done within the same resources, we weren't given extra resources for it, so it was very much fit it in when you can. (R44)

Another personnel specialist similarly observed that:

> So essentially it looks good on paper...when they see it...I mean that is the reality...because there was nobody here to do it when the system was set up, there was nobody here to do it. (R40).

Apart from the extra human resources required, provisions were also not made with respect to computing facilities. Such facilities were not available at all within the Unit Personnel Departments, and although a micro-computer was available at the District Personnel Department it had not been adapted for the analysis of the recruitment monitoring forms.

### Organisational barriers at the micro level

Three interacting processes have been singled out in this chapter which have inhibited the establishment of applicant monitoring systems in the case-study Districts. The processes involve a lack of cooperation from personnel staff in the processing of the monitoring information; a lack of expertise and resources; and a lack of commitment from policy makers in the Districts to the full implementation of all stages of the monitoring system. None of the processes are reducible to the shortcomings of particular individuals,

indeed all of the individuals involved in the equal employment-opportunities policy process in both Districts appeared to be personally committed to implementing the policy. However, in the presence of constrained resources and other demands that required greater priority - arising, for instance, from the NHS reorganisation and the implementation of a new grading structure for nurses during the fieldwork period - the commitment to the implementation of the applicant monitoring system could not be sustained. As one respondent suggested - in relation to the implementation of equal employment-opportunities policies in general - in the face of other demands the policy is put on the "back-burner" in that it is relegated down the list of priorities. One personnel specialist - in the course of discussing the progress of the applicant monitoring system in their District - summed up the process of competing priorities;:

> The idea originally has been that the Units start doing it (the applicant monitoring) at source, because of the White Paper issues, and the general pressure of work, we sort of said "yes, well that's the long-term objective but we're holding back on that because there's just so much happening." Only one Unit has the computer facilities, and there's the resource implications about the facilities and time. So I think what we need to do is look at it here, as a temporary measure, how are we going to get the system working, and then integrate it a little bit later on once more of the White Paper issues have been sorted out at Unit level, so they can take it on. (R40).

In short, this particular personnel specialist was indicating that the lack of commitment to the establishment of an effective applicant monitoring system arose from the pressure of having to deal with other aspects of personnel work that intrinsically demanded greater priority. The failure, therefore, of the applicant monitoring system in East Thames District and the delay in implementing a system in West Thames District was not due to

intentional acts of obstruction fuelled by an ideology of 'race' or sex, instead it was due to the work of non-intentional, non-ideological processes operating within the organisations. But by preventing the implementation of a measure that could serve as a potential deterrent to discrimination the processes help to perpetuate the structural and political inequalities between black and white workers and women and men at work. In perpetuating the inequalities the processes are integral elements of racism and patriarchy at work - conceived as systems of dominance.

# CHAPTER 8

## FORMALISING RECRUITMENT AND SELECTION

In chapters three and four it was argued that the recruitment and selection process provides the core focus of an equal employment-opportunities policy as the greatest potential for discrimination to occur in an organisation is during the recruitment and selection of new employees, the promotion and re-deployment of existing employees, and the selection of employees for training courses. Line-managers responsible for recruitment and selection - the *gatekeepers* to employment in an organisation - therefore occupy the most central role in relation to the implementation of policy and the provision of equal employment-opportunities. Accordingly, the success or failure of policy is determined by the extent of their cooperation, and this chapter presents an analysis of the degree of cooperation by line-managers in the two case-study Health Authorities. The analysis is based on semi-structured interviews conducted with thirty line-managers across the two Authorities. Earlier research - in the NHS and in the private sector - has indicated strong resistance on the part of line-managers to the increased formalisation of the recruitment and selection process inherent to the implementation of an equal employment-opportunities policy. The interviews in the two Health Authorities in contrast indicated a strong degree of cooperation from line-managers, although there were some notable

exceptions. In concluding the chapter a number of possible reasons for the contrast will be discussed.

In considering, firstly, the earlier research, Harding reported that in a "small survey" of "equal opportunities specialists" carried out for the National Steering Group on Equal Opportunities for Women in the NHS each of the respondents reported "widespread resistance to their policy prescriptions, and often outright antagonism to their existence." (Harding 1989: 60). A number of possible reasons for the resistance were suggested by Harding, and amongst them two dimensions are apparent. The first dimension concerns resistance which does not have any explicit equal opportunities context; the existence of an equal opportunities specialist might be regarded by managers as an implicit questioning of the fairness of their managerial practices; the resistance might be a reaction against a perceived erosion of their managerial discretion (see also Wainright 1983: 15); and equal opportunities practices might be regarded as an "intrusion upon the 'serious business' of managing the NHS." The second dimension of resistance clearly does have an equal opportunities context as it involves explicit hostility to the principle of equal opportunities. It is obvious, therefore, that such resistance by managers to the implementation of an equal employment-opportunities policy - whether it is rooted in opposition to the principle of equal opportunities or not - would constitute a significant barrier to policy implementation.

Collinson et al have also indicated - in the case of the private sector - how line-managers have resisted efforts by personnel managers to intervene and challenge their

control of the selection process. Their resistance was found to be sustained by a "bread-winner ideology" "which insists that they are the independent, creative source of the company's well-being, upon whom all other employees are ultimately financially dependent." The corollary is that personnel managers are "dependent and unproductive" and "can often be dismissed as a welfaristic soft option, whose role is best confined to administration." (Collinson et al 1990: 88-89). Some line managers defended their autonomy by claims to their self-proclaimed successful track record of contributing to the productive capacity of the organisation and claimed that in contrast to personnel managers they were held accountable for their decisions through their company's financial control system. In the light of the earlier research findings one aim of the thesis was to determine whether managers involved in the recruitment and selection of employees in East and West Thames Health Authorities were similarly resistant to the formalisation of the recruitment and selection procedures. If - on the whole - they were resistant, they would pose a significant obstacle to the implementation of the equal employment-opportunities policy and would therefore constitute significant components of the systems of racism and patriarchy at work.

## Selection of line-managers

Thirty line-managers were interviewed - 15 each from East and West Thames Health Authorities. To select respondents the Directors of Personnel in each District were asked to provide a list of line-managers who they believed were frequently involved in the recruitment and selection of new employees or the promotion of existing employees.

The Directors of Personnel delegated the task in both Districts to the Unit Directors of Personnel and five separate lists were obtained which represented the five units across the two Health Authorities. For two units, a complete list of "Heads of Department" was provided, but for the other units the potential respondents were personally selected by the Directors of Personnel. In total, the names of 115 managers were provided. The sampling frame was stratified into the five units, and the occupational groupings within them. Within each stratum a random sample proportionate to size was selected with the aim of achieving a total sample of thirty line-managers. In addition to the initial sample of thirty, reserves were drawn as replacements in the event of refusal and non-response.

Each selected line-manager was sent a letter explaining the objectives of the research and asking them if they would agree to be interviewed. They were asked to indicate their agreement or refusal on a reply slip to be returned in a stamped addressed envelope. Those agreeing to be interviewed were subsequently contacted by telephone and arrangements made to interview them in their workplace. In total, 52 managers had to be approached to achieve the sample of thirty interviews. Thirty-three managers replied to say that they agreed to interview, but three of them were away on maternity leave when they were subsequently followed up. Only one manager returned the reply slip to indicate that he did not want to be interviewed. The remaining 18 did not respond. non-respondents were not followed up as it was agreed with the Directors of Personnel that a non-response would be interpreted as a refusal, avoiding a perhaps alienating pursuit of reluctant individuals.

Semi-structured interviews were conducted using a list of headings as a topic guide, and they ranged between approximately twenty minutes and one hour in length. The interviews focused chiefly on three issues to gauge the degree of cooperation of line-managers with the implementation of the equal employment-opportunities policy in their Authority. Firstly, whether they thought a policy was needed in their Authority and how they themselves justified the existence of the policy. Secondly, whether line-managers believed that the policy had made any impact upon their work when involved in recruitment and selection. Thirdly, their attitudes towards elements of the increased formalisation of the recruitment and selection process, specifically requirements concerning the production of job description, person specifications, and the recording of selection decisions following shortlisting and interview.

The interviews were tape-recorded except for three managers. Two of them refused, and the interview with the other manager had to be conducted in the staff dining-room at lunch-time as his office was being decorated, therefore it was not possible due to background noise to tape-record the discussion. The tape-recordings were subsequently transcribed onto to word-processor files for the analysis. The transcripts were analyzed using an approach which followed the 'grounded theory' method of analysis (Glaser 1965), as discussed in the introduction to the thesis.

From the analysis of the interviews a typology of line-managers is presented below in relation to their cooperation with the formalisation of the recruitment and selection process. Three 'types' of line-manager are distinguished: the *receptive* type who is

favourable towards the increased formalisation and appears to actively make use of the policy provisions; the *passive* type who also appears favourable towards the policy but does not personally adhere to the requirements, depending instead upon the close support of personnel managers; and the *resistive* type who could either be agreeable or unfavourable towards the policy in principle but resists efforts by personnel managers to increase the formalisation of the recruitment and selection process. The three 'types' will be discussed in detail below. In evaluating the material it should be noted that there could be a bias within the group of line-managers interviewed towards the Authorities' equal employment-opportunities policies. For instance, it is feasible that the non-respondents were less favourable, or even opposed, to the policies, but they did not want their objections known. In addition it is also possible that the initial lists of line managers were biased, possibly towards those managers who might report favourably on the personnel managers. It was certainly clear that - in the case of one Personnel Manager - a conscious selection had been made as she advised me that she had constructed her list to represent a spectrum of known views - from favourable to unfavourable - across line-managers. In the light of the potential sample bias two points should be emphasised. The first is that no claim is being made at all to suggest that the managers interviewed or - or their views - are representative of all line-managers across the two Health Authorities. The aim of the interviews was to attempt to determine a range of attitudes towards the formalisation of the recruitment and selection process, not to quantify those attitudes. The second point is that if the lists were biased to some extent, they did not exclude managers who were

unfavourable towards equal employment-opportunities policies - as will shortly be made apparent - therefore a range of views was indeed obtained.

**The receptive manager**

All of the line-managers categorised as *receptive* stated - when asked - that an equal employment-opportunities policy was needed in their District. In elaborating upon the need for a policy line-managers in the *receptive* group referred to the enabling role of the policy in facilitating good selection practice. For instance, for one manager the policy appeared to provide a benign intervention in the case of unconscious prejudices that managers might hold by raising their awareness of the presence and potential effect of unconscious prejudice:

> How would I justify it ? I suppose I would justify it by saying that we all, that we all have a tendency to be prejudiced one way or another and that an equal opportunities policy would...I mean it won't get rid of people's prejudices...but it would give at least an objective way of reducing the employment of people, or the non-employment of people, who people may feel prejudiced against. I don't know if that makes any sense ? It's not a cure all, but it's not a complete preventative either. But that at least it makes people aware of what they are doing, and why they are doing it. So why we might employ somebody as opposed to somebody else. And I think that you can be unconsciously prejudiced against somebody's colour, disability or religion or whatever, and having something like the equal opportunities (policy) makes you think about those things. (R54)

This manager was prepared to admit the potential of poor practice due to her own unconscious prejudices. In this context, the policy and the personnel function are seen as having a supportive or nurturing role in helping the manager to become aware of possible poor practice and working against it with the aim of selecting the best candidate for a job.

The usefulness of the policy in relation to possible unconscious prejudice was also indicated by another manager:

> I think we have to be honest, and say that there are a number of people still, a number of managers within the district that have got prejudices, and are perhaps not aware of them and therefore are perhaps are not overtly discriminatory, but actually discriminate without realizing that they are doing so, and that can be seen by certain departments, and looking at the mix within the department and recognising that it doesn't reflect the local community, so I think there has to be a policy within the district if nothing else to make managers aware of their obligations. (R55)

Similarly, another manager reported that:

> I think it's needed to actually give fairness and opportunities to people because...//...we all have our thinking, our own discrimination, our own sense of values and beliefs. (R48)

According to one manager the policy works through the application of 'objective' and consistent selection criteria for all candidates:

> it's often difficult to take away from the recruitment process your own feelings and prejudices if you don't have some objective guidelines that you have to follow...//...you ask people the same sorts of questions so you get a fairer feedback I think from a fairer choice of people, in that way it tends to help. I think it tends to help make the selection of people much more objective. (R54)

Similarly, another manager suggested that the policy provides a "logical" and a more "scientific" approach to recruitment and selection. They believed that the policy:

> helps you to clarify in your own mind what you're looking for, and then going ahead and sifting out the application forms, and continuing you need to actually specify in your person spec how you're going to actually judge that quality. (R35)

Another manager referred to the policy as a "methodology", a source of reference, which is available to guide good practice:

> it does work to ensure good practice really, it's not just a statement to say we do it but it's actually a methodology, if you like, behind the actual statement that enables you to see that things do work in practice, and should people feel any worry about equal opportunities in practice, then they can refer themselves to the procedure to ensure things are happening. So I think there's a value in it for sort of very practical reasons. (R64)

The same manager also suggested that the policy indicates a commitment on the part of the Health Authority:

> it affirms to the people within the Authority and interested in joining the Health Authority that there is that commitment there, that it's stated on paper and it's owned in a formal sense by the members and employees of a Health Authority. (R64)

For another manager the policy should work through the provision of training in equal employment opportunities:

