

Upgrading California's Home Care Workforce

THE IMPACT OF POLITICAL ACTION
AND UNIONIZATION

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THE POPULATION OF ELDERLY AMERICANS IS EXPANDING SO RAPIDLY that in the next half-century the number of seniors in the United States is expected to increase by 137%. The population of Americans with disabilities is also growing, and the number of people requiring long-term care is expected to more than double before 2050 (DHHS and DOL 2003). In California the number of persons aged sixty-five and over is expected to increase 22.7% between 2000 and 2010 (California Budget Project 2004), and the overall rate at which the elderly are living with one or more disabilities is rising quickly (Heinritz-Canterbury 2002). As a result, California, like the nation as a whole, is experiencing a growing demand for long-term care. Yet, during the next twenty years, the demographic group from which caregivers are generally drawn, women between the ages of thirty-five and fifty-five, is expected to increase by only 9% nationwide (GAO 2001).

Demand for in-home care in particular is also on the rise, and California is facing a critical shortage of home care workers. Seniors are often isolated or distant from family members who might provide care, and, influenced by the scandals surrounding the nursing home industry, many are reluctant to seek care in institutional settings (Heinritz-Canterbury 2002). This crisis will not be averted until one all-important issue is resolved: that of low-wage work. Home care jobs do not pay enough to sustain most working families.

Nearly one-quarter of the workforce—27.5 million Americans—earned less than \$8.70 an hour in 2001. As many as 4 million work as direct care providers in hospitals and nursing homes, through home care agencies, or as independent providers of home care (BLS 2004). At least 2 million provide home care nationwide, earning an average hourly wage of \$8.00. Because wages are so low, turnover in direct care occupations ranges from 40% to 100% annually, meaning that the workforce shortage will be resolved only when recruitment and retention increase.

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In California home care is provided to low-income elderly and disabled persons through the In-Home Supportive Services Program (IHSS). Until 1995 no IHSS worker was paid more than the state minimum wage and none received health insurance. Sixty-one percent of IHSS workers still earn less than \$8 an hour, and although many are now offered employer-based health insurance, most cannot work enough hours to be eligible. Eight percent are still being paid the current state minimum wage of \$6.75 an hour. IHSS wages were the only source of earnings for 77% of IHSS providers in 2000; they took home a median monthly wage of \$436.00. In 2003 this wage was only 34.3% of the 2003 federal poverty level for a family of three (California Budget Project 2004).¹

The home care industry in California is gradually being transformed by unionization and related changes obtained as a result of pressure from a coalition of unions and home care consumers who recognized their mutual interest in a well paid, stable workforce. What has for decades been a uniformly bad minimum-wage job, done largely by women out of love for their clients or the need for temporary part-time work, has become a pretty good part-time job in some California counties. Roughly one-fourth of the IHSS workforce now earns at least \$9.50 an hour and has access to health, dental, and vision care insurance with low eligibility requirements.

This paper documents the impact that raising wages and benefits has had on turnover in California's home care industry. It begins by relating the impact of unionization and political action on home care jobs, then summarizes findings from focus-group sessions with home care providers in four California counties. A review of results from a longitudinal study of the effects of wage and benefit increases in San Francisco County on home care worker turnover provides background for the presentation of new evidence from a cross-sectional analysis of the effect of wage differentials among broad county categories and between Los Angeles and San Francisco counties. The findings show that higher wages are correlated with lower turnover at the state level.

BACKGROUND

Home care is long-term care that is provided in the home to frail elderly and disabled persons who would otherwise require care in an institution such as a nursing home, a residential care facility, an intermediate care facility, or a state hospital. The very large majority of people needing long-term care services receive them in non-institutional settings. A nationwide survey conducted between 1995 and 1997 found that approximately 13.2 million people living at home needed some assistance with the basic activities of daily living such as eating, bathing, and dressing, as well as assistance with shopping and housekeeping. In 1958 only 2,000 people were employed as home care workers. Although most home care is still provided by unpaid family

1. The median wage is based on data for the fourth quarter of 2000.

caregivers, home care has grown since the early 1960s into an occupation that employs an estimated 2 million people nationwide.² In California in 2000, approximately 2 million people living at home needed some assistance (Medi-Cal Policy Institute 2001). And, as of December 2003, approximately 270,000 IHSS workers were providing home care services to more than 300,000 Californians.

This transformation of home care into a substantial occupation resulted from a combination of factors: the expansion of health and social services in the 1950s and 1960s to cover more groups, equal opportunity legislation that favored the provision of long-term care in community and home-based settings, federal emphasis on funding social services programs that help recipients become self-sufficient, an increase in the proportion of the population that is living with one or more disabilities (DHHS and DOL 2003), a decline in the size and geographic proximity of families, and the movement of women into the workforce since the 1960s. IHSS was officially created in 1972 to consolidate organization and provision of home care at the state level. Today IHSS has two components. The Personal Care Services Program (PCSP) provides nonmedical personal care services, such as assistance with administration of medication, bathing, oral hygiene, grooming, and dressing; these services are funded by the federal government as well as counties and the state. The Residual Program provides these same nonmedical personal services, as well as assistance with household chores, such as cleaning, shopping, and yard work; these are funded by counties and the state. A number of people currently covered under the Residual Program would qualify for the PCSP program but for the fact that they are being cared for by a parent (in the case of a disabled minor) or spouse. IHSS participants must meet income eligibility requirements for both programs.

Initially, all funding for the program came from state revenues, but in 1975 IHSS received a significant boost when Title XX of the Social Services Act was enacted specifically to fund services that would help recipients achieve self-sufficiency, reduce their dependency, and prevent inappropriate institutional care—a goal that clearly encompassed funding for home care services. Under Title XX, renamed the Social Services Block Grant (SSBG) in 1981, California was able to shift a substantial portion of the cost of its attendant care services (as well as other services including adoption, adult and child day care, foster care, and protective services) to the federal government. The federal government paid 75% of the costs of the SSBG programs,

2. The Bureau of Labor Statistics estimates that there were 2.2 million formal long-term care workers, including 478,000 home care workers, nationwide in 2003 (BLS 2004). BLS counts only those home care providers who work at wage and salary employment in nursing and personal care facilities, residential care facilities and home health services, which excludes some of the principal modes in which home care aides are employed—namely, through temporary help agencies and public agencies or as self-employed independent providers. In 1999 there were an estimated 100,000 home care providers in six other states that have similar public programs (LeBlanc et al. 2001). There is virtually no information about the number of people who work as independent contractors to those private employers; however, an estimate of 1.5 to 2.0 million home care workers nationwide seems reasonable.

but only up to a nationwide cap of \$2.7 billion (Committee on Ways and Means 2000). States paid the full marginal cost of programs once they exceeded their share of the allocated monies.

By the early 1980s, although some counties still contracted with agencies, the IHSS program was established as a largely consumer-directed program, meaning that the consumer (the recipient of home care services) can hire, supervise, and, if need be, fire the provider.³ The county social services authorized hours of service and maintained timesheets for workers, and the state paid the wages from a combination of federal and state funds. IHSS workers were public employees, but the public entities that employed them were not clearly their employers. Wages constituted the bulk of the cost of the program, and while the federal government paid a share of the costs, IHSS workers and IHSS services, like all public employees and services, were still vulnerable to the state's fiscal problems.

Because IHSS is a consumer-directed program, a far larger share of California's long-term care services are provided in home- and community-based settings than is the norm nationwide, and a much larger proportion of the population receives the service at lower overall cost.⁴ Because of this contrast, political support for IHSS funding was weak. Moreover, because workers were not classified as employees under the National Labor Relations Act, they could not legally join a union.

During the 1980s the United Domestic Workers (UDW), now an AFSCME affiliate, and the Service Employees International Union (SEIU) began trying to organize the growing home care workforce.⁵ UDW concentrated on IHSS workers who were employed by proprietary and nonprofit agencies under contract to counties. SEIU concentrated on the so-called independent providers (Boris and Klein 2003). In 1987, following an extensive grassroots organizing effort in Los Angeles in

3. The consumer-directed mode has its origins in California's nonmedical-model attendant care program, which was started in 1960. California's nascent disability rights movement struggled to define this program as consumer directed from its inception (Reif 2004).

4. In 2002 California ranked fourth among states in per capita spending on the Medicaid Personal Care Services Option and second behind New York in total expenditures on the PCS Option, but it ranked forty-seventh among states in per capita spending on all Long Term Care. Medicaid spending on California's PCS program grew by 285% between 1997 and 2002, but spending on total LTC increased by only 60%, which is somewhat above the national average of 46% (Burwell et al. 2003).

In 1999 California, compared to Texas, provided more hours of service to roughly the same proportion of its population at half the cost per consumer; agency-based provision of services is the norm in Texas. In California the Medicaid personal care service reached 4.32 out of every 1,000 in the population, providing up to 10.1 hours of service a day, based on need, and the annual expenditure per Medicaid recipient was \$2,389.00. In contrast, Texas provided a maximum of 7.1 hours a day to a very slightly higher proportion of the population—4.52 consumers per 1,000 in population—at twice the cost, \$4,716.00 per consumer annually. (Estimates are author's calculations based on data from LeBlanc et al. 2001.)

5. The path to unionization has been well documented in other sources (Delp and Quan 2002; Heinritz-Canterbury 2002; Walsh 2001).

which the union signed up 20,000 workers to file for an early election, SEIU Local 434B sued Los Angeles County to establish the county as the employer of record. The court found that the consumer, county, and state each performed some employer functions but that no single entity performed all, so none could stand as the employer of record (Walsh 2001). With no employer of record, workers had no right to organize a union or bargain for better wages and benefits.

