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Love, Money or Flexibility: What Motivates People to Work in Consumer-Directed Home Care?

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Purpose: The purpose of this study was to investigate the impact of wages and benefits (relative to other jobs available to workers), controlling for personal characteristics, on the recruitment and retention of providers working in a consumer-directed home care program. ***Design and Methods:*** I used the results of focus groups to design a survey that was administered to 2,260 workers stratified by ethnicity and working in eight California counties that represented the range of wage and benefit packages available. I used logistic regression to measure the effect of wage and benefit levels, controlling for covariates, on home care workers' stated reason for entering and remaining in the job. ***Results:*** Two thirds of respondents reported that commitment to their consumer was the most important reason why they took the job and flexibility was the second most important reason, regardless of wages and benefits and personal characteristics. However, in the county in which very part-time workers were eligible, health insurance was the most important reason for retention. Wage levels above $9 an hour mattered somewhat, especially where the increase was recent. Family providers responded to wage and benefit incentives similarly to non-family providers. ***Implications:*** To improve recruitment and retention of consumer-directed home care workers, jobs should be flexible and provide affordable health insurance for part-time workers. The effect of wages suggests that recruitment might be improved with higher wages, but only when they reach the $9 to $10 range (in 2004 dollars). Finally, policy must recognize that family caregivers have financial needs similar to non-family caregivers.

Key Words: Long-term care, Consumer-directed home care, Home care workers, Recruitment and retention, Workforce turnover

Background: Home Care Workforce in Crisis

Long-term-care jobs are stressful, low-wage jobs that rarely provide health insurance benefits (Kaye, Chapman, Newcomer, & Harrington, 2006; Yamada, 2002); long-term-care facilities frequently do not have sufficient staffing levels, and many still employ management practices characterized by tight supervision and control, rigid work patterns, and limited opportunity for worker input (Eaton, 2000). The national median hourly wage for a nursing home aide in 2005 was $10.31; home health aides were paid a median wage of $9.04. Among long-term-care jobs, consumer-directed home care has generally ranked at the bottom of the wage distribution, paying a median hourly wage of $8.34. Despite the low pay, many home care workers choose this kind of work over work in facilities or other occupations such as factory worker, cashier, hairdresser, child care worker, or food service worker, none of which pay well, but many of which pay just as well or slightly better than personal care services (Howes, in press).

The problems of recruitment and retention of long-term-care workers to nursing facilities, community-based facilities, agency-based home care, and even consumer-directed home care (in which the consumer hires and supervises the worker) are well documented. Seavey (2004) reported that recent national surveys of nursing homes, home health agencies, and assisted living facilities show direct care turnover estimates of 71%, 25%, and 28%, respectively. Other studies have reported estimates for home care turnover of more than 40% (Paraprofessional Healthcare Institute and the Medstat Group, 2003; Stone, 2000, 2001; Stone & Wiener, 2001). Turnover rates of this magnitude are associated with very high costs at the enterprise level; as well as to consumers, who may receive lower quality of care; and to third-party payers, including the public sector and private insurers (Seavey, 2004).

A substantial body of research on the determinants of turnover among facility-based direct care providers (reported in Dawson, 2007) has found that family-sustaining wages (Mickus, Luz, & Hogan, 2004); affordable health insurance (Duffy, 2004; Rodin, 2006); stable and adequate work hours and adequate staffing ratios (Dawson, 2007); training (Castle, Engberg, Anderson, & Men, 2007; Hollinger-Smith, 2002; Konrad & Morgan, 2004; Leon, Marainen, & Marcotte, 2001; Stone &Wiener, 2001; participation in decision making (Bishop, Weinberg, Dodson, Gittell, & Leutz, et al., 2006; Parsons, Simmons, Penn, & Furlought, 2003); good supervision, and good management that supports, respects, and empowers workers (Bishop, Weinberg, Dodson, Gittell, & Leutz, et al., 2006; Castle, 2005; Tellis-Nayak, 2007) all increase retention and improve the quality of care (Castle & Engberg, 2005, 2007; Hatton & Dresser, 2003). Much of this research has concluded that it is important to bundle empowerment with decent jobs, which includes paying adequate wages and benefits (Bishop, Weinberg, Dodson, Gittell, & Leutz, et al., 2006; Ejaz, Noelker, Menne, & Bagaka, 2006; Parker, 2006).