> Well the policy...has a commitment for training in the District. Now if that actually occurred, which it hasn't, I feel it's the one area of the policy I feel, that hasn't actually achieved anything. If that actually occurred to make people more aware then I think the policy could be a lot more successful. I mean, at the present we have equal opportunities officers in the district that send out a certain degree of information, but I actually think that we've got to train the managers and staff to recognise within themselves any prejudices that they may have, and to also understand about equal opportunities because a lot of them see it a positive discrimination, and are very unhappy about it, and I think we need to be taught what it actually means. (R55)

For this group of managers their perceptions about the impact of the policy upon their work must be evaluated in the context of their views about the need for the policy. A number of dimensions of the impact of the policy amongst these managers were apparent. The selection process had become far more formalised, or "objective", as two of the managers described it:

I think it's helped us really in terms of how we conduct informal interviews for example, that previously people who would be interviewing actually were seeing people on informal interviews. Now that doesn't happen any more...//...they actually now speak to a well briefed colleague rather than a person who might be on the interview panel. We're much clearer about having job specifications than we were previously, which have given us, which has helped us again, be more objective really now with the recruitment process. We've looked at job descriptions obviously, and in terms of reviewing them, we do as well, and in terms of actually shortlisting, I think, we've been more objective, I think, and we've had a much more structured system for shortlisting than we've previously had, And, in terms of interviewing then we've now got a much more structured system for interviewing, that we plan the questions, that we ask all candidates exactly the same questions, we mark, we don't discuss candidates in between interviews, we wait till afterwards, all those, all those sort of things that I think are much better practice really than what was happening before. (R37)

I've not been conscious of it, but as we didn't have one before I can look back in the past and think of one or two things that we might of said, or behaved in a certain way, and thought...no I wouldn't say it contravened good practice, it might have not been so..handled so well as we're now conscious of, and certain things are built into interviews that are not, that hadn't been in the past...allowed to ask prospective candidates what their views are on equal opportunities...to exclude certain things from interviews like the colour, their creed, their religion, their sex, or question them about that in a way that might compromise their opportunity to get the job. (R64)

Secondly, the policy appears to have made some of the managers more conscious about being aware of their own biases and prejudices in the selection process:

more aware of not being influenced hopefully by people's sex, age, marital status, nationality, religion, and those sort of things that may at least subjectively have influenced us before. (R37)

I'm a person who...who a person's visual presentation is quite striking to me, (unclear) I know that by following the policy I'd employ somebody who visually put me off right at the beginning of the interview, who is an excellent worker. So I think it has helped me in that sort of way. (R54)

Additionally, it appears as if the policy inspired some managers to attempt to recruit staff of the same ethnic groups as their minority ethnic clients, using the 'genuine occupational qualification' provisions of the 1976 Race Relations Act (Part 2, section 5):

> it's made us much more aware of what we might put in an advert, we, I can't remember which part of the Act, but we've actually, we've actually specifically advertised for (Asian) women workers at times, which has been, we thought, essential really to meet the needs of our service. (R37)

> to actually encourage us to look for people who would be helpful to communicate with, understand and work with the mixture of ethnic minorities we've got here. I think all of that is enshrined in the policy.(R64)

In turning to consider managers' attitudes towards the increased formalisation of the recruitment and selection process introduced by the equal employment-opportunities policy it seemed that a source of resistance to the policy might lie in the fact that managers might regard the policy as introducing more and unnecessary work in the shape of the production of person specifications for all job vacancies and the recording of selection decisions. The managers classified into the *receptive* group did not indicate such resistance. They admitted to initial reticence but recognised the benefits of increased formalisation:

> I think initially we thought it might be a problem, but I think that partly relates to our general workload, that before we were restructured...//...my own personal workload was far greater than it is now, and I think when it was first introduced there was some sort of feeling that it would be more work, but I think we've already seen the benefits of doing it, so, and we now understand it much better, so therefore it doesn't take us as long as it had to do in the first place. But I think there was definitely some feeling, 'oh why are they interfering anyway, we haven't got these problems. (R37)

> It probably does yes (create more work), because we've got to sit down, as well as the job description they've got to write down particularly what we're looking for in that individual, qualities, qualifications, skills, employment. So it does entail a bit more extra work, but we can see the benefit of it in terms of making good appointments, so it, I would guess, the value outweighs the inconvenience, I hope, I think. (R64)

Another manager (R54) who stated that they were not required to draw up person specifications for all vacant posts - but was aware of this becoming a requirement - saw it as producing extra work initially, but felt that a standard format could be produced and then adapted to particular vacancies in her department - therefore minimizing the workload. Two other managers had already pursued this strategy. For example, one reported that:

> we've now developed a standard job specification. Say, for example, for a health visitor, but in every job then there are specific things about that job which may or may not make us put something specific in the job specification, maybe an interest with working with G.P.'s or a particular type of client group, those sort of things. (R37)

It was possible - for two of the managers in this group - that they did not regard the increased formalisation of the selection process as producing more work because personnel staff actually did much of the work for them:

> they have a member of the personnel people here at all interviews, I mean they might miss the odd one if they have a road traffic accident on the way here but virtually all there's a member of the personnel staff present, and they come accompanied with all the relevant information and forms, included in which is a form which they fill in the questions and the answers given, and the actual practice and procedure of the interview itself, on that they're very conscious and conscientious about completing because it's an expectation of their job, plus the fact that there has been occasionally, not many in the District I recall, occasional complaints after the interview's been held regarding the fairness of the appointment. So they know that they have to provide information when this does

occur.(R64)

Personnel staff similarly attended and recorded the selection decisions in the other manager's department, but it was notable that the manager also kept their own records following interview. The fear of complaints appears to have been a major consideration:

I'd rather them do that at the interview than us have a tribunal. (R54)

One manager who did not have the same degree of assistance from personnel staff and consequently maintained their own records certainly did not regard it as unnecessary work:

> we tend to make notes on everybody, and then there's a sort of summary of those put together, which are kept by personnel, and obviously people are ringing up, which we encourage people to do if they haven't been selected then that helps us give them some feedback about how the interview went, or perhaps why they haven't been selected, and what there is they could improve on, or whatever. So that's very helpful, it's almost essential really to give good feedback, to have some kind of notes. I think personnel are taking their own notes, or some people in personnel are taking their own notes now as well. But certainly as managers we have a sort of sheet to make notes on. (R37)

The provision of feedback to candidates and the consequent value of maintaining records of selection decisions was stressed by another manager:

> I believe in making records because I have a policy of giving, of writing, to everybody who has taken the trouble to attend for interviews, whether they are successful or not. I do get in touch with them, and they know that they also have the option to ring up and find out why they haven't been appointed and, where possible, if they would like to come along and have feed-back, I do invite them along. So I need to have some sort of note. I keep those notes for a brief period of time, for a few weeks, and then I send them off to be shredded. (R48)

Likewise, another manager reported that:

> personally I've always recorded why I've...because if sometimes somebody sort of rings up I've liked to have a justified reason for not having either shortlisted them or invited them for interview. (R35)

However, one manager who appeared very receptive to the principles of an equal employment-opportunities policy indicated some resistance to the formalisation of the recruitment and selection process:

> So I would say, for something like a laundry worker, a catering assistant and things, I would think, I would think it very unlikely that person specifications are written up by the managers in advance of those posts, because again...//...we do have problems with recruitment, and these areas are very poorly paid...//...I mean, they have been trying here, and I have tried myself sometimes to write a persons specification. I find them very difficult to write personally. I'm not so sure it's the managers see it as an extra job, I mean it is an extra job. But to actually sit down, and I actually like to go into an interview without any preconceived ideas about who I want, I mean, I know what the job is, and I always feel there is an inherent danger in sitting down, and writing something down on a bit of paper, this is your person specification for somebody, that you, the danger is, that you put somebody out who perhaps was well able to do the job, but for some reason didn't match up to this piece of paper that you've written, whereas, if you haven't got any preconceived ideas, you might be willing to take the chance on that person, and say yes. I think they could do. But it's very difficult. I think they'll start in this District demanding that they're done for all jobs. I think certainly my managers in departments with high turnovers will find it quite difficult. (R55)

On the basis of her comments it would seem that the classification of this manager as *receptive* might be uncertain, but she did indicate active efforts to attain guidance in recruitment and selection from the Health Authority's equal opportunities adviser:

> I think all the managers who I work with, who are involved in recruitment and selection, along with myself, yes, I think they are very much aware of it, in fact we have actually had the equal opportunities officer with us in a number of interviews to actually, in the various departments, to actually observe, and to advise us to do our own form of training within the (department), because it doesn't exist anywhere else, as to where, you

> know, if we are doing things correctly with the policy, if we're using it in the correct manner. So yes, we do, we obviously do try to observe the policy, but again, unless you get feedback and training of where you may be doing something inherently wrong, it doesn't... you don't know. Which is why in this department we involve... we involve our equal opportunities officer in interviews, they do random checks for various departments, interviews, and things for me. (R55)

In turning to consider managers' perceptions of the role of personnel staff in the recruitment and selection process, and particularly their role in monitoring the implementation of policy, none of the managers classified into the *receptive* group objected to their presence in interviews or saw the personnel staff as encroaching upon their managerial territory and discretion:

> I don't have any difficulty with that. I would expect them to pick me up if I was doing something that was..that didn't agree with policies, and I'd rather them do that at the interview than us have a tribunal...//...maybe we've got really good personnel officers, but yes, I see them as being supportive. (R54)

> I don't at all (object), and maybe that's partly because I know them all quite well now, we've got generally good relationships with personnel, that makes the big difference really, I think if we had people coming in we didn't know, who we felt didn't understand what our jobs were about, then it would be more difficult, but I think because we have got a good rapport with them, a good relationship, and they are, you know, supportive in their recruitment process in terms of advertising etc. (R37)

> I feel OK about that personally, I guess I would like to think that there's certain things that one has to do correctly...and if they felt there was something they didn't like, and I've never experienced them actually challenging an interview panel I've been on, then I would welcome it, knowing that they in their professional sense believed it was somehow contravening good practice. I'm comfortable with that because I'm an employee of the Health Authority and it has to be personnel practice so I would respond to their guidance. I think we're aware well enough of what is good practice to know when we shouldn't do certain things, at least not lightly. So I'm comfortable with them being present for that purpose to sort

of keep an eye on things being right. It's OK with me. (R64)

> I don't see them as checking up on me, but I see them as being there to make sure that the procedure has been followed...//...so I don't see that as an infringement on me or anything, but they are there to help make sure that everything is going as it should. (R34)

The significance given by the first two managers above to the importance of a good rapport with personnel officers in determining their reception in the interview setting was also emphasized by another manager when asked whether managers whom she supervised in her department felt that the involvement of personnel staff was an encroachment upon their managerial territory:

> I think it's very dependent on the individual in the sense of also the personnel officer, it depends on how much they wish to take over the interview, I mean, I think you've also got to accept, in the same way, there are managers who are unhappy in the interview situation, I mean, they have to do it because they have a vacancy, and they would much rather that personnel interviewed. I think that there are times when they are resented, yes, especially certainly if you get a new one who comes in, and she has got a whole list of questions she wants at the interview, and that's perhaps not the manager's technique. But I think most of the managers here are pretty vocal, and would say, and would express any disquiet if they were unhappy. (R55)

Whilst recognising their monitoring or policing role, they also recognised the support provide by personnel staff:

> I think they've got a number of functions, I think they are there for giving information to the people who are being interviewed. I think they... one of their roles is to be an objective observer at the interview. And I think that they should be a sort of arbitrator when you are making the decision at the end especially if you have two people who are interviewing them, you know, there are some sort of disagreements there, and also they're the experts, at least I gather they're the experts on the equal opportunities policy, whereas I would have a certain amount of knowledge on it, I regard them as being the expert. (R54)

> for me they're there to prompt, guide, check us if anything were to go wrong, but for us to ask them questions and for me to put them on the spot, and say what's the latest information on this term or phrase, can we ask this candidate a question on contracts or conditions, or ages. So having them there to do that for us is an advantage actually. (R64)

One manager stressed the "supportive" over the "policing" role:

> I don't see it as checking, I have a very, very good working relationship with the personnel department...//...I encourage them...I see it more as support for me as well as the candidate in the fact that somebody is actually there to ensure that I stay in the middle of the road and that I am constantly fair and do not start off with a bias, or end with a bias. (R48)

In summary, line-managers of the *receptive* type believed that their own awareness of either conscious or unconscious prejudices affecting their selection decisions had been alerted - and the awareness of other line-managers potentially alerted - by their Authority's equal employment-opportunities policy. The policy works for them by providing a "methodology" for objective selection and the avoidance of prejudice in selection decisions. They initially regard the increased workload arising from the formalisation of the recruitment and selection process with some reticence, although they come to see the benefits of it in terms of, for instance, the production of good quality appointments and the protection against claims of unfairness. Line-managers of the *receptive* type also regard the role of the personnel function in the recruitment and selection process as a supportive role and in that context regard the "policing" - or the potential policing of the recruitment and selection process by personnel managers in positive terms. Although the style of the approach by personnel managers is crucial to their reception.