Following that defeat, the union continued its organizing drive in Los Angeles. It lobbied for and won voluntary dues deductions for those who had signed up and developed a series of services for members, nonmembers, and consumers, including a registry to help consumers find providers. Because there is no single workplace in which IHSS workers can come together, the union developed a strategy of direct action that included marches, rallies, demonstrations, and civil disobedience to help workers cohere around a common agenda (Heinritz-Canterbury 2002; Walsh 2001).

By the late 1980s, following rapid growth of the consumer population, California was spending well beyond its allotment of SSBG funds, and IHSS was absorbing an increasingly large share.⁶ Roughly 170,000 consumers in fifty-eight counties were receiving IHSS services from a poorly organized program that still paid workers the minimum wage. Pay checks were frequently late, turnover was very high, and, as a Little Hoover Commission report documented, consumers lived in fear that providers would find better jobs and leave them unattended (Little Hoover Commission 1991). The commission recognized that although many in the independent living community preferred consumer-directed care, some of the severely disabled, frail elderly, and cognitively impaired had difficulty finding, screening, and supervising providers. At the same time that IHSS was facing this criticism from the commission, the state was embroiled in a budget crisis that further threatened the program. In October 1991 the governor cut IHSS hours by 12% to reduce expenditures, adding to the fiscal pressure engendered by the flat budget requirements from the SSBG (Heinritz-Canterbury 2002).

Galvanized by fear that problems in IHSS would threaten the program's consumer-directed model, the disability community joined with a senior advocacy group and SEIU to fight for improvements in the program. This coalition pressed for the passage of significant legislation in 1992 that authorized, although it did not mandate, the creation of a public authority at the county level to deliver home care services. The legislation did require that public authorities either had to be or had to create an employer of record for workers; public authorities also had to develop a countywide registry that would link consumers with available workers and provide access to training. Once a county established an employer of record, unions could organize the workers and, upon recognition, bargain directly with it. A consumer-majority board with worker representation was to act as director and advisor to the public authority (Heinritz-Canterbury 2002).

6. Much of the material in the rest of this section is based on an interview with Laura Reif (2004).

So that resources would be available to raise wages and establish public authorities, the coalition also helped devise a plan that would allow the state to shift much of the expense of the IHSS program to Medicaid. The disability community had opposed state adoption of the PCSP option up to this point because consumers could participate only if their personal care services plan had been written by a doctor and was supervised by a nurse. The coalition successfully pressured the state to apply to the federal government for a waiver on the grounds that the state already had a program in place and was doing effective assessment through social services without the involvement of doctors and nurses. The waiver was accepted, and when the state adopted the Medicaid PCSP option in 1993, making personal care an entitlement for all eligible consumers, federal matching funds at a rate of 50 cents on the dollar brought a large new infusion of cash into the IHSS system.

New money and expanded eligibility brought many new consumers and providers into the rapidly expanding program. Between 1994 and 1999 seven counties organized public authorities: Alameda, Contra Costa, Monterey, San Francisco, San Mateo, Santa Clara (all in Northern California), and Los Angeles. All seven had union elections, culminating with a successful election in Los Angeles that brought 74,000 new home care workers into SEIU. New legislation in 1999 mandated the creation of employers of record and consumer majority advisory committees in all counties by 2003.

Bargaining for higher wages, however, triggered a new set of political and legislative challenges. About the time that the Medicaid PCSP option was adopted, the state also pushed through a new budget agreement, referred to as “realignment,” in which part of the cost of some programs, including IHSS, would be reassigned to the counties. The state provided revenue to cover the new county costs, but it was only as good as the tax base from which it was drawn. What realignment meant for IHSS funding, specifically, was that after the federal government had paid 50% of the PCSP costs, the state would pay 65% of the remaining costs and counties would pay 35% from funding that might not be sufficient to cover the costs. Moreover, the state agreed to pay 65% of remaining costs only up to a maximum wage rate of \$6.75, which meant that if a county agreed to pay wages higher than \$6.75, it had to pick up the entire additional nonfederal share. Not surprisingly, many counties were reluctant to take the risk of increasing their wage obligations to a program that was growing rapidly and for which the funding was shaky.

Significantly, the 1999 legislation also required the state to contribute the difference between the minimum wage and a target wage that would rise over a four-year period—beginning in fiscal year 2002—to \$11.50 an hour plus \$0.60 per hour for benefits (Heinritz-Canterbury 2002).⁷ As of June 2004 all counties had set up public

7. The state is only required to pay its share of increased wages if the revenue in the general fund has increased by 5% in the previous fiscal year. California entered a recession in 2000, so that condition has not been met for most of the years since the law was passed.

authorities (or, in three cases, nonprofit consortia), and thirty-nine had conducted successful union elections (Keeslar 2004).

Nearly fifty years after the first attendant care program was established in California, and after decades of union organizing and political action on the part of a labor-consumer coalition, home care has been transformed into an above-minimum-wage job with benefits in some counties. In those counties where workers are still paid the minimum wage and union elections have yet to be held, at least the institutional conditions for unionization are in place. Budget politics are the next frontier.

THE NATURE OF THE JOB

During the spring of 2004 we conducted a series of focus-group conversations with home care providers in four California counties.⁸ The participants represented the range of home care providers, from family providers, to career providers, to retirees who were working not because they needed the money so much as because they enjoyed the work. Our conversations with these men and women revealed a great deal about the nature of the job.

Among the family providers were three who were caring for their disabled children. The first was a seventy-six-year-old woman who had been caring for her forty-two-year-old Down syndrome son since birth. Twelve years ago she learned that she could be paid by IHSS for providing this care, and she was able to resign from her other job, that of running a regional center for developmentally disabled children. Because her son could accompany her to work, the position had allowed her to avoid institutionalizing him. The second of the three was a man who was caring for his fifteen-year-old autistic son; he had left his job in transportation when his former wife was on the verge of putting their son in an institution.

The third, a woman who was caring for her Down syndrome son, said that to avoid a medevac every time her son had a medical emergency, she and her husband had moved closer to hospital services. Her husband had given up his ministry when they relocated. He was able to find other employment, but it was only because she was being paid by IHSS that they were able to afford decent housing for themselves and their four children. When asked what she would do if the wages in her county were cut from the present level of \$9.50 to the state minimum wage, as had been proposed by Governor Arnold Schwarzenegger, she began to weep. She and the man caring for his autistic son told us that they would probably have to institutionalize their children if the wage dropped that low. Both knew what it would be like to try

8. These focus groups were conducted as part of the process of preparing a comprehensive provider survey to be administered in these counties during the summer. The focus groups that I participated in were conducted in two rural counties by Lea Grundy of the UC Berkeley Labor Center. Linda Delp of the UCLA Labor Center conducted focus groups in other counties in Southern California.

to live on \$6.75 an hour: they would not be able to provide for their families' basic needs. Both were unwilling to impose that hardship on family members, and both said they would have to find other full-time jobs. These three family providers received approximately ten hours of pay a day from IHSS for a round-the-clock job. Were these caregivers not subsidizing the state with their free labor, the state would be spending twice as much to keep their children in institutions.

It is tempting to think of people who provide care to family members as temporary workers who will move on to other jobs when the family member no longer needs their care, and it is easy to forget that they are often career care providers. Moreover, evidence from these focus groups suggests that many people who enter the workforce as family providers decide to stay and become nonfamily providers, a choice that is surely influenced by the wage they expect to earn. Many nonfamily providers also ultimately care for their family members. This is supported by a previous survey done in Alameda County (Howes 2003), which found that 10% of providers who were currently working as nonfamily providers had entered the workforce as family providers and that only 30% of those who were currently working as family providers had actually entered IHSS as a family provider.

Home care offers important employment opportunities within the community. These jobs are available to high school educated workers, and since they are part-time and somewhat flexible, they can be combined with family responsibilities, including caring for children or other dependents, and other part-time, or even full-time, employment.⁹ Forty percent of the providers we surveyed in Alameda County had another job: some worked in food services, retail shops, or offices; others sewed or drove trucks; still others provided private-care home care or child care. For most, though, IHSS was their primary employer.

Several of the focus group participants were long-time caregivers who "specialized" in aged alcoholics. One woman was working full time for several consumers, and IHSS was her only job; another woman, retired from a previous career, was providing care because she wanted to continue working and enjoyed taking care of people. Yet another woman had made a career of home care. Her career started when she lost the welfare subsidy that had allowed her to stay home and care for her disabled son. She needed multiple clients to make home care a full-time job, yet she could not afford to own a vehicle or pay for gas. She was able to make a career of home care only because a friend drove her to her clients' houses.

Home care is not a full-time job for most providers. Consumers need the same kind of assistance at about the same time of day, and most consumers are not authorized enough hours to employ a caregiver full time. Depending on the level of impairment, an IHSS worker's tasks may range from helping an elderly person with

9. Appelbaum et al. (2004) report that the majority of low-wage workers in the United States have no credentials beyond a high school diploma and that many, particularly immigrants, fall short even of that. For this reason they refer to the low-wage workers who are the focus of their study (and of this study) as "high school educated workers."

limited mobility complete his or her weekly shopping, cleaning, and cooking, to providing extensive personal care. Many consumers need assistance getting up in the morning and with bathing, dressing, feeding, and toileting. One-third the consumer population is made up of disabled adults of working age; many do work, but they are able to do so only because their attendant assists them with the activities of daily living, giving them the time and freedom to do other activities. Because IHSS workers provide these homemaking and personal care services for their clients, few can create a daily or weekly schedule that combines two or more clients without putting the client at risk or causing the provider tremendous stress. Home care is a physically demanding and emotionally draining job, and about three-fourths of the IHSS workforce earns poor wages and has no benefits. Findings from the focus groups indicated that many providers would not stay with the job were it not for their personal commitment to their clients.