Little of this research has focused on consumer-directed home care, yet this is the fastest growing area of long-term care. Most consumers prefer to receive long-term care in a home-based setting (Mahoney, Simon-Rusinowitz, Loughlin, Desmond, & Squillace, 2004), and, for the majority of consumers, home care is less expensive than facility-based care (Howes, in press). Consumers in the California In-Home Supportive Services (IHSS) program are allowed to hire friends and family members directly and avoid going through agencies where hourly rates are as much as twice the cost of consumer-directed home care. Among home care workers, and particularly among consumer-directed home care workers who frequently are caring for family members, turnover may be lower because the workers often have a significant personal commitment to their client and greater autonomy and flexibility than they would in a facility.

(Howes, 2004, showed that in 2003, 70% of California IHSS providers were family providers. Other estimates [Benjamin, 2006; California Department of Social Services, 2001] are somewhat lower, but all exceed 50%.)

My studies of retention among workers providing consumer-directed care through the IHSS program in San Francisco County (Howes, 2002, 2005a) found that wages and benefits had a significant impact. Using the IHSS program's administrative data, I demonstrated that when the wage increased from $5 to $10 an hour, combined with the introduction of affordable health insurance (making IHSS compensation as good or better than other jobs available to these workers), the annual turnover rate for new providers fell from 61% to 26%. A logit analysis that associated the change in wages and benefits with the probability of a new provider staying in the workforce for at least a year showed that a $1 increase in the wage rate from the mean wage of $8.85 increased the probability of a new worker remaining in the workforce for a year by 12 percentage points. Adding health insurance and dental insurance each increased the probability of a new worker remaining in the workforce by more than 17 percentage points. Thus, the research seemed to suggest that workers were entering the IHSS consumer-directed home care workforce because the wages had increased substantially and relative to other jobs and/or because health insurance benefits had been included in the compensation package. However, it was not possible to fully separate the effect of wages from benefits because both increased simultaneously, raising the question of whether retention rates improved because of wages or benefits or both. Rodin (2006) found that health insurance may be more important than wages in reducing turnover and increasing the supply of direct care workers.

In the project that is the subject of this article, I undertook a survey of IHSS workers to determine whether workers in higher wage counties where benefits were offered were more

likely to report that they entered and remained in the workforce because they were attracted by the wages and/or benefits compared to workers in low-wage counties.

Design of the Study

Population and Sample Construction

IHSS is the largest consumer-directed, Medicaid-financed home care program in the country. There are currently about 360,000 consumers in the program and just under 300,000 care providers work for IHSS. Wages and benefits are now set at the county level, but until 1996, when the Service Employees International Union negotiated the first contract for IHSS workers in San Francisco, all consumer-directed IHSS workers in California were paid the state minimum wage and no benefits (Boris & Klein, 2006; Delp & Quan, 2002; Heinritz-Canterbury, 2002; Howes, 2004; Walsh, 2001). San Francisco wages increased from less than $5 an hour to $10 an hour between 1996 and 2002, and San Francisco workers became among the highest paid IHSS workers in the state. In 2000, San Francisco County added a health insurance benefit for which any worker who had worked 35 hr per month for 2 consecutive months was eligible. As of the summer of 2005, 94% of workers in California were paid more than the then-minimum-wage of $6.75 an hour, and almost half were eligible for employer-sponsored health insurance as IHSS workers (California Association of Public Authorities for In-Home Supportive Services, 2005; Howes, 2005b). The improvements in wages and benefits for the workforce in some of the Northern California counties, not limited to San Francisco, have been substantial enough to make home care in those counties one of the best jobs that this less-than-college-educated population can get.