### The passive manager

The *passive* type of line-manager is formulated here on the basis of interviews with two line-managers, both in the same District - West Thames. Both managers stated - when asked - that there was a need for an equal employment-opportunities policy in their District. The reasoning behind the need for one of the managers was out of recognition of the potential for discrimination - as suggested by line-managers of the *receptive* type - but for the other manager his perceived need for policy was due to the desire to protect himself against complaints of discrimination. That manager did not agree to me tape-recording our conversation as he claimed that he was being very careful about what he was quoted as saying as a complaint of discrimination had been made against him and was currently being investigated. My notes recorded the following:

> Is the policy needed ? - He said "yes desperately" - and went on to describe how the policy prevents them from making mistakes which they have made in the past. He gave me two examples - on one occasion they did not check up on references adequately - lead to problems. On another occasion did not check on the applicant's criminal record which again lead to problems. (R62 - handwritten notes)

This manager therefore regarded the policy as a protective mechanism preventing mistakes being made for which he would be held accountable. In contrast to managers of the *receptive* type a recognition of his own potential for discrimination did not feature at all in his dialogue. Indeed, this manager expressed a racial stereotype without reticence as he informed me that "(Asians) are slow to learn the job", and when asked about sexual harassment in relation to female staff, he said, as recorded in my notes, that "it doesn't go on", but then said "trouble is with a couple of them - we don't half fancy them". It

appeared that this manager was therefore not personally committed to equal opportunities and would not be actively pursuing the policy, although he was most receptive to the policy for the potential protection that it offered. But he interpreted the policy as personnel staff being involved in recruitment and selection, and did not demonstrate any insight into the policy requirements. Judging from this manger's discriminatory remark about Asians his awareness of equal opportunities principles appeared limited and therefore it would seem that if a personnel officer was not present at interviews then clearly poor practice would occur.

The other manager of the *passive* type justified the need for the policy in the same way as managers in the receptive active group, with reference to the potential of discrimination:

> Yes - because of discrimination. Discrimination can and does go on. The policy can prevent that, for example, some managers think West Indians are 'lazy' and therefore they won't employ them. Some can have a bad experience with a person and then they label everybody from that ethnic group as the same. But it can work both ways, for example, black managers could discriminate against white people - if they have been called an 'ape without a tail' by a white person then they are likely to see all white people in the same way. (R53 - handwritten notes)

This manager therefore appeared receptive to the idea of an equal opportunities policy for the recruitment and selection of staff but it was apparent that the policy - as he himself stated - had not made any impact on his own work as personnel officers were actively involved in the recruitment and selection process with the manager being a passive participant in relation to the implementation of policy. He did not regard their involvement in that process as being problematic at all:

Are person specifications drawn up when recruiting staff ?
Yes - done in conjunction with a personnel officer.

Does this create more work for you - is it a problem ?
No.

A personnel representative is present at every interview.
How do you fell about them observing or checking on you in the interview ?
O.K. They are there to ensure fairness for the applicant - also a help for the manager to ensure that they are not asking questions that shouldn't be asked.' (R53 - handwritten notes)

This manager also had a limited awareness of the principles of an equal opportunities policy as when I asked him about positive action measures he stated that "women are encouraged - more suited to this type of work", indicating that he held his own biases in relation to employees in his department. Therefore, it would seem reasonable to speculate that in the absence of a personnel presence in the recruitment and selection process discriminatory practice would probably occur.

In summary, the two managers of the *passive* type were receptive to the idea of an equal employment-opportunities policy, but the policy for them was largely operated on their behalf by personnel specialists, with the line-managers assuming a passive role. Whilst they were receptive to the policy on the one hand, they had very little idea of the principle and practice of equal opportunities on the other, and if personnel specialists were not policing their recruitment and selection activities they would clearly on occasion illegally discriminate in their selection decisions.

### The resistive manager

The formulation of the *resistive* type of manager emerged from interviews with four managers. Although they were resistant to the formalisation of the recruitment and selection process - as will be demonstrated shortly - two of the managers stated that there was a need for an equal employment-opportunities policy in their District. One of them justified the need for policy on the grounds of preventing discrimination:

> because of the general ethos in this country anyway it is important that we don't discriminate, not in my book anyway. (R36)

Yet according to his view - and in contrast to the managers in the *receptive* group - the potential for discrimination simply did not affect his department:

> I've been around here for some time now. We've worked very much a multi-racial group, and we, if you like were operating the spirit of equal opportunities policy for very many years before it came into existence. Certainly there's never any discrimination. (R36)

For one of the managers it was part of his professional responsibility to select the most suitable candidate for a job and consequently not to discriminate:

> Equal opportunities to me means putting the right person in the job. The colour of their skin, their creed, what have you, has nothing at all to do with it. I'm paid to get a job done here, and I don't care who does it...//...if there are people who are qualified to do a job...if you've got the qualifications then you come in on equal terms...//...What I can't afford to do is to say that everybody is equal and I'll appoint the first one who walks through the door because the whole thing would collapse if we did that. But I hope that's not what equal opportunities is about. (R56)

Another manager - a consultant - clearly believed that discrimination was not a problem in relation to medical staff, as when asked whether the equal opportunities policy was needed they replied:

> Well I suppose one has to have it in a way to be fair, so that people don't moan about it. It's...for most of us I think we are fair about these things. Most doctors are fair about these things. I don't know about others...//...what we want is the best person for the job whatever their background. (R32)

For the other manager it appeared to be a characteristic of their personal integrity not to discriminate:

> perhaps I'm pretty old fashioned, but equal opportunities is just sort of basic Christianity in a sense. That's not meant to sound pious or anything, that's just how I see that. (R36)

The manager emphatically acknowledged the contribution of the personnel skills to the recruitment and selection process, but not necessarily from the personnel staff themselves:

> If you've got a reliable personnel department clearly you would use them, because it's something you then don't have to do. If you haven't, you've got to get on with it yourself. Now for a whole variety of reasons we have had a switch on switch off personnel service here for some time...when it's been good it's been very, very good, and when it's been bad, it's been a pain in the neck. We might be going through a phase where we've tried to take...//...we have actually taken matters into our own hands, call it delegation by personnel if you like, because we feel more comfortable, more sure about that. Perhaps it sounds a little pompous, but we feel that we've got a reasonable amount of experience in sort of every day to day personnel issues, what the technicalities are, not the really complicated technicalities but we've got four members in my staff including myself who've done the Open University business course on management...//...so it isn't as if we're trying to pull a fast one, we genuinely feel as if we've done a reasonable amount of homework, and we can then basically get on with it..//...But you cannot mess around with personnel issues, they are absolutely key to running an organisation...//...therefore its up to me who has responsibility for running the service to ensure that we're securing the most effective personnel services, and if that means in part doing it ourselves, then we go ahead and do it. (R36)

Accordingly, this manager clearly acknowledged that the personnel role is central to the recruitment and selection process. But the reception towards personnel staff by line

managers depends on how much support they give them. Support, not guidance, as this manager was arguing that he and some of his staff were well versed in personnel practice. It appears that there is nothing that personnel staff could tell them, rather they are seen to occupy a servicing role:

> the norm with us is that you will get a personnel officer into the interview session purely to get over the technicalities of employment and explain those to the candidates, but not usually to be involved in the rest of the process, unless it's on a more senior level, where beyond a certain level we do tend to get personnel officers in as part of the interview board. (R36)

The other manager argued that personnel specialists do not have the expertise to contribute to the selection of "professional" employees:

> we are picking people for professional training and development and short of a personnel officer having had experience in (a clinical capacity) - in any of the disciplines - just learning it by rote is not the best way of introducing anyone to a profession - a possible candidate - there are many things one has to discuss about development, registration, various aspects. It's better done by professionals like myself with my colleagues. (R56)

As with the previous manager, this manager similarly regarded the personnel function as a servicing role in dealing with the technicalities of the terms of employment:

> it is not my forte - not my business I think - to arrange the employing conditions as such. I may well be able to talk about some of them to the candidates, but that's not my prime function, that's what the personnel department's there for, and they do in fact do that...//...The only time I sit with a personnel officer is in matters of counselling or disciplinary procedures against staff. (R56)

Possibly because of the first manager's view that discrimination does not occur in his department, and possibly because of his view that he and his staff are well versed in equal opportunities practices, the influence of personnel officers has not permeated the

department's activities in recruitment and selection. For instance, in relation to the recording of selection decisions:

> I wouldn't put my hand on my heart and say it's done comprehensively, certainly persons specs, person profiles, job profiles, we do use. In terms of recording how each candidate actually measures up against the person spec, I know we should do it, we don't always do it. We don't always do it very simply because it's an extra task. I suppose in a sense we feel were being fair, and we feel a little bit annoyed to have to take on board significant extra paperwork in case we get challenged at a later date...//...which is so bogged down with paperwork of all sorts...//...You can see the reason behind it. (R36)

The other manager did not see the point of maintaining records of selection decisions:

> Well the only records we keep are their application forms...//...No, I don't think we ever write down why we didn't have a particular candidate...//...I would find it difficult I think to write down all those things. I suppose one could write down "he's not very articulate, poor command of English, wasn't able to solve a simple problem", I suppose one could do that but it seems a little pointless to me. (R56)

Records were, therefore, not always kept of selection decisions, and the requirement to keep records was viewed as an irritant, or even an intrusion, in the context of the manager's view that "fair" selection occurred anyway in his department.

Because of the previous manager's view that he was already being fair it was apparent that he had not examined the Health Authority's equal employment-opportunities policy requirements in detail:

> As you probably see, I haven't studied this in any detail at all, I'm just sort of using a gut feeling approach as a manager. (R36)

Another manager believed that the work involved in shortlisting and maintaining records was "totally unnecessary" and stated that "I resent it", as:

> it's now possible to spend the whole week going to committees and talking to people rather than actually seeing patients. (R32)

For one of these managers the equal opportunities adviser epitomises the sense of intrusion:

> it strikes me that the majority of equal opportunities officers have more of a chip on their shoulders than the people they're trying to convince about equal opportunities. Sorry, that's a pretty broad statement, but that's my experience...//...Anybody who wants to shove it down your throat is a bit of a pain in the neck. It's as simple as that. I'm just a straightforward ordinary sort of character, who just happens to be a manager. (R36)

A similar sense of intrusion was indicated by the other manager when he was asked about his view of the possibility of personnel specialists "policing" the equal opportunities aspects of interviews:

> I personally would not have that personnel officer present for those reasons. If they're monitoring it for quite wrong reasons I think, then I would object to it...I want to use the personnel officers, I don't want them to impose themselves upon me. (R56)

That manager also implied that equal opportunities specialists have a "chip on their shoulder":

> I have to tell you, and I know you are recording me, but, I did get myself into bad odour at one particular interview where there were mixed ethnic minorities - and majorities - where the equal opportunities officer here started off assuming that we were racists. I disapprove of that sort of thing most strongly, and I'm pleased to record so did a number of the West Indians and other people there. (R56).

In summary, line-managers of the resistive type believe that their own recruitment and selection practices are fair, and there is no possibility of discrimination in their decisions. Furthermore, it is part of their professional integrity - when selecting staff - to

appoint the best person for the job. They do not see the need, therefore, for the increased formalisation central to an equal employment-opportunities policy and they accordingly do not follow formalised procedures. They would resist efforts by personnel specialists to encourage and advise them in the use of formalised procedures. In their view, the personnel function appears to be a subordinate and servicing role in the recruitment and selection process in dealing with the technicalities of employment conditions, without intruding on their professional responsibilities which involve - when selecting staff - the appointment of the best person for the job.

**Indications of cooperation**

Before interviewing the thirty line-managers it was anticipated - on the basis of the earlier research cited in the chapter - that considerable resistance might be found to the formalisation of the recruitment and selection process inherent to an equal employment-opportunities policy. That resistance, would possibly be associated with a defence of managerial discretion, and even though it would not have had any 'racial' or patriarchal context, it would have been a significant element of the institutional dimension of racism and patriarchy at work. The interviews revealed, however, a considerable degree of cooperation with the equal employment-opportunities policy, as three-quarters of the managers were receptive towards the policy requirements. It might be suggested that their practice in recruitment and selection could be quite the opposite to their stated views. But in the light of the expectation of resistance, managers were strongly probed during interview - when they expressed cooperation - to evaluate the extent to which their stated

views were genuine. In the event, it did not appear that large-scale deception had occurred. Their cooperation in comparison to respondents in earlier research could be due primarily to two factors. Firstly, the implementation of equal employment-opportunities policies might be considerably more extensive compared to when the earlier research was conducted, and therefore managers in general are more familiar with their requirements. Certainly, as discussed in chapter five, considerable progress appears to have been made in the NHS in the late 1980s. Secondly, employees of large public organisations might be more used to the bureaucratic control of their work compared to the private sector where some of the earlier research was conducted. In short, although no attempt is being made to generalise the findings from a small sample of managers to line-managers in general, it appears that considerable cooperation might be found to the equal employment-opportunities policy requirements, if a sensitive approach is applied by personnel specialists.

## CONCLUSIONS: REMOVING THE BARRIERS TO EQUAL OPPORTUNITY

In concluding the thesis, two objectives are pursued. One objective is to discuss the interactive nature of the many processes discussed in the thesis which inhibit equality of opportunity at work. Concepts of racism and patriarchy have been used in an effort to order and bring a theoretical coherence to the analysis of the disparate processes disadvantaging women and black workers. The analytic coherence provided by the concepts intrinsically suggests a number of targets for policy intervention. Accordingly, the other objective in concluding the thesis is to suggest a number of policy initiatives which need to be established, or strengthened - in the case of existing policy measures - to overcome the barriers to equality of opportunity at work (Suggested policy initiatives are italicised in the text for emphasis).