Fortunately, in some counties IHSS is no longer a minimum-wage job with no benefits. It is still inherently part-time, but some counties now pay wages as high as \$10.50 an hour and offer individual benefits that include health, dental, and vision care. Whether higher wages and benefits are producing a more stable workforce, as was envisioned by the consumer-labor coalition that fought so hard to get public authorities and unionization, is the empirical question that I address next.

WAGES AND RETENTION IN SAN FRANCISCO COUNTY

Between November 1997 and February 2002 the IHSS wage rate in San Francisco County increased from about \$5.00 an hour, which was then pennies above the minimum wage rate for the state, to \$10.00 an hour. Individual health insurance was offered at a low monthly premium to any provider who had worked at least twenty-five hours per month in two consecutive months, and dental insurance and vision care were added for providers who had worked six months. To assess the effect of these wage and benefit increases on the recruitment and retention of new home care workers in San Francisco County, I conducted a time series analysis using a longitudinal database that covered the fifty-two-month period (Howes 2002, 2003, forthcoming). The data were drawn from the California Management, Information and Payrolling Database (CMIPS), which is maintained by the California Department of Social Services, Adult Services Division.¹⁰

This study looked specifically at the retention of new providers. Since wages and benefits improved greatly over the period of study, I was concerned that there would

10. These confidential data, which are updated monthly, provide the information necessary to construct a detailed demographic profile of the workforce and, when sufficient months are available, to estimate turnover. The author was given access to fifty-two months of confidential CMIPS data, from November 1997 to February 2002. I received permission to use the data as part of a research project funded by Atlantic Philanthropies and the Robert Wood Johnson Foundation.

be considerable short-term movement in and out of the workforce as people tried out the now better-compensated job, then went back to previous jobs when they either discovered they did not like home care or perhaps had received deferred medical treatment and dental care. To measure turnover that results from extreme dissatisfaction with the job, including unhappiness with wages and benefits, as well as the negative impact turnover has on the consumer, I measured the percentage of the workforce that left IHSS even though the consumer remained with the service.¹¹ This measure netted out “natural” turnover—that is, turnover that occurs when a provider leaves along with a consumer. Natural turnover is less likely to be affected by trends in the wage rate. More than half of IHSS providers work for a family member, a close friend, or someone to whom they have become close while providing care services. On the one hand, workers who have a personal commitment to a consumer are rarely willing to quit if, as is often the case, it puts the consumer at risk; on the other hand, as many providers in focus groups and survey pretests told us, providers often do quit as soon as the consumer no longer needs them.

Only 39% of new providers who entered the IHSS workforce between November 1997 and February 1998 remained for at least a year (Table 3.1).¹² This is equivalent to a 61% turnover rate for new providers. There were significant differences in retention rates across ethnicities and between family providers—those caring for a spouse, parent, child or other family member—and nonfamily providers—those caring for consumers who were not family members. The retention rate for new family providers was 44%; for new nonfamily providers it was 34%. Russian family providers were far more likely than any other group to stay in the job for a year, and African American nonfamily providers had by far the lowest retention rates. By the time the wage reached \$10 an hour, in 2001, the annual retention rate for new workers had risen by 94% to 74%. Both family and nonfamily worker retention nearly doubled. There were substantial increases in retention among all ethnic groups, and the variability in retention among ethnic groups had narrowed considerably, especially for family providers. Most striking is that retention rates among African American nonfamily providers rose 287%, rising from rates that were roughly half the mean for the nonfamily workforce. By 2001 retention rates for this group of providers had converged almost to the workforce mean for nonfamily providers—67%.

Wage and benefit improvements appear to have increased provider retention in San Francisco County, yet the magnitude of the wage effect was markedly different among ethnic groups. If our goal is to understand the factors that increase recruitment and retention so that we can design good public policy, we must evaluate how

11. Note that the estimated coefficients reported in this paper are only for the aggregate regressions. Readers should refer to the original article, where this measure of turnover was first used, for details of the regression results on ethnicity (see Howes forthcoming).

12. In the San Francisco study I counted a provider who exited the workforce for up to two months and then reentered as two distinct providers.

TABLE 3.1. Percentage of New IHSS Providers Who Remained in the Workforce for at Least One Year, by Ethnicity, San Francisco County, November 1997–February 2002

	ALL NEW PROVIDERS			NEW FAMILY PROVIDERS			NEW NONFAMILY PROVIDERS		
	1997–98	2000–01	Change	1997–98	2000–01	Change	1997–98	2000–01	Change
Latino	41%	68%	65%	52%	78%	50%	28%	57%	104%
Chinese	34%	75%	122%	39%	79%	103%	28%	67%	140%
Russian	58%	77%	32%	62%	80%	29%	56%	74%	34%
African American	27%	72%	166%	36%	80%	121%	16%	63%	287%
White	29%	65%	120%	27%	73%	170%	31%	55%	78%
Total	39%	74%	89%	44%	80%	81%	34%	67%	94%

SOURCE: CDSS n.d.

NOTE: Excludes natural turnover—that is, turnover that occurs when a provider leaves IHSS because a consumer discontinues IHSS services. Retention rates are averages for new entrants in November 1997–February 1998 and November 2000–February 2001.

these factors are related to ethnicity. Ethnicity may affect turnover through at least two channels. First, some ethnic groups are more likely to care for family members because of cultural norms. In San Francisco, African Americans and Latinos are traditionally more likely to hire family providers than are Whites, Russians, and Chinese. If turnover is lower among family providers, having a higher proportion of family providers will pull down the average turnover rate in an ethnic group. Whether trends in the wage rate will have differential effects by family and ethnicity is another matter. In addition, new family providers have consistently lower turnover rates than do new nonfamily providers, possibly because family providers are more committed to their consumers and are less likely to abandon them if a better opportunity presents itself, at least as long as the consumer needs them.¹³ Retention of family providers might be less affected by trends in the wage rate for the same reason: some people in the focus groups said that they would care for their family member regardless of the wage. If being a family provider mutes the effect of wage trends, then being a member of an ethnic group that disproportionately is made up of family providers will also depress the effect of wage increases on that group’s retention.

Another mechanism that causes differing wage effects is related to ethnic variations in the employment opportunities that are available to potential caregivers.

13. Solari (2004) provides a good example of how provider attitudes to family caregiving vary by ethnicity. In the case she describes, Russian Christian home care providers see themselves as “saints” and, like a family caregiver, as caregivers who have a personal commitment to the client, whereas the Russian Jewish providers model themselves more as professionals.

Most home care recipients try to hire someone who lives close or who belongs to their community, which more often than not means someone of their own ethnicity. In ethnically diverse areas, or areas in which concentrations of minority ethnic groups are embedded in a majority community, the labor market will usually be segmented by ethnicity. Latinos are frequently employed in food services; Chinese often work in garment factories in the Bay Area.¹⁴ Home care is an ethnic niche job in some rural areas of California, including the perimeter of the Sacramento Valley, where there are concentrations of Hmong home care workers. Waldinger and Lichter (2003) have shown that job opportunities are hierarchized by ethnicity, with African Americans occupying higher strata than Latinos or newer Southeast Asian immigrants of similar educational attainment. Chinese, Latino, White, and African American home care workers in Alameda County reported distinct associations between ethnicity and type of job for jobs other than their IHSS jobs (Howes 2003). African Americans, for example, were able to get much better alternative jobs than either Chinese or Latino home care workers. Members of groups with a better range of alternatives will need higher wages to convince them to stay in home care, explaining why the impact of wage increases might vary by ethnicity.

Home care becomes relatively less attractive when labor markets are tight and more attractive during periods of high unemployment, so any attempt to parse out the effect of wages and benefits must control for local labor market conditions. A multivariate logistic regression model was used to estimate the impact of wage and benefit increases on the probability of a new provider staying in the home care job for at least a year. The model included an independent variable to measure trends in the wage rate, a dummy variable to indicate whether the worker was a family provider, and an interactive variable (termed “wage×family”) between the wage rate and the family dummy variable to calculate the effect on responsiveness to wage changes of being a family provider. A second dummy variable was used to indicate whether health insurance was available in each month, and a third was used to indicate the availability of dental insurance as well. Finally, to control for local labor market factors that would affect retention, a trend variable was included, measuring employment in the labor market in San Francisco County. Equations were estimated regressing the probability of a new provider lasting a year in the job on the independent variables for the entire population.¹⁵ (See Appendix A for a summary of the research design.)

I found that the probability of a new provider lasting a year in the job increases as wages rise and as health and dental insurance are added, as Table 3.2

14. See Waldinger 1996 and Waldinger and Lichter 2003 for a discussion of ethnic niche jobs in the United States.

15. See Howes forthcoming for greater detail on the methodology and for estimates by ethnicity. I estimated separate equations for each ethnic group because I assumed the underlying causal mechanism would vary by ethnicity owing to differences in culture and economic opportunity.

TABLE 3.2. Probability of a New IHSS Provider Remaining in the Workforce for a Year or More, San Francisco County, November 1997–February 2002

	<i>Estimated Coefficient^a</i>	<i>Standard Error</i>	<i>Z Statistic</i>	<i>BIC^a</i>
Wage rate	0.737****	0.039	18.9	361.8
Family provider	-1.403****	0.035	-40.1	31.4
Wage×family	0.205****	0.035	5.9	18.4
Health insurance	1.035****	0.090	11.5	129.0
Dental insurance	1.155****	0.116	10.0	95.6
San Francisco employment	-0.097****	0.003	-32.3	902.4
Constant	32.539****	1.252	26.0	672.4
Probability of retention at mean of all independent variables	0.790			
N		10,574		
pseudo R2		0.374		

SOURCE: CDSS n.d.