In order to capture the impact of wages and benefits on workers' reported reasons for taking the job, I administered a survey in a set of eight urban and rural counties that represented the broadest range of variation in compensation and that contained 42% of the entire population of IHSS providers in the state. (Although IHSS wages are set at the county level and are uniform within the county for consumer-directed workers, a small proportion of IHSS services in California are still provided through an agency model, and those workers are paid more than the "independent providers" working in the consumer-directed mode.) I chose Los Angeles and San Francisco as the low-wage/moderate-benefit (Los Angeles) and high-wage/good-benefit (San Francisco) urban counties. Yuba and Sutter counties, which are contiguous to one another and were sampled and surveyed as a single county; Nevada, Sierra, and Plumas counties are also contiguous and sampled and surveyed as a single county. I selected these five counties (YSSN) as the low-wage/no-benefit rural counties. I selected Yolo County as the high-wage/moderate-benefit and somewhat rural county. As Table 1 and Figure 1 show, Los Angeles paid $7.50 at the time the survey was conducted and offered individual health insurance for anyone who had worked 80 hr a month for the previous 2 months. San Francisco paid $10.28 and offered health insurance to anyone who had worked at least 35 hr in 2 months. Workers were paid $9.60 in Yolo County and were eligible for health insurance if they worked 80 hr in 3 consecutive months, and in Yuba and Sutter counties workers received no benefits and were paid the state minimum wage of $6.75. Sierra, Nevada, and Plumas county workers were paid $7.11 with no benefits.

[Table 1 and Figure 1 about here]

The IHSS provider population includes a large proportion of African Americans, native-born Whites, Latinos, Russians, Armenians, and Chinese (see Table 2). Because previous work (Howes, Greenwich, Reif, & Grundy, 2002) indicated that there is tremendous variation in social and economic circumstances of workers based on ethnicity that would likely affect outcomes, the sample was stratified by ethnicity (African American, Latino, Armenian, Russian, Chinese, and native-born White) and the survey was administered in five languages (English, Spanish, Chinese, Russian, and Armenian). I drew a random sample separately for each county using the state administrative database for the IHSS program (Case Management, Information & Payrolling System). In each county, I oversampled any ethnic group for which a proportional sample would not have had 200 observations with an anticipated response rate of 50% to ensure that no cell had fewer than 100 observations. Because the survey sample included Los Angeles, which has a large Armenian population, and San Francisco, which has a large Chinese population, these two ethnic groups were slightly overrepresented relative to their representation in the state population.

[Table 2 about here]

The survey was mailed to a total of 5,019 providers drawn from random samples in eight counties. The survey was conducted in five counties between July and September of 2004; the three remaining counties were surveyed in August 2005. Respondents were called within a week of receiving the survey to remind them to complete and mail the survey or, if they preferred, to complete it over the phone. Respondents were sent a $15 grocery store voucher after they completed the survey.

The overall response rate was 45% (see Table 3). Ten percent refused to complete the survey. For 20% of the providers, I was able to confirm that I had bad contact information and would be unable to find them. Another 7% said they would send in the survey but never did, and 17% did not return the survey. I could never reach those 17% by phone and was unable to confirm whether they had received the survey, so I had to assume passive refusal. As with any low-income group, this population, especially in Los Angeles, tended to change residence frequently, and so I could not find many people because contact information was inaccurate or out of date. Subtracting from the sample the 20% for whom contact information was known to be inaccurate gives a response rate for providers whose contact information was known to be accurate or could not be confirmed as inaccurate of 56%. The gross response rate—including the providers with bad contact information—across counties ranged from 41% (Los Angeles) to 51% (Yuba/Sutter). The net response rate ranged from 47% (Sierra/Nevada) to 60% (Los Angeles). The response rate by ethnicity ranged from 42% (native-born White) to 51% (Chinese), whereas the net response rate by ethnicity ranged from 53% (native-born White and Russian) to 63% (Latino and African American). The gross response rates for Whites, Russians, and African Americans in Los Angeles were low at 31%, 34%, and 39%, but the net response rates were 49%, 46%, and 60%, respectively. Nonetheless, with the exception of Russians in Los Angeles and Whites in San Francisco, there were at least 100 responses for each ethnicity for each county; or in the case of Yolo, Yuba/Sutter, and Sierra/Nevada, the responses represented such a huge proportion of each ethnic population as to be highly representative. In sum, the response rates by county and by ethnicity were sufficiently high for me to have confidence that each ethnicity/county cell would provide statistically significant information and the that sample interviewed was representative of the original sample population.

