The Glass Ceiling: Gender Segregation

by Nuzulul Putri

The Glass Ceiling: Gender Segregation Within Health Workforce Leadership with Matriarchal and Patriarchal Societies in Indonesia

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Despite women's increased participation in leadership within the health system, equal participation of men and women in decision-making is not guaranteed. This is the result of embedded patriarchal norms which favour masculine leadership structures and characteristics. While the number of women leaders in health organizations is increasing, this has revealed what is known as the glass ceiling. The glass ceiling, first introduced by Gay Bryant in 1984, is the presence of invisible barriers that impede the career advancement of women (Barreto et al., 2009). It is called a brass ceiling in military organizations and the celluloid ceiling in the cinematic industry. Since the healthcare workforce is dominated by a significant number of women, there is an urgent need to systemically describe how the glass ceiling in health care has occurred and its impact.

This chapter discusses gender leadership succession and gender segregation in the context of the health workforce within matriarchal and patriarchal societies in Indonesia, demonstrating how the increasing number of women as leaders at the top of the health system does not guarantee that women at lower levels have an equal opportunity to obtain leadership positions compared to men. In the last 15 years, the Indonesian health system has been led by women ministers; the chapter describes how even though the health system within Indonesia was led by women, gender segregation still occurs in its lower structural and technical levels. The chapter finishes by presenting recommendations for researchers and practitioners in analysing gender segregation in health care.

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Women at the Top

The health workforce in Indonesia is composed mostly of women. Many studies have found that female leaders in the health sector lag considerably behind their male counterparts in advancing into strategic decision-making positions (Elwér et al., 2012; Paoloni & Demartini, 2016; Rincón et al., 2017; Wanigasekara, 2016). Since becoming an independent country in 1945, Indonesia has had 20 Health Ministers, and only 4 of them were women. However, women have started to occupy strategic positions in the health sector.

Since 2004, presidents of the Republic of Indonesia chose women to act as Ministers of Health, even though the number of female ministers is always much fewer than male ministers in the cabinet. In his first 5-year term of office, President Susilo Bambang Yudhoyono appointed a senior female cardiologist as the Minister of Health. She was the very first woman who served as Minister of Health in Indonesia and was 1 of 4 female ministers among all 34 ministers at the time. President Yudhoyono appointed another female as Minister of Health in his second presidential run, a doctor with expertise in public health. She was 1 of 5 female ministers of 34 ministers at the time. Unfortunately, she passed away in her third year of service due to lung cancer and was replaced by her male Vice Minister. After only 2 months in this position, President Yudhoyono replaced him with a female paediatrician. President Joko Widodo, the following president, also chose a woman as Minister of Health, who was 1 of 8 female ministers among 34 ministers at the time. A senior ophthalmologist, who was also the wife of a former Health Minister, was appointed as the fourth female Minister of Health in Indonesia. The trend of having female Health Ministers in Indonesia, however, ended after the second presidential run of President Joko Widodo at the end of 2019 when he assigned a male military doctor. After 15 years of being led by a woman, the Indonesian Ministry of Health was officially led by a man. President Joko Widodo's agenda to counter-terrorism and radicalism in Indonesia is one of his reasons for assigning a male Health Minister with military background.

Even though there is no research that focuses on the impact of women leaders on public health in Indonesia, the leadership of four women had other effects within the country. The first female Minister of Health demonstrated that women could also be good leaders. She persistently fought for the non-commercialization of the avian influenza vaccine. The second woman health minister proved that women in leadership result in more woman-sensitive policy in health care. Even though she served as minister for only 2 and a half years, she placed a strong emphasis on maternal and child health care. She was the first Indonesian Minister of Health to legally regulate exclusive breastfeeding and banned health workers from promoting formula milk, obligating the existence of a breastfeeding room in all government offices. The third female minister also advocated for woman-sensitive policy. Based on her experience as Deputy Chair of the National Commission on Violence Against Women, she initiated the establishment of the National Commission for Indonesian Children Protection. The final female minister initiated a social innovation movement that

advocated for team-based health workers as opposed to individual medical workers to solve high maternal and neonatal mortality. While women had attained leadership at the summit of the system, it is unclear how their leadership had been accommodated at the lower levels of the system in Indonesia, and whether it allowed for greater opportunities for women to be leaders in the lower levels of the health system.