^a* 0–2: weak; ** 2–6: positive; *** 6–10: strong; **** 10+: very strong.

shows.¹⁶ The coefficients on these three variables were all positive, as predicted, and all were highly statistically significant.¹⁷ Surprisingly, the results suggest that the probability of a new provider lasting a year is lower for family providers, but the results were mixed because the coefficient in the aggregate equation was statistically significant but was not significant for most of the ethnic groups. The wage*family interactive variable does not support the hypothesis that new family providers are less likely to base their decision to stay in the workforce on wage level; rather, it suggests that they are more likely to be influenced by higher wages. Finally, the results show not only that tightness in the labor market does reduce home care retention but also that had it not been for the IHSS wage increases, a net exodus from the San Francisco home care labor market would have occurred between 1997 and 2001.

Table 3.3 shows the probable impact on retention when new workers receive higher wages or insurance or are family providers. Probabilities were determined by increasing each independent variable by one unit while holding all other variables constant at their mean values. Increasing the wage by \$1.00 from its mean of \$8.85 increases the probability of a new worker lasting a year by 12.3 percentage points. The probability for a new family provider (determined by adding the probabilities

16. Marginal probabilities are calculated from the coefficients and are presented later in the text.

17. This was true also for the separate equations estimated for each ethnic group; see Howes forthcoming.

TABLE 3.3. Marginal Probability of a New IHSS Provider Remaining in the Workforce for a Year or More, San Francisco County, November 1997–February 2002

	<i>Mean</i>	<i>Marginal Probability</i>
Wage rate	\$8.85	0.123
Family provider	0.495	−0.235
Wage×family	4.487	0.034
Health insurance	0.818	0.173
Dental insurance	0.713	0.193
San Francisco employment	406.900	−0.016

SOURCE: CDSS n.d.

NOTE: Measures the marginal probability of a worker remaining a year or more associated with an additional unit of the independent variable, measured at the mean of the independent variables.

for wage rate and wage×family) increases by 15.7 percentage points.¹⁸ Increasing an hourly wage of \$8.00—the average wage paid to home care workers in the United States—to \$9.00 increases the probability of a new worker remaining for a year by 17 percentage points.

Table 3.4 shows the impact of various wage levels on retention.¹⁹ If the wage drops to \$6.75, the estimates suggest that retention will fall to 44%. Significant variability by ethnicity is evident, and particularly remarkable is the retention rate for African Americans, which is estimated to be 11% at this low wage. One of the significant findings of this study is that the wage has to increase to far higher levels for African American and White workers before their retention rates rise to the levels that other ethnic groups achieve at around \$8.50 an hour. As Table 3.4 shows, the retention rate for new African American workers does not rise above 70% until the wage reaches \$10.00 an hour. These results support the hypothesis that retention will vary across ethnic groups at the same wage level because of differences in alternative opportunities.

Although Table 3.3 shows the marginal effect of increasing health and dental insurance at the mean, the more meaningful comparison is the effect on turnover

18. Since the logit function is nonlinear, the marginal probability measures the rate of change at a single point on the function associated with a small change in an independent variable. A \$1.00 increase in the wage rate is a large change, so the actual change in the probability of remaining a year is only an approximation and is in fact somewhat smaller than 12.3 percentage points.

19. In each case I assume that the other independent variables are held at the mean of the population, meaning that 81% had access to health insurance, 71% had access to dental insurance, and 50% were family providers.

TABLE 3.4. Probability of a New IHSS Provider Remaining in the Workforce for a Year or More after Entry, Associated with Wage Level, San Francisco County, November 1997–February 2002

	<i>All Providers</i>	<i>Latino</i>	<i>Chinese</i>	<i>Russian</i>	<i>African American</i>	<i>White</i>
\$6.75	44%	57%	52%	70%	11%	19%
\$8.00	66%	65%	66%	77%	47%	57%
\$8.85	79%	75%	79%	85%	68%	72%
\$10.00	90%	84%	90%	92%	87%	87%

SOURCE: CDSS n.d.

NOTE: Measures the probability of a new worker remaining a year or more, holding other independent variables at their mean.

TABLE 3.5. Probability of a New IHSS Provider Remaining in the Workforce for a Year or More after Entry, Associated with Insurance, San Francisco County, November 1997–February 2002

	<i>Without</i>	<i>With</i>
Health insurance	61%	82%
Dental insurance	62%	84%

SOURCE: CDSS n.d.

NOTE: Measures the probability of a new worker remaining a year or more when there is no health insurance or no dental insurance and when all have access to insurance, holding other independent variables at their mean.

when health insurance is not available. Table 3.5 shows that adding health insurance increases the retention rate for a new worker by 21 percentage points; adding dental insurance has a similar effect. In the real world, Governor Schwarzenegger’s proposal to cut the wage to \$6.75 also includes eliminating health insurance. Under that scenario the model predicts that retention will drop to 25%.

Although the San Francisco study found that retention was higher for home care providers who were caring for family members, as is the case statewide, it also showed that wage and benefit increases had roughly the same marginal effect on the retention of both family and nonfamily providers. Family providers may do this job for love, the results suggest, but it is still the case that they need to provide for their entire family. When caring for one family member jeopardizes the providers’ ability

to care for all family members because wages are too low, they are forced to make the same choices that other workers make.

WAGES AND TURNOVER IN CALIFORNIA

Since IHSS wages and benefits (above the minimum of \$6.75 per hour) are set or negotiated at the county level, county administrators and union locals need to know what factors increase retention at county and community levels when they are negotiating contracts, be it wages or benefits. The San Francisco County study provided solid statistical evidence that higher wages and benefits reduce turnover among home care workers, holding other factors constant. Each group analyzed displayed different underlying rates of turnover and unique response patterns to changes in the wage and benefit structure. The next step was to expand the study to the entire state through a cross-sectional analysis. Two new variables not considered in the San Francisco study were included in the statewide study: the number of consumers per provider, and the number of hours of work authorized to each provider. Although it is difficult to provide IHSS services to more than one client, especially where travel between clients is required, a larger number of clients may reduce turnover since the provider is more likely to achieve an adequate income from the job. The same argument holds for the number of hours authorized per month for the provider. The descriptive data and logit analysis for this statewide study used CMIPS data for the period December 2002 through December 2003.²⁰

As in San Francisco, the IHSS workforce in California is highly diverse. Table 3.6 shows the ethnic distribution of the state's workforce and the proportion of caregivers who are family providers; also included are the average age and the proportion who are female within each ethnic group. Twenty-three percent of providers were Latino, 16% were African American, and 35% were White. The five other largest distinct ethnic categories, each representing at least 3% of the provider population, were Chinese, Russian, Armenian, Filipino, and Vietnamese.

An estimated 70% of all IHSS workers were family providers in 2003.²¹ As in San Francisco, there was tremendous variation among ethnic groups; Filipinos, Vietnamese, and other Asians were far more likely to be family providers, and Russians, followed by African Americans and Whites, were the least likely. The data presented

20. Most of the descriptive statistics are for December 2003, whereas the regression analysis uses data for the thirteen-month period.

21. This estimate of the percentage of family providers differs from calculations made by the state (CDSS 2001). Providers do not have to say whether they are family providers during their interview with a social worker, so the data are incomplete in CMIPS. I have done my own measure, identifying as a family provider anyone who reports that he or she is a family member of a consumer, lives in the same house as a consumer, has the same last name as a consumer, or is given a certain tax code that indicates that he or she is a relative of the consumer.

TABLE 3.6. Characteristics of IHSS Providers, California, December 2003

	<i>Number of Workers</i>	<i>Percentage of Workforce</i>	<i>Percent Family Providers</i>	<i>Percent Female</i>	<i>Average Age</i>	<i>Percent Turnover</i>
Latino	61,001	23%	73%	87%	46	26%
Chinese	13,830	5%	71%	78%	49	23%
Russian	8,236	3%	56%	66%	42	17%
Armenian	11,831	4%	75%	71%	41	15%
African American	42,228	16%	64%	75%	44	33%
White	94,044	35%	64%	76%	47	28%
Filipino	8,134	3%	88%	77%	51	27%
Vietnamese	7,852	3%	90%	72%	44	21%
Other Asian	15,397	6%	85%	72%	42	23%
Other	5,810	2%	75%	78%	48	24%
Total	268,363	100%	70%	78%	46	27%

SOURCE: CDSS n.d.

in Table 3.6 are unadjusted turnover for all providers;²² nonetheless, when compared to the findings from the San Francisco study, the statewide data show similar relative turnover by ethnicity. Armenians and Russians had the lowest rates of turnover, while Whites and African Americans had the highest. Since the patterns of ethnic variation in turnover rates persist statewide, one possible explanation for the differences in turnover rates that we will see by county may be due to differences in ethnic composition and the proportion of family providers. Counties with high proportions of Whites and nonfamily providers, for example, would be expected to have higher turnover rates.

In the analysis that follows, counties and their IHSS workers are grouped into categories with similar labor market and IHSS employment conditions. The demographic characteristics of the workforce tend to be similar within categories and to vary across categories. Table 3.7 shows the county categories that were used. I assigned each of the fifty-eight counties to one of six geographical categories: Northern Urban, Southern Urban, Northern Suburban and Coast, Southern Suburban and Coast, Rural Mountain and Coast, and Rural Agricultural. IHSS wages are distributed into three categories: low (less than \$7.50), medium (\$7.50 to 8.50), and high (greater than \$8.50).

All counties that fall into any one category have several features in common. The first broad differentiator is whether a county is rural. Counties are defined as rural if less than half of the population is concentrated in one or two major towns. All

22. Recall that I looked at retention rather than turnover rates in the San Francisco study, but that turnover is simply 1 minus the retention rate. Recall also that in the San Francisco study I was measuring adjusted turnover of new providers only, netting out the effect of natural exits.