The analysis of policy intervention presented in the thesis has largely concentrated on measures aimed at providing equality of opportunity in the recruitment and selection process. In concentrating on recruitment and selection there is a shared focus with recent research (Collinson et al 1990) on gender discrimination at work published whilst the research for the thesis was being carried out. In evaluating equal opportunities policy implementation the focus on recruitment and selection seems worthwhile for a number of reasons. Most importantly, the recruitment and selection process for employment, promotion, training, and re-deployment of workers provides the main arena within the workplace in which equality of opportunity is either actively denied, or alternatively ensured. In addition, policy prescriptions for equal opportunities policies produced by the

Commission for Racial Equality and the Equal Opportunities Commission have also been largely concerned with recruitment and selection. Likewise, policy development and implementation in the two case-study Health Authorities and within the NHS as a whole have also shared a similar focus. Therefore, in trying to analyze actual experience of policy implementation the research for the thesis has been constrained by the stage of policy development prevailing in the NHS as a whole, and in the two case-study organisations in particular. But as the data presented in chapter four show, many health service employers have not even implemented the barest minimum of equal opportunities measures aimed at recruitment and selection practices. In this context, both of the case-study Health Authorities are considerably advanced in relation to the rest of the NHS, but as the analysis in chapter seven concerning 'monitoring' has shown, they still have a long way to go , even with regard to the recruitment and selection process.

From her recent research on sex equality in organisations Cynthia Cockburn (1991) has shown that some "equality activists" distinguish between a short and a long agenda for change. The focus on recruitment and selection in this thesis falls squarely within the short agenda, as that is where policy development in the NHS currently lies. The long agenda - as identified by Cockburn - includes a transformative change in management style to a more open, democratic, cooperative, and less competitive hierarchical style associated with the supposed qualities and attributes that women bring into management. The long agenda also includes a restructuring of jobs to flatten the jobs hierarchy and to provide greater value and reward to the traditionally lowest jobs, usually dominated by women. It is arguable that the long agenda is more concerned with equality than equal opportunity. But the key point to be made is that the short agenda for change - which is concerned with equality of opportunity - has barely yet been achieved in the NHS. In this

context, attention to the short agenda seems crucial until some progress is made.

The interactive nature of the processes which inhibit equality of opportunity at work, and appropriate policy measures, will now be discussed. The concepts of racism and patriarchy used to bring coherence to the processes have been de-composed into 'political', 'structural', and 'institutional' dimensions. The remainder of the chapter will be structured around these three dimensions. To take the structural dimension first, the data presented in chapter two from East Thames Health Authority show that men, and particularly white men, dominate the positions of power and authority both within and between the different occupational groups in the NHS. For instance, males have a much stronger representation compared to females amongst medical staff who - along with senior administrators - occupy the most powerful positions in relation to the organisation and control of the workforce as a whole. Males and whites are also over-represented at senior level in every occupational group. Therefore, males as a group, and whites as a group, dominate and control the workforce. There are indications too - although the data are extremely limited - that a similar pattern of domination characterises the NHS as a whole. To date, though, the data produced by East Thames Health Authority provide the most comprehensive data set for the NHS workforce. The data also indicate though that whites and blacks, women and men, are not homogeneous groups with regard to their relative position in the workforce. The strong representation of males amongst ancillary staff who are at the bottom of the ladder in relation to the control and organisation of the workforce, and the higher representation of the black workforce compared to whites amongst medical staff, demonstrate that there isn't a simple linear power hierarchy of white men ruling over white women, who in turn rule over black men, with black women at the bottom of the pile, as has been suggested by some analyses of the interaction

between 'race' and sex (cf. Sykes 1984, Fesl 1984). Similarly, a differential distribution between the various groups of black nurses indicates that black workers are not a homogeneous group in relation to their distribution across the occupational hierarchies. However, as a consequence of their domination of the senior positions of each occupational group, males as a group, and whites as a group, dominate and control the workforce. The degree of sex segregation is stronger than the extent of 'race' segregation both within and between the occupational groups - although the position of women is arguably affected more by events occurring outside the workplace - but when the interaction of the two variables is taken into account empirically, it is obvious that white males have a 'double advantage' whilst black females have a 'double disadvantage' at work. The policy implications of the structure of domination will be dealt with shortly, after discussing the political dimension of racism and patriarchy at work, as the two elements are closely interconnected.

If the inequalities between the two groups were due to a differential distribution of merit in relation to job requirements between individuals in the groups then the group inequality would not be problematic according to the moral foundation of the principle of equal opportunity as discussed in chapter three. It would simply be a statistical inequality. But it appears that the structural inequalities are due in some measure to the denial of opportunities to women and black workers. Clearly, in the case of women, events occurring outside of the workplace have restricted their opportunities within the workplace. Chiefly, as a consequence of childrearing some women take career breaks, some give up their jobs altogether, and some remain or return to work in part-time positions which have traditionally been excluded from career paths. There is, therefore, a diminished supply of women who could progress to senior positions. In the case of

black workers, events occurring outside the workplace such as differences in educational experience and attainment also affect their participation within the workplace. It is arguable though that the impact of external factors upon women is greater as a consequence of the normative expectations concerning their domestic responsibilities. However, the home is not the only source of male advantage at work as exclusionary processes occur inside the workplace which deny women equal opportunity with men. Likewise, exclusionary processes occur which deny black workers equal opportunity with whites. In common-sense and in legal terms some of the exclusionary processes would be interpreted as acts of discrimination. Accordingly, in both East and West Thames Health Authorities there was a unanimous view amongst senior personnel specialists interviewed that discrimination occurred within their organisations.

In analyzing the characteristics of discrimination at work in the NHS there is a congruence between the exclusionary processes affecting both women and black workers. Three processes have been discussed in the thesis in chapter one, and whilst they have different ideological bases operating in relation to 'race' and sex, they appear to work fundamentally in the same way. Whilst in any particular spatial or temporal context exceptions will be found, on the basis of the considerable quantity of anecdotal evidence and the limited research evidence cited in chapter one, the processes identified appear to represent common occurrences. Firstly, stereotypical assumptions about women interfere with their career prospects, affecting decisions concerning selection for employment and promotion opportunities. It is assumed by some managers, for instance, that women are not as interested in their careers as men as they are biding their time until they marry and leave work to have children. It is also assumed therefore that women will inevitably disrupt the organisation when they resign or reduce their work commitment for family

responsibilities. Such assumptions affect the career prospects of all women whether they are married or not and whether or not they have - or are intending to have - children. In general, their status as women at work is therefore stronger than their status as workers. In the same way, the status of black workers as being black is stronger in general than their status as workers, as negative stereotypes affect their career prospects. On some occasions they are regarded as being difficult and uncooperative, and on other occasions they are seen as being compliant and more suited to a servile role. Instances of harassment illustrate the ways in which 'race' and sex are ascribed the dominant status. Instead of being recognised for their professional skills or their contribution to the health-care system, individuals are seen firstly in terms of their 'race' or sex by the harasser. Racial and sexual harassment affect the quality of the working environment, potentially affecting work performance, and potentially inhibiting the promotion of women and black workers into areas of work - such as management - that are characterised as being 'male' and 'white'. Such areas of work are representative of a second broad exclusionary process whereby certain jobs are 'gendered' and some are 'racialised'. Whilst the processes involved affect all staff, they usually benefit male and white staff, to the detriment of women and black workers. For instance, the promotion of women into managerial positions in the NHS has been inhibited by expectations about a 'macho' style of management with which women are stereotypically less likely to comply. The 'macho' character of management provides an instance of what Cockburn (1991: 218) has argued is a "masculine cultural hegemony" of certain areas of work that inhibits the entry of the women. A third broad exclusionary process concerns the pathways of entry to NHS occupations and subsequent career success. There is some evidence to indicate that the path of entry to nurse training and medical training has been a 'white' path, as black

applicants have been less likely than whites to satisfy entry requirements on the basis of both academic and non-academic criteria. In the same way, in the case of health service administrators and doctors the path to career success appears to have been a 'male' path.

It will be apparent from the discussion in chapter one that a number of aspects of the exclusionary processes which disadvantage women and black workers have an ideological basis if a conceptualisation of ideology is used in terms of "everyday representations". It was observed in the introduction to the thesis that Robert Miles (1989), for instance, in drawing from Gramsci's (1971) notion of *'common sense'* conceived of racism as ideology in this way, in terms of every representations that whites make of blacks. The views just discussed, that women are not as committed to their careers as men, or that black workers are uncooperative, are examples of everyday representations made about women and black workers by some health service managers. However, in the context of the presence of structural inequalities between black and white workers, and women and men at work, a conception of racism solely in terms of ideology does not present the full story. Neither does it guide policy formulation to effectively challenge inequality at work. This is because *the structural inequalities themselves, on the one hand, provide a power differential which enables the exclusionary processes to operate. In other words, the domination of men and white workers in positions of power and authority enables them to exercise the exclusionary processes against women and black workers. On the other hand, the operation of the exclusionary processes reproduces and sustains the structural inequalities. Part of a cycle - or system - of dominance therefore confronts women and black workers. A recognition of the interaction between the two elements - structure and politics of dominance - is therefore crucial to policy analysis targeted at either the structural inequalities at work, or processes of exclusion, or both.*

It will be apparent that the relationship of dominance and subordination of white over black workers, and men over women at work, is more than a question of authority. It is a question of exploitation. The power, authority, autonomy, income, and status of male and white workers rests upon the subordination of women and black workers to comparatively low-paid, low-status work, in which their discretion and autonomy is confined. There are, of course, many exceptions to this pattern of domination as it has been observed that neither white nor black workers, and likewise neither men nor women at work, are homogeneous groups in relation to their distribution across the occupational hierarchy. In addition, if it was argued that men, and white men in particular, constitute a monolithic power group that consciously and collectively strove to maintain a position of dominance in the workplace this would amount to a conspiracy theory bereft of any empirical foundation. Cockburn's (1991) analysis, for instance, has shown active resistance by men, but it does not provide evidence of a conspiracy. Whilst undoubtedly some individuals in the two case-study Health Authorities were consciously practising exclusionary processes, the key point is that the processes work to the advantage of men - as a group - and especially white men who have a double advantage, and they work to the advantage of individuals as members of the group whether they agree with it or not. Often, advantaged individuals may not even be aware that they are being favoured as the processes are covert and concealed, so they will not have any choice in the matter. In the same way, women in relation to men as a group, and black workers in relation to whites as a group, are disadvantaged by commonly hidden processes.

It has already been stated, but the point cannot be emphasised too much because of its significance; *effective policy intervention against either the structural dimension or the political dimension of racism and patriarchy at work requires policy provisions for*

*both elements because of their interactive relationship.* But policy intervention in Britain has been targeted nearly exclusively, though, against the political dimension, as intervention on the structural dimension encounters a number of limitations. In discussing policy intervention, the structural dimension and the associated limitations shall be addressed first of all.

There appear to be three possible policy strategies aimed at the structural dimension alone; positive discrimination, 'targets', and positive action. Positive discrimination involves preferential selection - of women and black workers for instance - for employment. Targets involve the establishment of numerical goals for the representation of target groups - eg. women and black workers - across the occupational hierarchy of an organisation, with the aim that they will be achieved not by positive discrimination, but by equal employment-opportunity practices. Positive action involves a number of measures to remove barriers arising from previous discrimination and disadvantage.

Policies of positive discrimination would constitute a direct and open form of redressing structural inequalities in the workplace through the use of the group characteristics of either 'race' or sex as the overriding criteria for selection for employment or promotion. But irrespective of the desirability of the practice - which is the subject of much controversy - positive discrimination would contravene dominant liberal notions of social justice whereby the individualistic criterion of merit is the deciding criterion for the distribution of employment opportunities. Positive discrimination would also contravene the Sex Discrimination Acts and the Race Relations Act in Britain unless 'race' or sex are genuine occupational qualifications according to the Acts. In the current legislative context, therefore, positive discrimination is not an option.

A second possible policy strategy aimed at the structural dimension of inequality alone is the establishment of targets - or numerical 'goals' - for the representation of certain groups - women and black workers for instance - in various positions across the occupational structure. In comparison to the USA, targets have rarely been used in Britain, and the Department of Health has pushed forward the boundaries of equal employment-opportunities policy by establishing in early 1992 - as a participant in the "Opportunity 2000" - a number of targets for the representation of women in the NHS labour force. The Department of Health's contribution to the campaign has been its most prominent and direct intervention to date in relation to the implementation of equal employment-opportunities policies in the NHS. Amongst the eight "goals" of the campaign four targets were established, and they were to:

1. Increase the number of women in general management posts from 18 per cent in 1991 to 30 per cent in 1994

2. Increase the number of qualified women accountants in the NHS

3. Increase the percentage of women consultants...from 15.5% in 1991 to 20% by 1994

4. Increase the representation of women as members of authorities and Trusts from 29% in 1991 to 35% by 1994

(NHS Management Executive 1992)

It is notable that the target date for the 3 precise numerical goals is 1994, the year in which the 'demographic time-bomb' had been primed to explode, but it will be argued shortly, however, that the time-bomb has now fizzled out.