Leadership in Decentralized Matriarchal and Patriarchal Systems

Indonesia has embraced decentralization and is comprised of 34 autonomous provinces that contain districts. The districts are the local government who manage and perform their public services independently. District Health Offices are coordinated by local government as a result of decentralization. Civil servants in the District Health Office get promoted only by the recommendation of an advisory board at the district level that is responsible for suggesting the name of expectant structural officers to the regent or major as district head. Besides considering the fulfilment of basic qualifications regulated nationally, this board takes into account the work performance of the individual. The promoted officers will either become the top-level, middle-level, or low-level manager in the District Health Office.

A series of position reviews of the organizational structure of District Health Offices (Fig. 1) were conducted to analyse the glass ceiling in leadership succession. Position reviews, or position analysis, is a systematic process that is commonly used in human resource management. It identifies the set of knowledge, skills, and abilities required to perform the responsibilities and duties of a specific
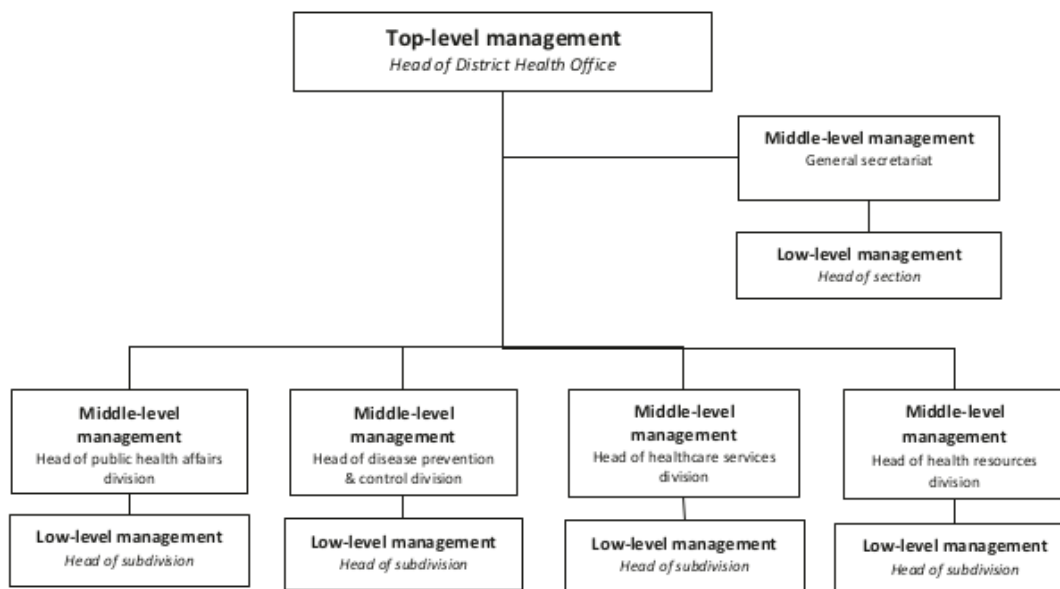