TABLE 3.7. IHSS Wages and Benefits, by County Category, California, December 2003

<i>Urban Counties</i>		<i>Suburban and Coast Counties</i>		<i>Rural Mountain and Coast Counties</i>		<i>Rural Agricultural Counties</i>	
<i>Northern</i>		<i>Northern</i>					
Alameda	\$9.50 ^b	Contra Costa	\$9.50 [?]	Alpine	\$7.11	Fresno	\$7.50 ^a
Sacramento	\$9.50 ^a	Marin	\$9.75 ^a	Amador	\$6.95	Imperial	\$6.75
San Francisco	\$10.28 ^b	Monterey	\$9.50 [?]	Butte	\$7.11	Kern	\$6.75
Santa Clara	\$10.50 ^b	Napa	\$9.50 ^b	Calaveras	\$6.75	Kings	\$6.75
		San Mateo	\$9.50 ^b	Colusa	\$6.75	Madera	\$6.75
		Santa Cruz	\$9.50 ^b	Del Norte	\$6.75	Merced	\$6.95
		Solano	\$9.50 [?]	El Dorado	\$6.75	San Joaquin	?
		Sonoma	\$9.50 ^a	Glenn	\$7.11	San Benito	?
		Yolo	\$9.60 ^a	Humboldt	\$6.75	Tulare	\$6.75
				Lake	\$6.75		
				Lassen	\$6.75		
				Mariposa	\$6.75		
<i>Southern</i>		<i>Southern</i>					
Los Angeles	\$7.50 ^a	Orange	\$8.00 ^a	Mendocino	\$7.11		
San Diego	\$8.50 ^a	Riverside	\$8.00 ^a	Modoc	\$6.75		
		San Bernardino	\$8.50	Mono	\$7.11		
		Ventura	\$7.11	Nevada	\$7.11		
				Placer	\$6.75 ^a		
				Plumas	\$7.11		
				San Luis Obispo	\$6.95		
				Santa Barbara	\$7.11 ^a		
				Shasta	\$6.75		
				Sierra	\$7.11		
				Siskiyou	\$6.75		
				Stanislaus	\$6.95		
				Sutter	\$6.75		
				Tehema	\$6.75		
				Trinity	\$6.75		
				Tuolomne	\$6.75		
				Yuba	\$6.75		

SOURCE: CDSS n.d.; Keeslar 2004.

^a Health insurance available requiring 60–80 hours of work per month to qualify.

^b Health insurance requiring less than 35 hours of work per month to qualify.

twenty-nine counties in the Rural Mountain and Coast category largely fit this description; all are located in the mountain regions or on the northern coast of the state. In addition, the population in each of these counties is more than 80% White, and IHSS wages are low—below \$7.11. Seventeen of these counties still pay the state minimum of \$6.75. Note that with the exception of counties with a large tourist trade, all had unemployment rates that were well above the state average of 6.7% for 2003 (EDD 2004).

Rural Agriculture is the second rural category, although populations are not as diffuse in these counties as they are in the Rural Mountain and Coast counties. These counties are part of the San Joaquin Valley, and a high percentage of the population in each county is Latino. IHSS wages are low—below \$7.11—in these counties, with the exception of Fresno, which reaches \$7.50. These counties had unemployment rates that exceeded twice the state average in 2003.

The remaining county categories encompass urban counties and suburban and coastal counties. These counties have dispersed populations but are close to major urban areas, and all prosper from living in the shadow of the urban centers they bound. Unemployment rates are below the state average, except in Monterey and Santa Cruz, which encompass large rural agricultural areas as well.

The urban counties are San Francisco, Alameda, Santa Clara, and Sacramento in the north and Los Angeles and San Diego in the south. Unemployment rates in the urban areas are all at about the state average, except for San Diego, which is far below, and Sacramento, which is somewhat below the state average. As Table 3.7 shows, the IHSS wage rates in the Northern Urban and Northern Suburban and Coast counties are all high—above \$8.50—while those in the parallel southern regions are all \$8.50 and below.

Descriptive Statistics

Table 3.8 shows the ethnic distribution of providers in December 2003 by category. The Northern Urban counties were extremely diverse, with no ethnic group exceeding 28% and all the major ethnic groups significantly represented. Forty-six percent of all providers statewide were in the Southern Urban counties of Los Angeles and San Diego, with 40% in Los Angeles alone. The Southern Urban counties were also diverse, although Latinos and Armenians made up a much greater share of the provider population here (there are virtually no Armenians in the north), and there were far fewer Asians and Russians. Eighty-four percent of the population of the Rural Mountain and Coast counties was White, with a few concentrations of Latinos found mainly on the periphery of agricultural areas. Agricultural rural areas had disproportionately more Latinos relative to their share in the state population. A large population of Laotians and Cambodians has settled in towns in the Central and Sacramento Valley counties; this group is captured in the “Other Asian” category. The Northern Suburban counties had more Latinos and Whites than did the

TABLE 3.8. Ethnic Distribution, by County Category, California, December 2003

	<i>Northern Urban Counties</i>	<i>Southern Urban Counties</i>	<i>Northern Suburban and Coast Counties</i>	<i>Southern Suburban and Coast Counties</i>	<i>Rural Mountain and Coast Counties</i>	<i>Rural Agricultural Counties</i>
Latino	9%	26%	18%	31%	7%	36%
Chinese	15%	5%	2%	1%	0%	0%
Russian	11%	2%	2%	0%	0%	0%
Armenian	0%	9%	0%	0%	0%	1%
African American	18%	19%	13%	14%	2%	11%
White	28%	24%	52%	37%	84%	39%
Filipino	3%	4%	5%	2%	1%	2%
Vietnamese	6%	2%	1%	7%	0%	0%
Other Asian	6%	6%	4%	5%	3%	8%
Other	3%	2%	3%	2%	4%	2%
Number of workers	42,750	123,947	19,452	31,308	23,698	27,208
Percentage of workforce	16%	46%	7%	10%	9%	10%
Percent family providers	70%	70%	64%	79%	58%	72%

SOURCE: CDSS n.d.

Northern Urban counties. The Southern Suburban and Coast counties had more Latinos and Whites and, notably, Vietnamese and peoples classified as Other Asian (principally Cambodians, Laotians, and South Asians) than did the urban areas.

Table 3.8 also shows that providers in the Southern Suburban and Coast and Rural Agricultural areas are most likely to be family providers, while those in the Rural Mountain and Coast area are least likely to be family providers. On average, 70% of providers in urban areas were family providers; however, it should be noted that most urban and suburban counties in the north, with the exception of Santa Clara, San Mateo, Monterey, and Sacramento, have a low proportion of family providers, whereas family providers exceed 73% of the population in all southern urban and suburban areas when Los Angeles is excluded.

Turnover varied by the family status of the provider and ethnicity, just as it did in the San Francisco County study; in addition, turnover varied by region at the state level. As Figure 3.1 shows, turnover—measured as the percentage of all IHSS providers in the workforce in December 2002 who had left the workforce by December 2003—was 35% for nonfamily providers and 23% for family providers.²³ The aggregate rate was 27%. Turnover was highest, both for nonfamily and family pro-

23. Note that this measure of turnover (or its inverse, retention) includes both new and continuing providers.

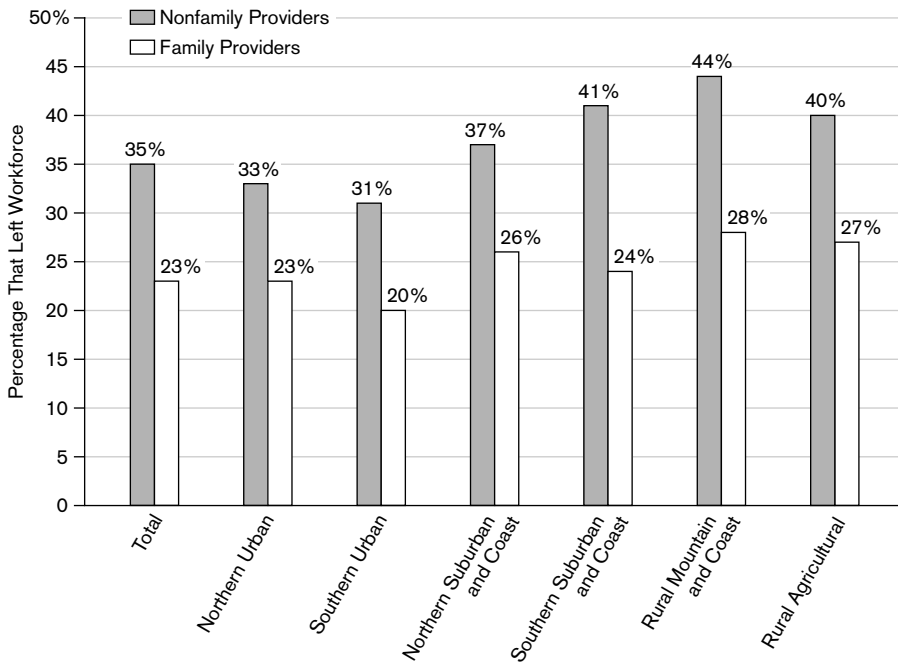


FIGURE 3.1. Annual Turnover for IHSS Workers, by Region, California, December 2002–December 2003

SOURCE: CDSS n.d.

viders, in the Rural Mountain and Coast counties and lowest in the Southern Urban counties.

Similar to the situation in San Francisco County before wage increases were instated, turnover was also well above the average among African American nonfamily providers and even more so among African American family providers. Turnover was lowest among Armenians and Russians. That pattern of ethnic variation persisted throughout all counties, suggesting that turnover rates are at least partially culturally determined or reflect the differing economic opportunities available to providers depending on their ethnicity.