In comparison to explicit practices involved in positive discrimination the practice of establishing 'targets' is somewhat ambiguous. In the light of the prohibitions against positive discrimination the targets cannot be achieved by preferentially selecting for

employment positions individuals from the targeted groups at the expense of other candidates. The targets must be achieved by measures aimed at the political dimension of racism and patriarchy at work - which have been the chief elements of equal employment-opportunities policies - and also by the use of positive action measures. It is not clear, though, exactly what the objectives of targets are supposed to be. One unintended consequence - at least according to the principles of British anti-discrimination legislation - might indeed be covert practices of positive discrimination as managers strive to meet their required targets. It is possible though, that targets provide a clear public statement of commitment at the highest level of an organisation - in this case by the Department of Health - that will provide a stimulus for the implementation of equal employment-opportunities policy. Indeed, the Department of Health has gone much further than merely the provision of stimulus, as it is actually in effect *requiring* policy implementation as all NHS employers were expected by the end of July 1992 to submit implementation plans for scrutiny by the Department. In addition, in its implementation guidance for the ""Opportunity 2000"" campaign the NHS Management Executive (1992) stated that it expects Health Authorities and Trusts to include - in the context of the new business culture in the NHS - the establishment of the campaign goals in their usual business planning procedures, and summaries of progress will be expected to be included in their annual management reports which will be monitored by the Management Executive. Additionally, the implementation guidance states that achievement in relation to the campaign goals will also be evaluated through the annual review process between the Management Executive and Regional Health Authorities, which is a potentially powerful stimulus for policy implementation as discussed in chapter six. Whether such high-level commitment will continue remains to be seen, particularly as the likelihood of

the potential labour crisis to which the "Opportunity 2000" campaign appears to have been a response, now appears to have diminished - as discussed in chapter six. In the meantime, however, *the apparent high profile commitment to the implementation of equal employment-opportunities policies at the highest level in the Department of Health is a key to policy progress. It is also essential for progress that the Department monitors the achievement of health service employers in meeting their targets, and establishing the equal opportunities initiatives required. In short, health service employers will need to be held accountable for their progress to maintain policy momentum.* The "Opportunity 2000" campaign, however, only covers part of the problem of inequalities of opportunity at work, as a similar high profile commitment has not been apparent in relation 'race' inequality in the NHS. Two of the respondents from the Department of Health have indicated, however, that the required public commitment will soon be forthcoming, and again, that remains to seen. *The public commitment to equality of opportunity for women workers demonstrated by the Department of Health as a participant in the "Opportunity 2000" campaign also needs to be demonstrated with regard to the position of black workers in the NHS, and the discrimination and disadvantage they face.*

The third possible policy strategy aimed at the structural dimension of inequality alone involves positive action measures. For instance, although merit must remain the overriding criterion, the encouragement of women and black workers to apply for promotion, and the provision of special training in the skills required for promotion, are examples of positive action measures that may increase the representation of women and black workers where they are currently under-represented in management. Accordingly, in the case of women, the fifth "goal" of the "Opportunity 2000" in the NHS campaign advocates positive action by health service employers through the "introduction of a

programme allowing women aspiring to management positions to go through a development centre with a view to establishing their own personal development needs." (NHS Management Executive 1992). The NHS Management Executive itself has also stated that it will develop a number of positive action programmes for women which will include the establishment of "national networks" of women in senior management posts, the "identification of career sponsors" and "mentors", "women only management courses", "executive coaching", and "work shadowing".

The mail survey undertaken for the thesis - as reported in chapter four - revealed that very few Health Authorities - only 19 (or 11% of respondents) - had implemented any positive action measures by the time the survey was conducted - September 1990 to January 1991. The most frequently mentioned measure involved the encouragement of job applications from under-represented groups through statements of encouragement in job advertisements and recruitment aimed at local communities. These hardly amount to strong positive action measures that are going to have an impact on structural inequalities across the workforce. The mail survey also revealed that there was clearly some confusion about the meaning of positive action as measures reported by an additional four Authorities did not amount to positive action at all. In addition, the interviews with line-managers also indicated a great lack of understanding and confusion about the meaning and possibilities of positive action. It would be unlikely, therefore, that suggestions for positive action initiatives would be generated by line-management. *Therefore, not only has the National Health Service as a whole got much to do to achieve the Management Executive's objectives in relation to positive action, but clear direction concerning the possibilities of positive action need to be provided by senior management at national level, which can then be taken up by management at local level. Such direction would also*

*demonstrate a clear commitment - as do 'targets' - to the erosion of structural inequalities at work, and provide a direct strategy of intervention against those inequalities.* Again, it remains to be seen whether the direction concerning positive action will be provided. *In addition, objectives concerning positive action in relation to racial inequalities at work also now need to be established by the NHS Management Executive - with the same high profile as the "Opportunity 2000" campaign - to provide a more embracing challenge to inequalities of opportunity.*

In turning to discuss policy intervention aimed at the political dimension of racism and patriarchy at work, there are a number of potential 'anti-discrimination measures'. It is argued in chapters three and four, though, that measures aimed at the formalisation of the recruitment and selection process for employment and promotion provide the core of an equal employment-opportunities policy as they are directly aimed at inhibiting the exclusionary processes by altering the behaviour of managers. As has already been argued, the exclusionary processes are commonly concealed not only from the individuals they disadvantage, but also from those whom they benefit. This is because selection decisions are made in the private sphere of the meetings of shortlisting and interview panels at one level, and in the selectors' minds at a deeper level of concealment. The decisions are not normally accessible for scrutiny by job applicants, and therefore the space that is free from scrutiny provides a 'discriminatory gap' where the exclusionary processes can work. The processes operate around normal personnel procedures, and the purpose of the formalisation of the recruitment and selection process is to open up those procedures to scrutiny by other members of the organisation, thereby closing the discriminatory gap. Therefore, in outline - as it is discussed in detail in chapters three and four - formalisation of the recruitment and selection process involves; the advertising of all job vacancies so

that no potential applicant is excluded; the preparation of a job description for each vacancy; the preparation of explicit specifications of a suitable candidate in relation to the job description; and the recording of the reasons behind selection decisions made at the stages of shortlisting and appointment. The purpose of recording decisions is not only to open up the decisions to scrutiny, but also to serve as a deterrent to the potential discriminator as they will have to rationalise their judgements on paper and possibly at a later stage defend them. Whilst it is clearly feasible that apparently legitimate rationalisations could be found by the determined discriminator, it also appears reasonable to argue that they might think twice before discriminating because they will have to make a conscious effort to cover their tracks. In the absence of formalised procedures such efforts would be necessary as the selection decisions would not be subject to scrutiny unless a complaint of discrimination is made. But in comparison to the volume of appointments by organisations, complaints are a rare occurrence. From a more benign perspective, the enforced rationalisation of selection decisions may make managers aware of their own subconscious prejudice. This function was suggested by a number of line-managers as reported in chapter eight.

The mail survey revealed that less than half of the respondent Authorities had established formalised recruitment and selection procedures. *Therefore, if inequalities of opportunity are to be seriously addressed in the NHS, many more Authorities will need to review their procedures - particularly as increased formalisation constitutes a large element of the NHS Management Executive's implementation guidance for the "Opportunity 2000" campaign.* Earlier research in the private sector (cf. Collinson et al 1990) - as discussed in chapter eight - had found resistance to formalisation by line-managers as many regarded it as a restriction upon their managerial discretion. The

majority of the sample of thirty line-managers interviewed for the thesis, in contrast, welcomed formalisation. They saw the procedures involved as an aid - not an inhibition - to their managerial practice, helping them to appoint the most suitable candidates for employment. Whilst it cannot be concluded on the basis of a small sample of thirty that line-managers throughout the NHS will be similarly receptive, *the research provides an indication that many managers will actively incorporate formalised recruitment and selection procedures into their managerial activity. Much depends, though, upon a sensitive approach by personnel specialists to what initially might be perceived as an encroachment upon managerial territory. Personnel specialists therefore need to be far more active in encouraging line-managers to use formalised recruitment and selection procedures. They should capitalise on the enthusiasm and genuine commitment to equal employment-opportunities of some Health Service managers by actively involving them in the process of encouragement to other managers. Such managers could provide a valuable network of support, advice, and encouragement to other managers, and serve as role models for others.* Whilst in some instances a sensitive approach is required as successful formalisation depends upon the nature of the relationship between personnel specialists and line-managers, *Health Service employers should also make it perfectly clear to line-managers that complying with responsibilities under the organisation's equal employment-opportunities policy - which includes the procedures involved in the formalisation of the recruitment and selection process - is a condition of their employment.*

Closely related to the formalisation of the recruitment and selection process is the procedure of job-applicant monitoring - as discussed in chapter seven - which involves the evaluation of selection decisions by the statistical analysis of success rates between groups of applicants - for instance, males and females, and black and white workers - at

the stages of shortlisting and appointment. The monitoring may provide prima facie evidence of discrimination which can then be investigated further by examining the rationalisations behind selection decisions recorded by the selectors. The monitoring is not only an analytic device, it could be a powerful deterrent to the potential discriminator by opening up their selection decisions over time to scrutiny by others in the organisation. The implementation of an effective monitoring system, however - as discussed in chapter seven - requires in addition to the cooperation of job applicants - which does not appear to be a problem - the cooperation of personnel staff; both computing and human resources for the processing and analysis of monitoring data; and the commitment at senior levels of the organisation to both providing the necessary resources and to the effective implementation of the system. As discussed in chapter seven, when these institutional requirements are not provided the system will fail to meet its objectives. (The institutional aspects of the failure of policy will be considered further below in a discussion of the institutional dimension of racism and patriarchy at work). It is likely that such a failure has affected many Health Service employers in addition to the two case-study Health Authorities. Whilst three-quarters of the respondent Authorities to the mail survey reported that they collect information on the ethnicity of job applicants, only half of them had analyzed the information. In the light of the validity test carried out for the survey, however, this might even be an over-estimate.

*The Commission for Racial Equality, the King's Fund Equal Opportunities Task Force, and the Department of Health have all advocated job-applicant monitoring, yet guidance on how to process, analyze and present the data is severely lacking. The Department of Health could provide this guidance so that Health Authorities can establish the appropriate expertise. In doing so they would potentially make a major contribution*

*to the provision of equal employment-opportunities. For their part Health Service employers need to provide the necessary resources and the commitment to ensure that their own job-applicant monitoring systems achieve their objectives. In addition, the Department of Health could follow the example set by the 1989 Fair Employment (Northern Ireland) Act - as discussed in chapter four - by requiring Health Service employers to submit for scrutiny an annual monitoring report on the characteristics of job applicants - on the basis of 'race' and sex - and their comparative success rates in attaining appointments. This would provide a powerful incentive for employers to formalise their recruitment and selection practices.*

A further anti-discrimination measure discussed in the thesis concerns provisions for racial and sexual harassment. *Prescriptions for policy intervention in relation to harassment at work - as discussed in chapter four - appear at first sight to be concerned primarily with investigative and disciplinary procedures, and to a lesser extent with support for the victim. However, if they are publicised throughout an organisation, and particularly if they are seen to be backed by the strong commitment of senior management to enforcing the policy, then the very existence of the policy provisions themselves could serve as a powerful deterrent to the potential harasser by perhaps making them think twice before they act.* The mail survey conducted for the thesis, however, indicated that only a minority of Health Authorities had made some policy provision for harassment in their staff discipline and grievance procedure. Even fewer respondent Health Authorities - only 14% - had established a procedure to deal with the complex area of racial and sexual harassment by patients and visitors. Yet the interviews with line-managers suggest that there is an urgent need for such provision, as it appears that the harassment of Health Service staff, particularly nurses, and particularly in the community, may be widespread.

There has been no investigation of the extent of the problem to date, however, and in general, in contrast to the large body of literature on sexual harassment in the workplace and the growing body of research in Britain in the 1980s on racial harassment and housing, the extent and the dynamics of racial harassment at work is greatly under-researched. *There is clearly a role for the Department of Health to investigate the problem of harassment of NHS staff by patients, and to provide clear policy guidance to health service employers, not least concerning the ways in which staff who are subject to harassment should be supported.*

A third anti-discrimination measure discussed in chapter four involves equal opportunities training. Whilst the formalisation and monitoring of the recruitment and selection process and policy provisions for harassment are directly aimed at altering behaviour by inhibiting the exclusionary processes at work, one of the aims of equal opportunities training appears to be to change the attitudes of managers, with the ultimate effect - hopefully - of changing their behaviour. The analysis of the policy process at the micro-level in the two case-study Health Authorities - as presented in chapters seven and eight - has not included, however, an evaluation of the impact of equal opportunities training. This is because it appeared early on in the fieldwork in both Districts that as the recruitment and selection process provides the main arena in which equality of opportunity is either provided or denied, then the primary concern should be with measures focused directly on recruitment and selection. In this context, equal opportunities training appears to have a roundabout route to recruitment and selection practices. In the context of some of the entrenched attitudes evident behind the operation of the exclusionary processes it seemed that attempting to directly alter behaviour by requiring formalised procedures would be more successful than by attempting behavioral change by firstly changing

attitudes. This must remain an assertion as there is no empirical evidence to measure the relative effectiveness of formalisation against training. It does appear, however, that it is not practically possible to measure the impact of equal opportunities training (Brown & Lawton 1992), whereas it is possible to see the impact of formalisation in associated changes of behaviour. The case-study Health Authorities differed in the relative priority they attached to formalisation and training. West Thames District did not provide any equal opportunities training at all during the fieldwork period, but personnel specialists appeared to be actively involved in working with line-managers on formalising procedures for recruitment and selection. In contrast, East Thames applied considerable efforts into training, providing an equal opportunities training day each month and they were working through all levels of management by invitation. Yet their approach to the formalisation of the recruitment and selection process was tentative, beginning with a pilot project, and the interviews with line-managers in the District suggested that the approach was much less pervasive when compared to West Thames. It seems to be the case that equal opportunities training is the easier option. Health Service employers usually have well established in-service training arrangements to which equal opportunities can simply be added - requiring only the additional time of the trainers involved. It is also a less confrontational form of policy intervention compared to formalisation which requires managers to demonstrate actual changes in behaviour, whereas on training days managers simply have to sit and listen to exhortation for change. For these reasons perhaps, the mail survey revealed that in comparison to the formalisation of recruitment and selection, respondent Health Authorities had been far more active in the provision of equal opportunities training. *Formalisation and training should be seen as complimentary - not opposed - elements of equal employment-opportunities policy, but there does appear to*

*be a need for Health Service employers to give much greater attention to recruitment and selection procedures, and the monitoring of those procedures.*

To this point, the discussion has chiefly focused on the structural and political dimensions of racism and patriarchy at work and associated policy initiatives. The two dimensions only provide a partial analysis, though. *To fully understand the ways in which inequalities of opportunity are reproduced and sustained, and to most effectively develop policy intervention, various 'institutional' factors need to be considered.* The largest portion of the thesis - chapters five to eight - has been concerned with such factors. In aggregate, they are conceptualised here as the institutional dimension of racism and patriarchy as systems of dominance. The analysis of institutional factors draws considerably from concepts of "institutional racism", particularly - as discussed in the introduction - from Wellman's proposition (1977) that 'any' activity or process which preserves or inhibits challenges to racial inequalities can be classed as 'racism'. This proposition sensitizes analysis to significant processes that do not have any racial context at all, but serve to reproduce and maintain inequalities of opportunity. The impact of these processes cannot be underestimated for - as has been demonstrated in the thesis - they constitute significant barriers to policy measures aimed at the structural and political dimensions.