Fig. 1 Organizational structure of the District Health Office

job position through job analysis (Mathis & Jackson, 2008). Human resource specialists execute this activity to review the job description which determines the value of the job (Griffin, 1978). The position analysis was conducted in Minangkabau, one of the biggest matriarchal societies in the world (Stark, 2013). Minangkabau tribes are the only matriarchal society in Indonesia. They live at the West Sumatra province where every child born to the Minangkabau tribe follows his mother's tribe.
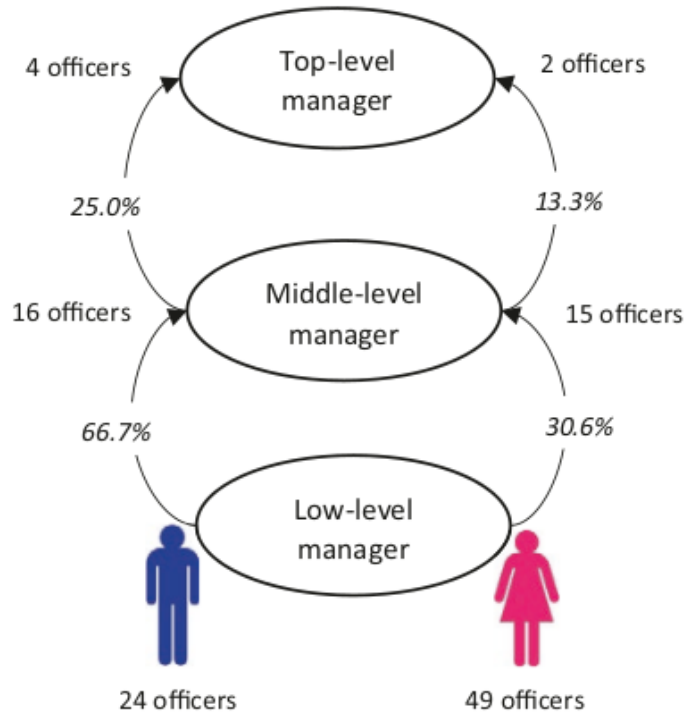
The analysis was compared to the patriarchal society of East Java. Various books and studies are still debating whether matriarchy should be considered the opposite of patriarchy (Eisenstein, 1979; Murray, 2005; Walby, 1991; Witz, 2004). Patriarchy is defined as a social system where men predominate above women in the roles of political leadership, moral authority, social privilege, and control of the property. It is not the result of sex differences between men and women, but the gender roles which are constructed for each gender by society. A matriarchy accommodates women as a maternal symbol, which has a significant influence on the next generation of both men and women. It emphasizes the central role of women in all social practices. Women in matriarchal societies are placed in positions with the highest control and power over men. On the other hand, matriarchy has been described as equal power-sharing between men and women with an egalitarian perspective (Leacock, 1978). Minangkabau is a non-class-based society and the women are autonomous; Minangkabau women do not depend on their husbands; moreover, their brothers are responsible for their children rather than their husbands (Stark, 2013).

The position reviews were held in 6 districts of West Sumatra province and 11 districts of East Java province. These districts were chosen based on the District Health Office transparency (publishing its organizational structure along with the officer's names on the official website). 338 health managers in both District Health Offices were observed in this position review: 110 managers in the matriarchal setting (West Sumatra) and 228 managers in the patriarchal setting (East Java).
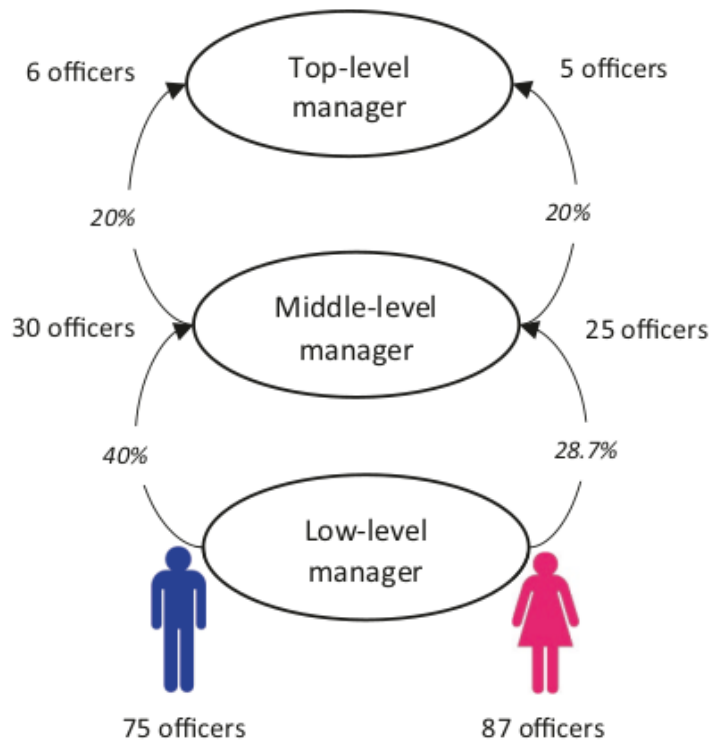
Glass Ceilings Within Matriarchal and Patriarchal Societies