Figure 3.2 shows the turnover rate for providers after netting out natural turnover. This measure shows turnover for all new and continuing providers who did not leave when their client discontinued care. As expected, this turnover rate was considerably lower than the turnover rate of all providers. As with the previous measure, nonfamily provider turnover was higher than was family provider turnover. The Rural Mountain and Coast counties, which are all low-wage counties, had by far the highest turnover, running 8 percentage points, or 40%, higher than the state average. Note that once the natural turnover is netted out, family provider turnover rates converge across county groups (Figure 3.2), with the exception of rural counties, and ethnic groups (compare Figures 3.3 and 3.4), with the single exception of African

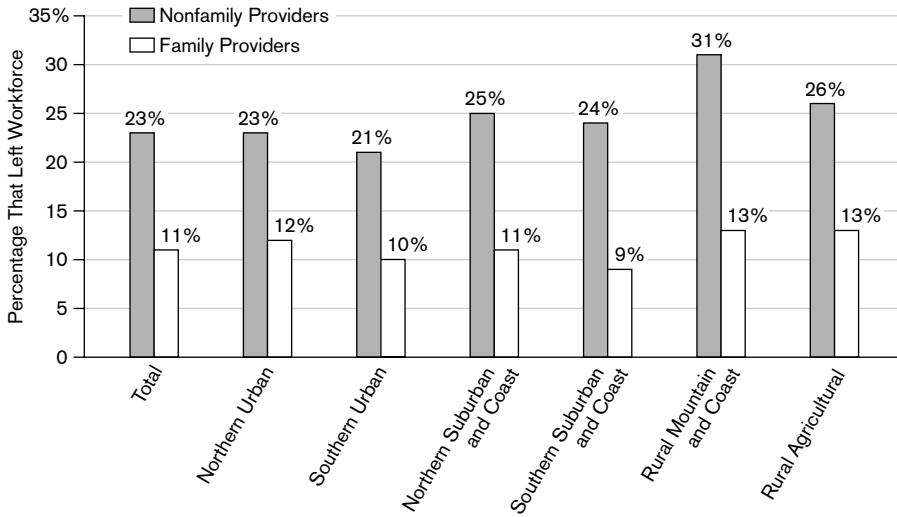


FIGURE 3.2. Adjusted Annual Turnover for IHSS Workers, by Region, California, December 2002–December 2003

SOURCE: CDSS n.d.

Americans, who still had significantly higher turnover than did other groups. The convergence of turnover rates for family providers offers some support for the hypothesis that once someone decides to be a family provider—the propensity does vary by region and ethnicity—the provider is equally likely to stay with the consumer regardless of the wage rate or the local labor market conditions in which they work.

Figure 3.5 shows adjusted turnover rates by wage category, confirming that turnover is higher in low-wage counties. The medium-wage category is dominated by Los Angeles County, where other factors keep turnover lower than it is in the high-wage counties.

Los Angeles and San Francisco Counties

Los Angeles and San Francisco counties offer a cross-sectional perspective on the effect of wage differentials among urban counties. Los Angeles and San Francisco have both adopted public authorities and have bargained over wages and benefits with the union, but the outcomes have been markedly different. San Francisco now pays its IHSS workers \$10.28 an hour and offers them health benefits as long as they work at least two months consecutively and twenty-five hours in a month; dental benefits are offered after six months. The Los Angeles County Board of Supervisors, which acts as the public authority in Los Angeles, has resisted substantial wage increases. IHSS workers in Los Angeles are now paid \$7.50 an hour, and health

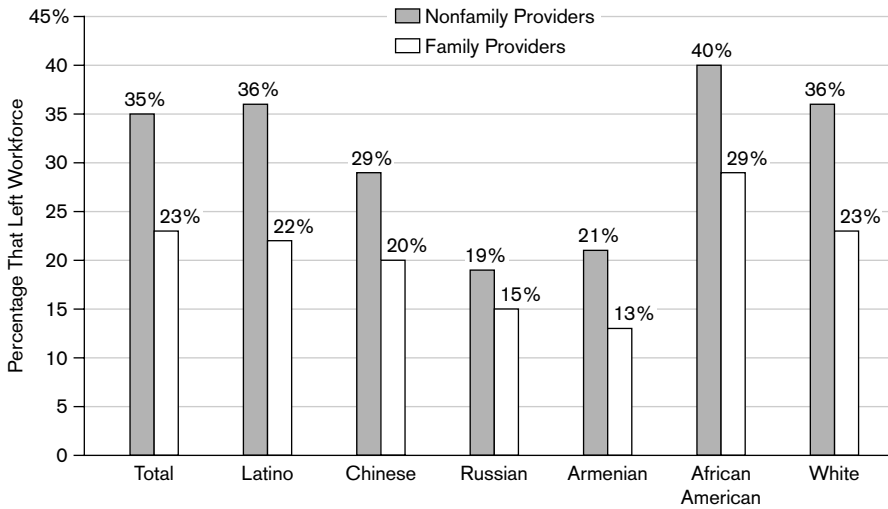


FIGURE 3.3. Annual Turnover for IHSS Workers, by Ethnicity, California, December 2002–December 2003

SOURCE: CDSS n.d.

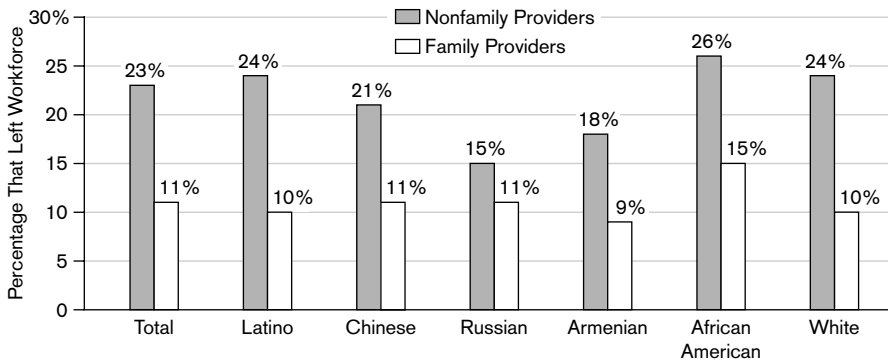


FIGURE 3.4. Adjusted Annual Turnover for IHSS Workers, by Ethnicity, California, December 2002–December 2003

SOURCE: CDSS n.d.

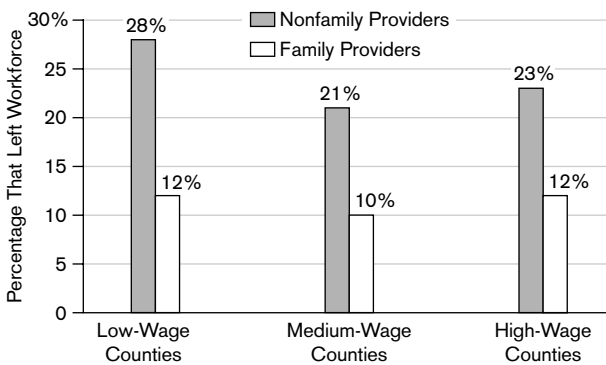


FIGURE 3.5. Adjusted Annual Turnover for IHSS Workers, by Wage Category, California, December 2002–December 2003

SOURCE: CDSS n.d.

TABLE 3.9. Ethnicity of IHSS Providers, Los Angeles and San Francisco Counties, December 2003

	LOS ANGELES COUNTY			SAN FRANCISCO COUNTY		
	<i>Number of Workers</i>	<i>Percentage of Workforce</i>	<i>Percent Family Providers</i>	<i>Number of Workers</i>	<i>Percentage of Workforce</i>	<i>Percent Family Providers</i>
Latino	28,542	26%	72%	1,068	9%	53%
Chinese	6,167	6%	72%	4,012	35%	68%
Russian	2,726	3%	47%	2,597	23%	37%
Armenian	11,521	11%	75%	7	0%	—
African American	22,086	20%	60%	1,411	12%	61%
White	23,416	22%	62%	1,290	11%	48%
Filipino	3,551	3%	87%	477	4%	80%
Vietnamese	2,034	2%	89%	200	2%	84%
Other Asian	6,224	6%	79%	274	2%	73%
Other	2,514	2%	74%	179	2%	67%
Total	108,781	100%	68%	11,515	100%	57%

SOURCE: CDSS n.d.

insurance is available only if they work a total of eighty hours a month. Whereas 97% of San Francisco providers are now eligible and 53% are enrolled in the San Francisco health insurance program provided through IHSS, the enrollment rate in Los Angeles is only 8%, at least in part because only 30% of active providers qualify for the program (SF IHSS Public Authority 2003; Zawadski and Radosevich 2003).

Table 3.9 shows the distribution of IHSS providers by ethnicity and the percentage of caregivers who are family providers in Los Angeles and San Francisco counties. Although both are very ethnically diverse, the mix is quite different. Latinos made up 26% of the Los Angeles workforce in 2003 but only 9% of the San Francisco workforce. Chinese and Russian providers represented only 6% and 3% of the workforce in Los Angeles, respectively, but 35% and 23% in San Francisco. Armenians represented 11% of the workforce in Los Angeles, but there were almost no Armenians in San Francisco. African Americans made up 20% of the Los Angeles workforce, but only 12% of the San Francisco workforce. Whites represented 35% of the workforce statewide, but only 22% in Los Angeles and 11% in San Francisco.