Significant barriers - revealed by the analysis of the macro policy process - have existed in relation to the organisation of policy for the NHS as whole, and policy expertise. *Now that considerable expertise in the development and implementation of equal employment-opportunities policies has been established, the Department of Health needs to continue to hold health service employers accountable for policy implementation, and ensure that adequate mechanisms for such accountability are maintained. Some*

*further expertise is still required though, as demonstrated - in chapter seven - in the analysis of the implementation of a job applicant monitoring system. The implementation of such systems at the micro level additionally requires commitment from the "top" of health service organisations, backed up by the necessary resources. Commitment from senior management, and adequate resources for policy implementation must therefore be given a high profile in policy prescriptions. They are not simply integral to the organisation of policy, they are essential.*

A further barrier to policy implementation revealed by the analysis of the macro policy process is inherent to equal employment-opportunities policies, and it is rooted in what has been referred to in chapter six as the 'paradox' of equal opportunities, that is, the more a policy is needed to challenge racism and patriarchy at work, the less likely it is to be implemented. Accordingly, when morality provides the sole argument to challenge racism and patriarchy, a significant barrier faces the implementation of equal employment-opportunities policy. Policy implementation therefore has to be an opportunistic process seizing the advantage provided by other policy imperatives. Three imperatives have been utilized by the Department of Health in the late 1980s and early 1990s, but it is questionable whether the concern of the Department has been with equal opportunity, or primarily with the other policy imperatives. Those imperatives have concerned the potential shortage of labour in the face of a demographic crisis; and the need to make the most efficient use of labour; and the need to make health service provision more responsive to the needs of minority ethnic communities. Whilst these imperatives have provided a stimulus for the implementation of equal employment opportunities policies, they will all potentially fail. The economic recession in Britain - with associated unemployment in the service sector which competes for workers with the NHS - has

diminished the potential labour crisis, as one of the respondents (R8) from the Department of Health admitted.

In addition, the efficiency argument is inherently flawed. As noted in chapter three, the principle of merit which lies at the heart of an equal employment-opportunities policy is synonymous with efficient recruitment and selection in the appointment of the most competent person for jobs. The efficiency of the job will therefore - in principle - be maximised as they are occupied by the most qualified individuals in relation to other potential candidates, and as a consequence the efficiency of the organisation as a whole is also maximised. But being qualified - or competent - for a job does not simply - or even always - involve educational or other certified qualifications. Many other characteristics - such as experience, motivation, ambition, initiative, reliability, punctuality, honesty - can be important indicators of suitability - or qualification - for a job in relation to the job requirements, and as Fullinwider has observed "Virtually every trait of personality can have a bearing on job performance." (1980: 73). An evaluation of a candidate's suitability for employment on the basis of those traits - in relation to job requirements - involves an "individualist" approach to selection whereby the suitability of the candidate is firmly located in the candidate's personal attributes. "Collectivist" criteria such as 'race' and sex of can also have a bearing on job performance though, and they therefore - in certain circumstances - serve as job-qualifications. The qualifications of 'race' and sex are recognised in the British Race Relations and Sex Discrimination Acts - which although they outlaw the use of 'race' and sex in general as selection criteria, exceptions are made for "genuine occupational qualifications". The principle that the collectivist criteria of 'race' and sex can be job qualifications is therefore enshrined in British legislation, and in some of the circumstances covered by the Acts - in the

provision of personal services for instance - it seems obvious that 'race' and sex as qualifications contribute to both the efficiency of the job and the efficiency of the employing organisation as a whole. In such instances 'race' and sex are clear criteria in the suitability for employment. There are additional circumstances - not included in the Acts - in which the 'race' and sex of employees can affect the efficiency of an organisation. But in these circumstances the "acceptability" (Jenkins 1986) of individuals on the basis of collectivist criteria is involved. For example, it was observed in chapter one that on some occasions the promotion of black workers to managerial positions might be inhibited by the resistance of white subordinates to working under them. In these instances the collectivist criterion of 'race' was used as the basis of an evaluation of whether individuals would 'fit in' - or in other words their "acceptability". If the rational and individualistic approach to selection was followed in such instances then it is likely that the appointment of the most qualified candidate on the basis of individualistic criteria - but an unacceptable candidate on the basis of collectivist criteria - would reduce the efficiency of the organisation as a whole due disruption arising from the resistance of established workers. In Fullinwider's words "efficiency may be compositive, to coin a term. How well the enterprise succeeds depends not only upon the individual skills of the workers but also upon how well they interact with one another and how well others interact with them." (Fullinwider 1980: 87). Formalisation of the recruitment and selection process therefore "need not be synonymous with greater efficiency." (Jewson & Mason 1986: 55), even further, as argued, it can reduce efficiency.

Other instances in which informal methods may be more efficient have been apparent in the recruitment process. Word of mouth recruitment, for instance, can be more likely to recruit workers that are acceptable to established employees and it is a

cost-effective method when compared to the formal practice of advertising job vacancies (Jewson & Mason 1986: 51). The comparative efficiency of informal recruitment methods is demonstrated - both with regards to suitability and acceptability criteria - by the practice of 'head-hunting', which involves the soliciting of qualified potential candidates known to the selectors for employment usually in senior positions. Head-hunting depends upon the existence of networks of informal contacts by which suitable and acceptable potential job applicants are known to selectors. The efficiency of such networks has been demonstrated by the Department of Health's initiative in 1992 - as part of the "Opportunity 2000" campaign - to establish a register of women in senior management which can be consulted by Health Authorities when seeking applicants for senior managerial positions (NHS Management Executive 1992). The register is an attempt - in the favour of women - to formalise a common informal practice.

With regard to the third policy imperative behind the implementation of equal employment-opportunities policies - the need to make service provision more sensitive to minority ethnic communities, the argument must be judged firstly on the basis of whether or not the minority ethnic groups singled out for special attention do have particular needs that are distinct from the needs of other groups. If such needs to do actually exist a second consideration is whether or not the provision of particular health services would in effect become more sensitive to the needs of minority ethnic communities by the appointment of workers from those communities. Increased sensitivity would depend upon a number of factors; the extent to which minority ethnic workers are employed to work directly with patients from the same group, or even other groups to which they are likely to be more sensitive because of their shared minority status; the extent to which they can effect the health care provided to members of their own group by other professionals from

other groups - it is likely that this would depend upon their degree of influence and authority within the health-care organisation; and the extent of the effectiveness of the health-care techniques applied to the needs of clients/patients generally, and the needs of members of their own group in particular. In cases where a particular group does have distinct health-care needs, and where those needs can be directly met most sensitively and effectively by health-workers from the same group - or by other health-workers under their direction - then the utilitarian argument clearly stands. Where distinct needs cannot be specified, and where it is uncertain that minority ethnic health-workers would be able to provide sensitive and effective care to members of their own community, then the validity of the argument is eroded. Likewise, when the issue primarily concerns preference for care or treatment from a member of the same group, the utilitarian argument has a weaker claim. When the former conditions do exist, however, the argument is not only utilitarian, it is also one of need, and discrimination on the basis of need - as stated in chapter three - is one of the "morally relevant criteria" by which it is commonly considered fair to discriminate between individuals in the allocation of social benefits - in this case, health care. Hence, 'positive discrimination' on the grounds of need is permitted by the 1976 Race Relations Act (section 5(2)(d)) and the 1975 Sex Discrimination Act (section 7(2)(e)), although it is couched in terms of appointment on the basis of 'genuine occupational qualification'. But a general appeal behind the implementation of equal employment-opportunities policies for the improvement in service delivery to particular groups through the recruitment of health-workers from those groups entails little utilitarian validity - according to the criteria of judgement specified above - where the health workers are not specifically employed for health-service provision to their own group. Even worse, they might even encourage claims for a form of 'reverse

discrimination' whereby members of the majority white community should be served by health-workers from that community.

Due to the entrenched attitudes and practices which disadvantage and discriminate against women and black workers in the NHS as discussed in chapter two, and the many other barriers to equality of opportunity discussed in the thesis, it seems likely that policy exhortation which appeals solely to morality must fail. But the opportunistic approach to policy implementation discussed above which seizes on the pragmatic instincts of managers will also potentially fail. The pragmatist will see through the transparency of the pragmatic arguments for equal opportunities at work that have been proposed to date. *The remaining viable approach to the provision of equality of opportunity at work in the NHS is for the Department of Health to make a firm and unequivocal public commitment to policy implementation by requiring health service employers to implement the dimensions of policy discussed in this chapter, and by imposing sanctions where they are slow to cooperate. Whilst this approach might be supported by policy exhortation appealing to both morality and pragmatic instincts, the obligations upon health service employers should be clear.*

# APPENDIX 1

## Maximising response to the mail survey

## Maximising response to the mail survey

As stated in the introduction to the research appendix, two of the key respondents for the research in relation to the macro policy process predicted a poor response to the mail survey, therefore particular efforts were applied to try and achieve a satisfactory response. In general, mail surveys achieve a lower - and therefore potentially less satisfactory - response compared to interview surveys. The satisfaction does not simply concern what might be felt to be an adequate number of responses. It concerns the possibility that the characteristics of the non-respondents may differ in some way from those of the respondents, as in such an instance a bias would be introduced into the findings when the parameters of the actual respondents are used to estimate those of the non-respondents. The most obvious strategy that could be used to alleviate the potential of non-response bias is to attempt from the outset to achieve the highest possible response within the resources available to the survey. This would not eliminate the potential of bias arising from the remaining non-respondents, but the higher the response the more likely it is that the survey findings will reflect the parameters of the survey population as a whole. A second strategy is to determine some relevant characteristics of the non-respondents which will provide the basis for estimates to be made of some of their parameters which are subject to inquiry in the survey. This methodological note focuses on these two strategies and explains how they were pursued in the mail survey.

In designing the mail survey, a number of measures were taken in an attempt to maximise the response. One measure concerned the length and layout of the questionnaire.

Instinctively it seems to be common sense that recipients of the questionnaire are more likely to complete it if it is short and if it has a spacious rather than a cramped format. Recent research evidence reveals however that such an assertion would be tenuous (Harvey 1988). It has been suggested, for example, that a longer questionnaire might achieve a higher response because it could signify the importance of the survey to the recipient (Haberlein & Baumgartner 1978: 459). Yet, having been advised - during the piloting of the questionnaire - of the demands made of the time of Directors of Personnel who were to be the recipients of the questionnaire, and having also observed those demands during the fieldwork in the two case-study Health Authorities, it appeared at the level of instinct at any rate, that the shorter the questionnaire, the more likely it was to be completed. This did mean, however, that some issues of interest had to be omitted.

Piloting of the questionnaire indicated that on average it took approximately ten minutes to complete, and that was stated in the letter which accompanied the questionnaire (appendix 3) in an attempt to encourage responses. Although emphasising the brevity of the questionnaire did not impress upon all Authorities as is testified by the response from one Authority which stated:

> Thank you for your letter...and previous correspondence concerning the Equal Opportunities Employment Form. This Health Authority does wish to participate in the survey and apologise for the delay which has occurred. I shall attempt to complete the form within the next four weeks and return to you as soon as possible. I am sure you appreciate that the completion of such a form needs to be worked in with other objectives within the section and we are rather overburdened at present.