Surprisingly, even in the District Health Offices within the matriarchal setting, there was evidence of the glass ceiling at work. There was a wide gap in promotion probability between male and female health officers. The promotion probability between male and female health officers is presented in Figs. 2 and 3. There were double the number of female officers as heads of subdivision in the matriarchal society, but only 30.6% of these were successfully promoted to become head of the division (see Fig. 2). This was lower than the probability of male officers getting promoted. In the patriarchal setting, the probability of male officers being promoted was higher than for female officers (see Fig. 3). A female low-level manager in matriarchal society has only 30.6% probability of being promoted into middle-level manager. This probability is much lower when compared to the probability of male low-level manager to be promoted to the middle-level. A male low-level manager in matriarchal

Fig. 2 Promotion probability in the matriarchal sample


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4 officers        Top-level        2 officers
                   manager
        25.0%                  13.3%
16 officers      Middle-level     15 officers
                   manager
        66.7%                  30.6%
                  Low-level
                   manager
     24 officers          49 officers
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Fig. 3 Promotion probability in the patriarchal sample


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6 officers        Top-level        5 officers
                   manager
         20%                    20%
30 officers      Middle-level     25 officers
                   manager
         40%                   28.7%
                  Low-level
                   manager
     75 officers          87 officers
```

society has a 66.7% probability of being promoted into middle-level manager. This glass ceiling reportedly not only happened among healthcare workforce but also in various aspects of public affairs in the matriarchal society (Idris, 2011; Mutolib et al., 2016; Rohman, 2014).

Women who successfully became an elite manager often need to apply extra effort to reach their position compared to men (Davies-Netzley, 1998). For this reason, the educational background of each health manager was analysed and compared to the job specification required for promotion. All of the health managers, both male and female, possessed a bachelor's degree in accordance with the job specification. In fact, more than half the female managers had a master's degree. This is 10% higher than male managers with a master's degree. This reveals that greater technical competence or merit is not necessarily a determinant that leads to men having higher proportional representation in managerial positions. Likely, it is invisible barriers, not merit, that limit women being promoted to higher levels of decision-making.

Conclusion

Our findings uncover gender differences in governmental offices in Indonesia. The existence of women at the top of the health system and the large number of women participating in the system does not guarantee that women are represented as decision-makers at its technical level. The glass ceiling still occurs both in matriarchal and patriarchal societies in Indonesia.

To overcome this issue in the setting of health workforce leadership, more transparent succession plans for leaders in district health offices are needed. Gender-sensitive instruments should be used to evaluate any indication of gender stereotyping and segregation in the job description and specification. Mainstreaming gender in the context of leadership succession plans in Indonesia is still underperformed, which leads to inadequate reporting and data collection about gender inequality. In order to establish policy frameworks to address gender-related differences in organizational settings in Indonesia, additional evidence related to gender equality within leadership in the government sector is needed. Future research should provide evidence on how gender segregation within governmental settings happens and how glass ceilings are formed and perpetuated. By uncovering these mechanisms, governments will be able to reduce gender inequality within leadership structures in Indonesia.

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