Family providers in Los Angeles made up a considerably larger share of the provider population than they did in San Francisco. This pattern holds across all ethnic groups with the exception of African Americans, suggesting that there is some underlying causal mechanism that transcends ethnic practices. One possible explanation is that hiring trustworthy nonfamily providers in the immediate community is easier in San Francisco, where the population is denser and where the wages and

TABLE 3.10. Average Hours Worked per IHSS Provider per Month, Los Angeles and San Francisco Counties, December 2003

	LOS ANGELES COUNTY			SAN FRANCISCO COUNTY		
	<i>All Providers</i>	<i>Nonfamily Providers</i>	<i>Family Providers</i>	<i>All Providers</i>	<i>Nonfamily Providers</i>	<i>Family Providers</i>
Latino	98.3	106.9	95.1	101.7	108.3	95.1
Chinese	86.6	103.1	81.2	80.9	92.9	76.2
Russian	123.1	138.0	111.9	87.8	88.8	83.5
Armenian	89.2	102.6	87.7	—	—	—
African American	95.6	99.6	93.8	94.4	95.9	93.6
White	107.6	110.3	107.6	102.3	95.2	111.8
Filipino	83.9	98.0	81.9	93.1	98.9	90.3
Vietnamese	88.9	97.0	88.6	70.3	91.1	67.2
Other Asian	93.9	108.4	90.9	94.1	90.3	95.4
Other	119.7	112.8	123.2	116.2	104.0	120.1
Total	98.4	106.6	95.4	89.8	94.0	86.5

SOURCE: CDSS n.d.

benefits are so much higher. The lower proportion of family providers in San Francisco, relative to Los Angeles, leads us to expect turnover to be higher, if other factors are similar, whereas the greater representation of non-White and non-African American ethnic groups would lead us to expect turnover to be lower.

Table 3.10 shows the average hours worked per month by providers in Los Angeles and San Francisco counties. On average, workers in Los Angeles worked 8.6 more hours per month than did workers in San Francisco, and, on average, nonfamily providers worked almost thirteen more hours in Los Angeles than in San Francisco. Except for Latinos and Filipinos, nonfamily providers in all ethnic groups worked substantially more hours in Los Angeles, again suggesting some underlying, noncultural determining factor. Family providers, on the other hand, do not seem to be affected by some common factor, since some ethnic groups—Chinese, Russians, and Vietnamese—worked more hours in Los Angeles while others worked fewer or similar hours on average. Providers in Los Angeles also worked for more consumers, on average, than did those in San Francisco (Table 3.11). This is true for both family and nonfamily providers and for every ethnic group, with the exception of nonfamily Latino providers.

There is a clear pattern at the state level of providers working for more consumers in counties with lower wages. Providers in Los Angeles County did not work more hours because their consumers were more impaired or had higher hours of authorization. The average number of hours authorized each month per consumer in Los

TABLE 3.11. Average Number of Consumers per IHSS Provider, Los Angeles and San Francisco Counties, December 2003

	LOS ANGELES COUNTY			SAN FRANCISCO COUNTY		
	<i>All Providers</i>	<i>Nonfamily Providers</i>	<i>Family Providers</i>	<i>All Providers</i>	<i>Nonfamily Providers</i>	<i>Family Providers</i>
Latino	1.19	1.35	1.13	1.21	1.35	1.10
Chinese	1.42	1.74	1.29	1.23	1.35	1.17
Russian	1.58	1.64	1.52	1.34	1.35	1.29
Armenian	1.48	1.54	1.46	—	—	—
African American	1.17	1.23	1.13	1.11	1.16	1.07
White	1.21	1.28	1.16	1.10	1.12	1.06
Filipino	1.21	1.43	1.18	1.15	1.33	1.08
Vietnamese	1.23	1.23	1.24	1.14	1.27	1.12
Other Asian	1.29	1.49	1.24	1.13	1.17	1.10
Other	1.09	1.15	1.07	1.06	1.07	1.04
Total	1.25	1.35	1.20	1.21	1.29	1.15

SOURCE: CDSS n.d.

Angeles was 80, compared to 79 in San Francisco. Again, in the context of the entire state, providers in low-wage counties worked more hours per month than did providers in high-wage counties, even when not justified by higher levels of hours authorized for consumers. Finally, it may be the case that providers worked more hours in Los Angeles because they needed to qualify for health insurance; but again, the evidence from the state as a whole is that workers worked more hours in low-wage counties. In sum, there is some evidence, based on descriptive statistics, that workers in urban areas work more hours for more consumers when they are paid lower wages.

Finally, we look at differences in turnover rates in the two counties to see what effect compensation differentials might have. Table 3.12 shows total turnover rates and turnover rates adjusted to exclude providers who left simultaneously with their consumers. Turnover in Los Angeles was 24%, just one point above turnover in San Francisco. Los Angeles and San Francisco had roughly equal turnover rates for family providers at 20% and 21%, respectively, but the turnover rate for nonfamily providers was considerably higher in Los Angeles: 31% compared to 26% in San Francisco. Turnover for nonfamily providers was consistently higher for most ethnic groups in Los Angeles, with the particularly notable exception of Whites. The higher proportion of nonfamily providers in San Francisco pulls up the aggregate turnover rate to the level of Los Angeles.

The pattern persists for adjusted turnover, as Figure 3.6 shows. The rate for all

TABLE 3.12. Turnover among IHSS Providers, Los Angeles and San Francisco Counties, December 2002–December 2003

	TOTAL TURNOVER			ADJUSTED TURNOVER		
	<i>All Providers</i>	<i>Nonfamily Providers</i>	<i>Family Providers</i>	<i>All Providers</i>	<i>Nonfamily Providers</i>	<i>Family Providers</i>
Los Angeles County						
Latino	24%	34%	20%	13%	22%	9%
Chinese	22%	28%	19%	14%	22%	11%
Russian	17%	20%	14%	14%	17%	11%
Armenian	15%	21%	12%	12%	17%	9%
African American	32%	38%	27%	18%	24%	14%
White	22%	26%	19%	12%	17%	8%
Filipino	26%	38%	24%	11%	24%	9%
Vietnamese	19%	29%	17%	11%	18%	10%
Other Asian	21%	30%	19%	11%	20%	8%
Other	19%	28%	16%	9%	15%	7%
Total	24%	31%	20%	18%	20%	10%
San Francisco County						
Latino	25%	27%	24%	14%	17%	10%
Chinese	23%	27%	20%	14%	18%	12%
Russian	16%	18%	13%	12%	13%	10%
Armenian	—	—	—	—	—	—
African American	32%	37%	28%	17%	23%	13%
White	27%	30%	23%	13%	17%	9%
Filipino	27%	35%	24%	12%	25%	7%
Vietnamese	21%	31%	19%	12%	12%	13%
Other Asian	27%	39%	21%	11%	18%	7%
Other	15%	18%	13%	6%	7%	6%
Total	23%	26%	21%	14%	17%	11%

SOURCE: CDSS n.d.

nonfamily providers was lower in San Francisco than it was in Los Angeles, and it was lower in San Francisco for all ethnic groups except Whites and Filipinos. Again, since turnover was lower for nonfamily providers among most ethnic groups in San Francisco, relative to Los Angeles, and since it was similar to Los Angeles for family providers across all ethnic groups, the differences in nonfamily turnover between San Francisco and Los Angeles cannot be due to the effect of aggregation. There is some underlying causal factor that is reducing turnover in San Francisco among nonfamily providers. Higher wages and better health insurance in San Francisco is the obvious explanation.

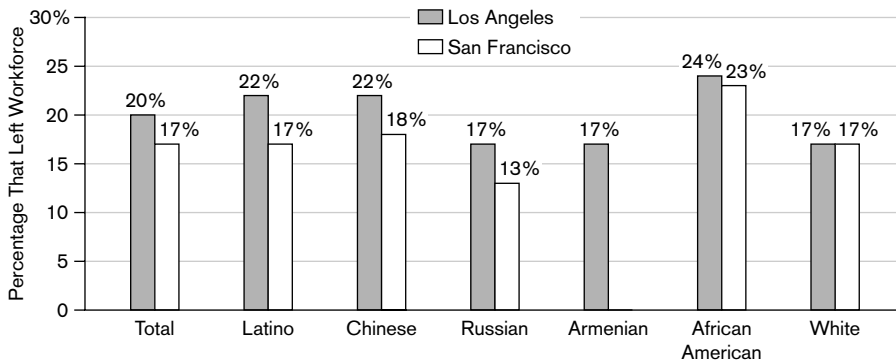


FIGURE 3.6. Annual Turnover for IHSS Workers, by Ethnicity, Los Angeles and San Francisco, December 2002–December 2003

SOURCE: CDSS n.d.

Regression Analysis

Logit regression analysis is required to parse out the effects of other deterministic variables from the effect of wages and benefits on turnover. Although it is tempting to do an analysis only of San Francisco and Los Angeles counties, there is not enough variation in wages to get meaningful results. Current data availability constrains analysis of any counties beyond San Francisco to a cross-sectional analysis, in which it is possible to control for some of the other sources of variation in turnover, such as the ethnic mix of the workforce, the proportion of family providers, and local labor market conditions, but not for others. It is not possible, for example, to control for the impairment level of the population of consumers, which may vary significantly, implying variation in the relative difficulty of the job.²⁴

I regressed the probability of any provider who was in the workforce in December 2002 and remained in the workforce for twelve months against a set of explanatory variables: wages, benefits, family relationship to consumer, the interaction between family and wage, and whether health insurance was available. (See Appendix B for a summary of the research design.) All these variables were included in the San Francisco study.