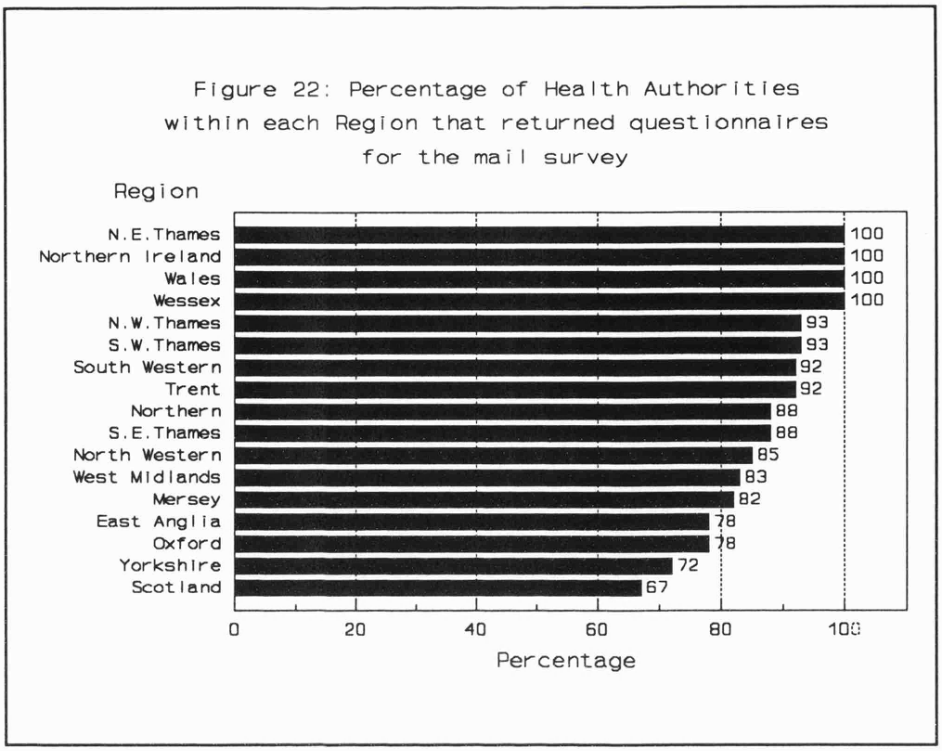
There is some irony in the probability that it would have taken less time to complete the questionnaire than it did to produce the letter containing the comment.

A number of other efforts were made in the explanatory letter to encourage responses. For example, an attempt was made to establish some credible auspices for the

survey by using London School of Economics headed paper, and stating the institutional sources of funding for both the survey, and the Ph.D studentship to which the survey was related - namely, the University of London Central Research Fund, and the Economic and Social Research Council. The deliberate intention of including the latter was to give the impression of quasi-government auspices as in general both academic and government auspices have been found to have a positive impact on response rates (Harvey 1988: 129).

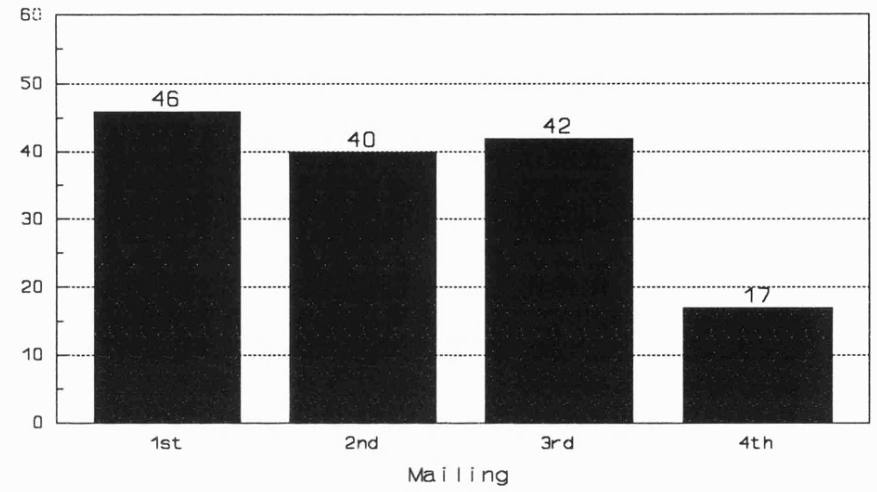
In addition to the length and layout of the questionnaire and the style and content of the explanatory letter, the use of follow-ups or reminder letters invariably increases responses to surveys (Linsky 1975: 85). Their use rules out the possibility that respondents could be anonymous to the researcher, but in the mail survey this was not an issue as an aim of the survey was to aggregate the findings on a Regional basis. Therefore the assurance given to respondents concerned the confidentiality of replies in that Districts and Boards were promised in the explanatory letter that none would be named in any reports of the findings. After the first mailing, three reminder letters were used, each sent three weeks after the previous mailing. The first reminder consisted simply of a reminder letter (appendix 3). The second contained the contents of the original mailing plus a further reminder letter (appendix 3). The final mailing (appendix 3) served as both a third reminder and also as an instrument to determine some of the characteristics of non-respondent Authorities to be used in estimating non-response bias.

In total, 201 - or 87% - of all Health Authorities returned questionnaires. The response varied across Regions as indicated in figure 22. A 100% response was achieved from Authorities in the North East Thames Region, Northern Ireland, and Wales, and Scotland produced the lowest response as only 67% of Health Boards returned the questionnaire.




The impact of the reminder letters is shown in figure 23. In the three weeks following the first mailing, 46% of Authorities returned the questionnaire. The first reminder produced responses from 40% of the remaining Authorities, and in response to the second reminder 42% of the outstanding Authorities returned questionnaires. The final reminder had the least impact as only 17% of the Authorities that had not replied to the earlier mailings returned questionnaires. However, the third reminder did produce some information for the estimation of potential non-response bias. Twelve Authorities that did not return a questionnaire after the third reminder provided information on whether or not they had a policy. In addition, a further 3 Authorities had also provided that information instead of returning questionnaires in response to earlier mailings. In total then, 43% of Authorities that did not return a questionnaire for the survey indicated whether or not they had a policy.

Figure 23: Response to the mail survey: Percentage of remaining Authorities that returned questionnaires after each mailing




It is observed in the discussion of the survey findings that 87% of Health Authorities that returned questionnaires reported that they have a written equal employment-opportunities policy which has been approved by their Health Authority. In comparison, 80% - or 12 - Authorities that did not return questionnaires similarly reported that they have a written approved policy. Therefore, on the basis of this one characteristic at least, there did not appear to be a great difference between Authorities that did and did not return questionnaires. It can be asserted with some confidence then that the survey findings do not appear to be affected by non-response bias.

# APPENDIX 2

## Research proposal

# EQUAL OPPORTUNITIES IN THE NATIONAL HEALTH SERVICE

## A RESEARCH PROPOSAL

PAUL IGANSKI

OCTOBER 1989

# EQUAL OPPORTUNITIES

# IN THE

# NATIONAL HEALTH SERVICE

This document specifies the details of a proposed research project concerning the formulation and implementation of equal opportunities policies in two District Health Authorities.

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## AIMS OF THE RESEARCH

The objective of the research is to evaluate and describe the experiences of two District Health Authorities concerning the formulation and implementation of equal opportunities policy on the basis of ethnicity, gender, and disability. It is hoped that from the analysis of those experiences, Districts which have not yet fully established an equal opportunities policy may draw some strategic guidelines for their own policy formulation. It is also hoped that the research will make a contribution to the evaluation of policy in the Districts in which the research is conducted.

The research will be concerned with four issues:

1) The antecedents to the establishment of policy in the two Districts.

2) The process of policy formulation.

3) The experience of implementing the policy.

4) An analysis of whether the policies satisfy possible objectives for them.

These four issues, and the aims of the research are discussed in detail in the following pages.

## CRITERIA FOR SELECTING THE TWO DISTRICTS

It is intended that the research will be conducted in two District Health Authorities in London; one in which considerable progress has been made in the implementation of an equal opportunities policy, and one in which the policy process is at an earlier stage.

It is not proposed that generalisations concerning all Health Authorities will be made from the study of two Authorities, but the rationale behind including two Districts in the research is that it could be determined whether they have had similar experiences in the development of their policies, and on the basis of their experiences some tentative conclusions could be drawn regarding the likely experience of those Districts which have not yet established an equal opportunities policy.

The analysis of the policy development will be based both on a retrospective reconstruction of the policy process, and by observing that process in action during the research period. In this context, the further rationale behind selecting two Districts at different stages in their policy development is that for the District which is at the earlier stage of policy development, the policy process can actually be observed during the fieldwork period, in addition to depending upon the accounts of that process from respondents in the fieldwork. The experiences of that District can then be compared to the other District which will be at a later stage in the policy process.

## ANTECEDENTS TO THE ESTABLISHMENT OF POLICY

The starting point for the research is an enquiry into the antecedents to the establishment of equal opportunities policy, and the all encompassing question for this issue is; what stimulated the initial interest in equal opportunities policy in the Districts ? The purpose of this question is to identify factors that have been significant in raising the issue of equal opportunities on to the policy agenda, so that they can be utilized by those interested in establishing policies in other Districts.

The role of any evidence of discrimination shall be considered, and it will be enquired whether the establishment of policy has been due to the recognition of evidence of discrimination in the District, or on the basis of other sources of evidence. It will also be considered whether any investigation of discrimination has been applied by the District as an antecedent to policy formulation. Further questions addressed will be whether those who have been involved in the policy process believe that it is necessary to have evidence of discrimination before establishing an equal opportunities policy, and whether the policy has been opposed at all on the basis of insufficient evidence ?

The role of participants in the policy process in raising the issue of equal opportunities onto the policy agenda will also be considered. It will be enquired, for example, whether the issue of equal opportunities policy has been raised due to directives from the DHSS, and subsequently the Department of Health ? If so, how have the Districts responded to them ? Has a flexible response been permissable ?

## THE PROCESS OF POLICY FORMULATION

The following questions will be addressed in analysing the process of the formulation of the equal opportunities policy in the Districts:
Was any individual or group responsible for the overall management of the policy formulation ? Particular attention will be given in this context to the role of the Equal Opportunities Officer.
What mechanisms for consultation with interested participants were constructed within the District, and who was actually consulted and involved in the shaping of policy ?

A description and summary of the equal opportunities policy in the two Districts will also be made, and a comparison made between them. The policies will then be compared to prescriptions from sources such as the Commission for Racial Equality, the Equal Opportunities Commission, Trades Unions, and Professional Associations.

In considering the characteristics of the equal opportunities policies in the two Districts, attention will be given to the moral basis for different types of policy. In relation to policy in the Districts, the following questions will be addressed:
Has some notion of social justice, for example the desire for equality of opportunity or the desire for equality of outcome, inspired those responsible for the shaping of equal opportunities policies in the Districts ?
It will also be considered to what extent the character of the equal opportunities policies reflect the moral standpoints of interest groups and those involved in the policy process ?
Have they felt constrained by the parameters of current legislation ?

What further scope would there be for the character of policy if they were not so constrained ?
If the characteristics of the equal opportunities policy fall short of those permissable under current legislation, have there been moral constraints felt by those responsible for shaping policy ?
Do the participants in the policy process and interest groups believe that the characteristics of the equal opportunities policy are just ?

## THE EXPERIENCE OF IMPLEMENTING THE POLICY

Particular attention will firstly be given to the mechanisms by which the policy has been communicated to those involved in its application, and then to any impediments confronted in attempting to apply the policy. A review of the literature will be made concerning prescriptions for the implementation of equal opportunities policy, and the experience of such implementation in other fields will be drawn upon to identify possible impediments, and the way that they were managed. The implementation of policy in the two Districts will then be considered in the light of those prescriptions and experiences with the aim of suggesting good practice for the implementation of equal opportunities policy in other DHAs.

Communicating the Policy.
When analysing the communication of the equal opportunities policy in the two Districts, the following questions will be addressed;
1) What has been the mechanism for communicating the policy to all those involved in applying it ? In the fieldwork, an evaluation will be made of the knowledge of

the policy by the key actors potentially involved in its implementation.
2) How successfully has it been communicated ? Any difficulties produced by shortcomings ?
3) What mechanisms were established to ensure that the policy is being implemented ?
4) What means of communication were established for the feedback of experiences of implementation ? Were any difficulties in the working of the policy experienced ?
5) How flexible has the policy process been to that feedback ?

Impediments to policy implementation.
When considering possible impediments to the implementation of the equal opportunities policy in the two Districts, a starting point will be the question of whether any targets were set for the achievement of policy initiatives, and if so, whether the targets have been met. If they have not, then attempts will be made to identify impediments to progress, and by reference to the literature, and from interviews with key participants in the policy process, good practice for overcoming the impediments will be considered. If the targets have been achieved, then it will be evaluated whether any impediments occurred and how they were successfully managed.

When considering the implementation of policy, particular attention will also be given to the role and influence of the Equal Opportunities Officer.

## DO THE EQUAL OPPORTUNITIES POLICIES IN THE TWO DISTRICTS SATISFY POSSIBLE POLICY OBJECTIVES ?

Possible objectives for the scope of equal opportunities policy will be derived from:

1) A review of the literature concerning the employment experience of women and ethnic minority workers in the NHS, and workers with disabilities.

2) A review of the literature concerning prescriptions for policy.

3) A review of the literature concerning the moral aspects of equal opportunities policy.

4) Expectations and aspirations of fieldwork respondents.

The actual characteristics of the equal opportunities policies in the two Districts will then be evaluated to consider whether they meet those possible policy objectives.

## RESEARCH METHODOLOGY

### DISTRICT DOCUMENTS

It is proposed that an initial construction of the policy process will be made by reference to relevant District documents, and access to such documents will be sought.

### DISTRICT MEETINGS

Access will also be sought to relevant District meetings which concern equal opportunities policy.

### INTERVIEWS

It is proposed though that the principal research method used will be informal interviews, or discussions with District personnel. The selection of potential respondents will be made on the basis of their contribution to the shaping of equal opportunities policy in each District,

and it is anticipated that two types of respondent will be identified; those who have been involved with executive decisions concerning equal opportunities policy, and those with or without the authority to determine the character of policy, but who have been influential in raising equal opportunities issues onto the policy agenda, or who have been influential in the actual shaping of policy.

The identities of potential respondents will be ascertained from the initial negotiations with the District Management, and also by reference to relevant policy documents and attendance at meetings. Each respondent will also be asked to suggest others who they believe have played a role in the policy process. In addition, those who would normally be expected to contribute, or at least have an interest in the policy process, such as representatives of professional associations, trades unions, and senior professionals, will also be approached to gauge their involvement in the process of formulating and implementing equal opportunities policy.

A list of potential respondents will be established, and it is not possible before embarking on the fieldwork to estimate precisely how many there might be, although it is anticipated that between approximately twenty-five and thirty interviews will be conducted. Through the discussions with respondents a description of the policy process will be constructed.

It is proposed that the interviews will be semi-structured, and the questions raised in the previous pages will serve as a topic guide. An aim of the interviews is not to constrain respondents by using a structured approach, as it is hoped that they will generate the material for the description of the policy process.

Because of this it is not possible to say precisely how long the interviews will take, or how many might be required with each respondent, although the aim in the first instance will be to complete the interview with each respondent in one hour. As far as possible, it will be suggested to each respondent that the interview will be held during lunch-breaks or directly after work if they are agreeable.

It is intended to tape-record and then transcribe as many interviews as possible.

TIMETABLE

It is proposed that the research will cover a period of twelve months between January and December 1990.

ASSISTANCE TO EQUAL OPPORTUNITIES OFFICERS

It is appreciated that the research will demand a considerable amount of time in total from staff in the District. To off-set this, the offer of unpaid assistance is made to the Equal Opportunities Officer in each District for up to one full day each week. The researcher has previous research experience and some computing skills which might be useful in such a capacity.

CONFIDENTIALITY

It is proposed that in any discussion, presentation, and publication of the research findings, the anonymity of the two Districts, and all informants, will be ensured.

## BIOGRAPHICAL DETAILS OF THE RESEARCHER


Name: Paul IGANSKI

Address: 41, Maltby Drive,
Enfield,
Middlesex. EN1 4EJ.
Tel: 01-443-4202


Age: 32

Work Experience: Psychiatric Nursing, 1975 - 1984
Cheadle Royal Hospital, Cheshire.
Charge Nurse, 1981 - 1984.

Academic Background: BA (Hons) Social Science & Administration, 1987
University of London, Goldsmiths' College.

MA (Econ) Applied Social Research, 1988
University of Manchester, Dept. of Sociology.

Current Position: Full-time Ph.D. research student,
Dept. of Social Science & Administration,
London School of Economics & Political Science.

Visiting Lecturer, Dept. of Social Science & Administration, Goldsmiths' College.
University of London.

Relevant Research Experience: July 1987 - July 1988, Research Interviewer,
Hester Adrian Research Centre,
University of Manchester.

July 1988 - October 1988, Commissioned by Leeds Council for Overseas Student Affairs, to design a research project to investigate racial discrimination and student housing.

Research Supervision: Supervision for the researcher is provided by:
Dr. Martin Bulmer,
Reader in Social Administration,
Dept. of Social Science & Administration,
London School of Economics & Political Science,
Houghton Street, London. WC2A 2AE.


Funding: The researcher is funded by the Economic and Social Research Council.

# APPENDIX 3

## Mail survey questionnaire and covering letters

# EQUAL OPPORTUNITIES IN EMPLOYMENT : A SURVEY OF THE NHS

Please circle the appropriate answer and provide details where required. -- -- -- --

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EQUAL OPPORTUNITIES POLICY

1. Does your Authority have a written equal opportunities policy ? YES NO (If No, go to Q6)

2. Does the policy cover staff groups on the basis of;

   Ethnicity YES NO

   Gender YES NO

   Disability YES NO

   Other (please specify) .....

3. In which year was it formally approved by the Health Authority ?.....

4. Does your Authority have a written programme of action for implementing the policy ? YES NO

5. Is there a timetable for implementing the programme of action ? (Go to question 8) YES NO

6. Does your Authority have a draft equal opportunities policy ? YES NO

7. If there is a draft equal opportunities policy, when will Health Authority members be asked to formally approve it ?.....

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EQUAL OPPORTUNITIES COMMITTEES

8. Has a Regional working party or committee been established for equal opportunities in employment ? YES NO (If No, go to Q10)

9. What are the terms of reference of the Committee ?.....

.....

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.....

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ADVISERS

10. Does your Authority employ an equal employment opportunities adviser or development worker ? YES NO

11. Has equality of opportunity in employment been included in the job description of a personnel or other officer ? YES NO
    (If Yes, please provide details).....

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.....

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REVIEW PROCESS

12. Is the development of equal opportunities in employment currently a review item for your Health Authority ? YES NO

13. Is it a review objective for any of the following;

    General Manager ? YES NO

    Director of Personnel ? YES NO

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RECRUITMENT AND SELECTION

15. Has the recruitment and selection process for employment been reviewed as part of the equal opportunities policy ? YES NO

16. Are person specifications <u>always</u> drawn up for all vacancies for employment ? YES NO

17. Are records <u>always</u> kept of the reasons for shortlisting or non-shortlisting of job applicants ? YES NO (If No, go to Q19)

18. Have they ever been analysed for equal opportunities purposes ? YES NO

19. Are records <u>always</u> kept of the reasons for appointment or non-appointment of job applicants ? YES NO (If No, go to Q21)

20. Have they ever been analysed for equal opportunities purposes ? YES NO

21. Has the process of selecting staff for management and other training provided or funded by the Authority, been reviewed as part of the equal opportunities policy ? YES NO

22. Is your Authority facing recruitment and retention difficulties for some groups of staff ? YES NO
(If Yes, please provide details).....

.....

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HARASSMENT

23. Are provisions concerning racial and sexual harassment specifically included in the staff discipline and grievance procedure ? YES NO

24. Does your Authority have an established procedure which concerns racial and sexual abuse and harassment of staff by patients and visitors ? YES NO

25. Is there an established procedure concerning harassment of Health Authority employees by staff employed by outside contractors ? YES NO

26. To whom would staff make complaints of harassment in the first instance ?.....

.....

27. Is there a counselling or support facility available to staff who have suffered harassment ? YES NO
(If Yes, please provide details)

.....

.....

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POSITIVE ACTION

28. Have any positive action measures permissable under the Race Relations Act and Sex Discrimination Acts been taken by your Authority ? (If Yes, please provide details).....

.....

.....

.....

29. Has your Authority taken any measures to increase the recruitment of people with disabilities ? YES NO
(If Yes, please provide details)

.....

.....

.....

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ETHNIC MONITORING

30. Has your Authority made an audit of the workforce concerning the ethnic origin of employees ? YES NO (If No, go to Q34)

31. In what year was this first done ? .....

32. For what proportion of the workforce do you currently have this information ? .....%

33. Has the information been analysed ? YES NO

34. Is information collected about the ethnic origin of applicants for employment ? YES NO (If No, go to Q36)

35. Is that information analysed regularly ? YES NO

---

OTHER MONITORING

36. Does your Authority have information available concerning the number and distribution of men and women in the workforce ? YES NO (If No, go to Q38)

37. Has that information been analysed ? YES NO

38. Is information collected about the sex of applicants for employment ? YES NO (If No, go to Q40)

39. Is that information analysed regularly ? YES NO

40. Does your Authority have available information about the number and distribution of employees who are registered disabled ? YES NO

41. Does your Authority have available information about the number and distribution of employees who are not registered disabled, but have disabilites ? YES NO

42. Is information collected about the ethnic origin and sex of employees <u>applying</u> for training courses run or funded by the Authority ? YES NO

43. Is information collected about the ethnic origin and sex of employees <u>attending</u> training courses run or funded by the Authority ? YES NO

---

TRAINING

44. Has your Authority provided training sessions concerned with equal employment opportunities for the following;

Health Authority Members YES NO

District Management Board Members YES NO

Unit Management Board Members YES NO

Personnel Staff YES NO

45. Is an equal opportunities component included in;

Induction Training YES NO

Management Training YES NO

46. Is attendance on a recruitment and selection course mandatory for;

<u>All</u> staff involved in the selection of new employees ? YES NO

<u>All</u> staff involved in the selection of existing employees for training courses provided or funded by the Authority ? YES NO

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Name and designation of person
who has completed the questionnaire.....

Thankyou very much for completing the questionnaire. Please return it in the pre-paid envelope to;
Paul Iganski, 26, The Towers, Crown Terrace, Lower Mortlake Road, Richmond, Surrey TW9 2JR.

# EQUAL OPPORTUNITIES IN EMPLOYMENT
# A SURVEY OF THE NHS

London School of Economics

26, The Towers,
Crown Terrace,
Lower Mortlake Road,
Richmond,
Surrey TW9 2JR.
Tel: 081-948-6557.

I am writing to you about a postal survey I am conducting of all Health Authorities in the National Health Service, concerning the development of equal employment opportunities policies. The survey is part of a larger study of the National Health Service which I am undertaking for my Ph.D research at the London School of Economics in the Department of Social Science and Administration. My studentship is funded by the Economic and Social Research Council, and this postal survey has been funded by the Central Research Fund of the University of London.

The objective of the postal survey is to provide an indication of the development of equal employment opportunities policies in the NHS as a whole. The information collected might serve as a benchmark for individual Authorities to compare their own progress against the progress made by other Authorities in general, and could therefore be of use in the planning process. To that end, all respondents in the survey will receive a summary of the findings. I appreciate that my questionnaire has been preceded by a similar survey by the Equal Opportunities Commission. However, whilst their survey has been concerned with gender issues, my concern extends beyond that to include race and disability.

Therefore, I would like to ask you if you would mind answering the enclosed questionnaire concerning equal opportunities in employment in your District. It should not take longer than ten minutes to complete, and the information requested should be available without you having to refer to any records. The anonymity of all individual respondent Districts and Boards is guaranteed in that none will be named in any report or publication, although the findings will be aggregated on a Regional basis. You may observe that the questionnaire has a code number written in the top corner of the first page. That is for my reference only in order to identify which Authorities have responded.

If you require further information about the research, please contact me at the above address or telephone number. Many thanks in anticipation.

Yours sincerely,

Paul Iganski.

# EQUAL OPPORTUNITIES IN EMPLOYMENT
# A SURVEY OF THE NHS

London School of Economics

26, The Towers,
Crown Terrace,
Lower Mortlake Road,
Richmond,
Surrey TW9 2JR.

I am writing to draw your attention again to the survey I am conducting on equal opportunities in employment in the NHS. You may recall that three weeks ago I sent you a questionnaire with a letter explaining the nature of the survey. To date approximately 50% of Health Authorities have replied, but I would like to achieve the highest possible response so as to accurately reflect the current position of the National Health Service. Therefore if you have the time to complete and return the questionnaire your contribution would be very much appreciated.

In a pilot exercise it took no longer than ten minutes to complete, and it should not require reference to any other documents. The anonymity of all respondent Districts and Boards is guaranteed in that none will be named in any reports of the survey findings.

If you have already returned the questionnaire, I apologise for troubling you further.

Many thanks again in anticipation,

Yours sincerely,

Paul Iganski.

# EQUAL OPPORTUNITIES IN EMPLOYMENT
# A SURVEY OF THE NHS

London School of Economics

26, The Towers,
Crown Terrace,
Lower Mortlake Road,
Richmond,
Surrey TW9 2JR.
Tel: 081-948-6557.

I am writing to you again about the postal survey that I am conducting of equal employment opportunities policies in the National Health Service. You may recall that six weeks ago I sent you a questionnaire with a letter explaining the nature of the survey, and this was followed by a reminder letter three weeks later. The majority of Health Authorities have now responded to the survey, but to accurately reflect the current position of the NHS it is necessary for me to achieve the highest possible response.

Therefore, I wish to enquire whether you might find the time to complete and return my questionnaire. I would like to point out again that it should not take longer than ten minutes to complete, and no individual District or Board will be named in the research reports.

For your convenience I have enclosed a further copy of the questionnaire, the original explanatory letter that I sent to all Directors of Personnel, and a stamped addressed envelope for return of the questionnaire. If you would like to make any enquiries about the survey, please do not hesitate to contact me at the above address or telephone number.

Many thanks again in anticipation.

Yours sincerely,

Paul Iganski.

# EQUAL OPPORTUNITIES IN EMPLOYMENT
# A SURVEY OF THE NHS

London School of Economics

26, The Towers,
Crown Terrace,
Lower Mortlake Road,
Richmond,
Surrey TW9 2JR.
Tel: 081-948-6557.

Further to my recent letters to you concerning my postal survey of equal employment opportunities in the National Health Service, I am writing to all Health Authorities that have not so far responded with a last request for completion and return of the questionnaire.

Over 75% of all Health Authorities have now responded to the survey, but it is important that I achieve the highest possible response to most accurately reflect the current position of the NHS as a whole. Therefore, if you do wish to respond, could i ask that you return one of the questionnaires that I have previously sent - with an accompanying stamped addressed envelope - as soon as is convenient.

If you do not wish to complete the questionnaire I apologise for troubling you further, but ask whether you might be able to provide the information requested below by completing the two questions and returning this letter to me:

Does your Authority have a written equal opportunities policy ?.....

Yes No

(Please circle appropriate response)

If yes - in what year was it formally approved by the Health Authority ?

.....

Yours sincerely,

Paul Iganski.

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