In the San Francisco study the health insurance variable simply measured the

24. This study was designed to control for as much of the variation across regions as possible so that the effect of different wage and benefit levels can be measured. Nevertheless, results from cross-sectional analysis are never as good as those from a time series simply because a cross-sectional analysis explains less of the variation in the dependent variable. With time series analysis most of the other variables that affect turnover, such as family status of provider or ethnicity, are held constant. The only other deterministic variable that is not reasonably constant, conditions in the local labor market, can be easily controlled for by using time series data on local employment levels.

effect of going from a condition in which no health insurance was available to a condition in which health insurance was available to most providers. The design for the state-level analysis was more complex since some counties (accounting for 21% of the workforce) offered no health insurance, other counties (66%) offered it to employees who worked at least sixty-five to eighty hours per month for two to three consecutive months, and still others (12% of the workforce) offered it to those who worked at least twenty-five hours per month for two consecutive months. I included two dummy variables to capture the effect of health insurance: one measured whether a provider was in a county that has any health insurance, and the second measured whether a provider worked in a county with low eligibility requirements.

I added several other variables that capture variation among regions rather than individuals. To economize on the number of variables while still preserving the effect of differing cultural norms and economic opportunities available to different ethnic groups, I included ethnic dummy variables. White is the omitted variable in this group. To control for differences in the economic environment across regions, I included a set of dummy variables for five county categories; here the Southern Urban region was omitted. Two new variables were added: a measure of the number of consumers served by each provider, and a variable measuring the number of hours authorized to each provider, each measured in December 2002.²⁵

As shown in Table 3.13, the logit regression analysis determined that the wage rate variable is negative, supporting the hypothesis that as wages rise, turnover falls. In contrast to the San Francisco study, the highly statistically significant family coefficient tells us that, other things being held equal, family providers are generally less inclined to quit than are nonfamily providers, but that their decision to stay longer is less affected as the wage rises. The county category variables were all significant except the Southern Suburban and Coast category. The Southern Urban county category was omitted; since this region is dominated by Los Angeles and San Diego counties, the result for the Southern Suburban and Coast region tells us that economic conditions there are similar to those in Los Angeles and San Diego counties. The results for the other county categories indicate that underlying economic conditions in those counties will cause turnover to be higher than it is in the Southern Urban counties. The unemployment rate is higher for the rural counties than it is for the southern urban counties, so this makes sense.²⁶ Whether a county has health insurance is not a statistically significant variable, but whether a county has low eligibility health insurance is. The results indicate that turnover falls as the number of consumers per provider rises and also as the number of hours the provider is authorized to work increases. Both results are unsurprising. And, as the San Francisco

25. The estimated coefficients on the wage rate, the family provider dummy, and the family×wage interactive are all highly statistically significant.

26. I admit to being perplexed about why the Northern Urban and Suburban counties would have higher turnover than those in the south after controlling for all other factors.

TABLE 3.13. Probability of an IHSS Provider Quitting within a Year, California, December 2002–December 2003

	<i>Estimated Coefficient^a</i>	<i>Standard Error</i>	<i>Z Statistic</i>	<i>BIC^a</i>	<i>Mean</i>	<i>Marginal Probability</i>
Wage rate	-0.079****	0.012	-6.6	39.6	7.863	-0.009
Family provider	-1.417****	0.083	-17.2	291.5	0.683	-0.164
Wage×family	0.056****	0.010	5.4	25.8	5.364	0.007
Northern Urban counties	0.491****	0.034	14.6	209.5	0.153	0.057
Northern Suburban and Coast counties	0.417****	0.033	12.7	158.5	0.071	0.048
Southern Suburban and Coast counties	0.050*	0.024	2.1	0.9	0.112	0.006
Rural Mountain and Coast counties	0.569****	0.028	20.3	408.5	0.092	0.066
Rural Agricultural counties	0.365****	0.023	15.8	245.1	0.075	0.042
Health insurance	0.040*	0.020	2.0	0.3	0.788	0.005
Good health insurance	-0.182****	0.027	-6.6	40.6	0.121	-0.021
Number of consumers to provider	-0.313****	0.014	-22.3	495.5	1.213	-0.036
Number of hours per month	-0.002****	0.000	-24.5	596.7	103.224	0.000
Latino	-0.009	0.017	-0.5	-3.2	0.204	-0.001
Chinese	-0.019	0.033	-0.6	-3.2	0.041	-0.002
Russian	-0.244****	0.043	-5.7	28.5	0.024	-0.028
Armenian	-0.049	0.038	-1.3	-1.9	0.036	-0.006
African American	0.291****	0.018	15.9	250.5	0.132	0.034
Other	-0.070***	0.020	-3.4	8.1	0.128	-0.008
Constant	-0.170	0.096	-1.8	-0.4	1.000	
Probability of turnover at mean of all independent variables	0.135					
N	244,074					
pseudo R2	0.047					

SOURCE: CDSS n.d.

** 0–2: weak; ** 2–6: positive; *** 6–10: strong; **** 10+: very strong.

study showed, being Russian reduces the likelihood of turnover, while being African American increases it.

CONCLUSION

Home care as an occupation in California has changed dramatically over the past fifty years. By the 1990s there were at least 2 million people providing home care nationwide and almost 300,000 working as home care providers in California. The enormous growth in the occupation did not make it a good job. That required greater resources and the political clout to translate those resources into better wages and benefits. Political power was realized only when a successful consumer-labor

coalition was formed in the early 1990s to fight for the resources and the institutional changes that improved the quality of consumer-directed services. The coalition successfully lobbied to revise state laws governing the IHSS program. Under the new law, an IHSS public authority could be formed in each county to serve as the employer of record and to provide referral services and training for consumers and providers. In 2004, more than a year after all California counties were mandated to establish an employer of record, and at a time when most counties have chosen to create public authorities, approximately thirteen pay wages above \$9 an hour, and most of those offer some level of employer-based health insurance.

What the research presented in this chapter and previous work suggests is that the creation of public authorities resolved many of the problems in the IHSS program that were identified by the Little Hoover Commission in 1991 and that unionization has allowed home care workers to bargain for higher wages and benefits.

Home care is among the top six fastest growing occupations in the United States. Nationwide, home care workers are paid, on average, \$8 an hour. These low wages and the lack of benefits are a big part of why there is a severe shortage of home care workers in the United States. Solving the problem of low-wage work (Appelbaum et al. 2004) and alleviating the shortage of direct care workers require the interest and intervention of the federal government. If Congress were to raise the minimum wage, at least to the same real value it had at its peak in 1979, which would be about \$7.00 in 2004 dollars, and if the NLRB enforced U.S. labor law, the wage floor could rise to the real value of the minimum wage twenty-five years ago. At least some of the direct care worker shortage would be mitigated by higher wages and employer-provided health insurance, especially for part-time jobs. Home care is a particularly strategic occupation, however, not the least because it represents such a large share of the low-wage workforce. The vast majority of home care services are funded by Medicaid (PHI 2003), which means not only that state and federal governments establish a floor for wages but also that, to a large extent, they pay the wages. Unlike the private employers in manufacturing, retail, and services, which also pay very low wages, state and federal governments are subject to direct political pressure from unions and consumer groups, often working in coalition.

California is possibly the most important venue in which such political action and union organizing has helped transform low-wage home care jobs into better jobs with benefits. Indeed, if home care jobs, which represent one in every ten low-wage jobs, pay a living wage with benefits, even for part-time work, other low-wage jobs employing the same pool of workers may benefit from a spillover effect. California, if only in some counties, is beginning to define a strategy that will remedy critical shortages and, at the same time, potentially define a new standard for low-wage, and especially part-time, jobs—one that makes it possible for low-wage workers to rise above the poverty line. But like many good ideas, the outcome of this experiment still depends on federal, state, and local financing and the politics behind it.

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APPENDIX A. Variables Included in Logit Regression Model of Workforce Retention for San Francisco County

<i>Variable</i>	<i>Definition</i>	<i>Sample Average^a</i>	<i>SD</i>
Dependent Variable			
Retention rate	Probability that a new worker will remain for a year after entry	0.68	0.46
Independent Variables			
Wage rate	Wage rate at time t	\$8.85	1.573
Family provider	1 if provider i is related to consumer; 0 if otherwise	0.495	0.500
Wage×family	Wage rate at time t×family for individual i at time t; 0 if otherwise	4.487	4.648
Health insurance	1 if there is health insurance available to all providers at time t; 0 if otherwise	0.818	0.386
Dental insurance	1 if there is dental insurance available to all providers at time t; 0 if otherwise	0.713	0.452
San Francisco employment	Employment in San Francisco county at time t (000s)	406.9	11.991

^a Means are for total new providers in workforce from December 1997 to February 2002.

APPENDIX B. Variables Included in Logit Regression Model of Workforce Turnover for California

<i>Variable</i>	<i>Definition</i>	<i>Sample Average^a</i>	<i>SD</i>
Dependent Variable			
Turnover rate	Probability that a worker will not be in workforce 1 year after 12/02	0.148	0.355
Independent Variables			
Wage rate	Wage rate in county j	\$7.86	1.11
Family provider	1 if provider i is related to consumer; 0 if otherwise	0.683	0.46
Wage×family	Wage rate in county j×family for individual i in county j; 0 if otherwise	5.364	3.76
Health insurance	1 if there is any health insurance available to individual i in county j; 0 if otherwise	0.788	0.40
Good health insurance	1 if individual i elig for HI after <35 hrs work/month in county j; 0 if otherwise	0.121	0.33
Number of consumers to provider	Number of consumers cared for by provider i in Dec 2003; 0 if otherwise	1.213	0.452
Number of provider hours per month	Number of work hours authorized to provider i for Dec 2003	103.2	71.1
County category	1 if individual i lives in County Category j; 0 if otherwise		
Ethnic category	Southern Urban is omitted category 1 if provider i is member of ethnic category j; 0 if otherwise White is omitted category		

^a Means are for total workforce in California in December 2002.

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