[Table 3 about here]

I did all statistical analysis using STATA SVY commands designed to analyze survey data, and I weighted the sample observations in the analysis to reflect each ethnic group's actual representation in the IHSS provider population of the county from which the observation was drawn.

Hypotheses and Survey Design

As noted earlier, I designed the survey after I had conducted focus groups in Los Angeles, San Francisco, and Yolo County. Many of the elements of the survey had also been used in a prior survey of IHSS workers in Alameda County (Howes et al., 2002). These two experiences shaped my hypotheses about the factors that affect providers' decisions to enter and remain in the workforce and the range of information that I needed to test those hypotheses. Table 1 presents some of the data on personal characteristics that I used to construct the covariates needed to test these hypotheses. As Table 1 shows, IHSS workers were mainly middle-aged women with low incomes, the majority of whom were people of color and foreign born. As this is a consumer-directed program, most providers worked directly for a relative or someone they knew prior to being hired. As a consequence, the demographic profile of the provider population was quite similar to the ethnic and socioeconomic profile of consumers in this means-tested, Medicaid-funded program.

In all, 58% of the weighted survey sample was foreign born; almost 99% of Russians, Armenians, and Chinese were foreign born, and 75% of Latinos and 23% of Whites (excluding

Russians and Armenians, who were in a separate category) were foreign born. Of course, as the table also shows, there was significant ethnic variation across counties: The IHSS provider population in the rural counties in this sample was mainly White. Overall 79% were women, the average age was 46, and 68% provided care for a family member, again with some variation by county.

IHSS workers were overall quite poor—53% of the weighted survey sample lived in households with average incomes of less than $24,000 per year. Family providers were only slightly less likely to have household incomes less than $24,000 per year. A total of 37% of providers worked more than one job, and 46% worked more than full time at all of their jobs combined. The other jobs available to these respondents, either as second jobs or alternative employment, varied by ethnicity because specific ethnic groups are sorted into specific occupations, either as a consequence of discrimination and/or immigrant network-based job searches. Low-income labor markets are particularly highly segmented by ethnicity, meaning that certain "ethnic niche" jobs will be disproportionately populated by specific ethnic groups (Hondagneu-Sotelo, 2001; Waldinger, 1996, 2001). For example, among IHSS workers, African Americans are far more likely to find employment in higher paying day care and private pay home care and in administrative jobs; Chinese women work in housekeeping, factories, and food service. Central American women work in housekeeping and janitorial services and as maids and nurses' aides; Mexican women work as waiters, cooks, and maids.

That many were family caregivers; that many worked other jobs and had limited employment options; that they were very low income, low education, foreign-born, and women contributes to the reasons why they entered and remained in consumer-directed home care jobs. Those caring for family members or friends may have been doing the job primarily because of a

personal commitment to their consumer perhaps despite the pay, though even family providers face the same challenges of low incomes and limited alternative employment opportunities. Higher wages and benefits could make the difference between being able to care for a family member, hiring someone else to do the job, or placing the relative in an institution.

Perhaps they were attracted to IHSS jobs because they were part time or flexible, allowing them the flexibility to work other jobs or to provide caregiving in the home. If the other jobs were low-paying, part-time jobs, they were unlikely to provide benefits, making an IHSS job with health care benefits for part-time work a potentially attractive option.

As with all labor markets, part of what draws people into home care is the relative attractiveness of the wages and benefits compared to other jobs that are available to these workers. What is a "good enough" job depends on the compensation workers can earn in the range of other jobs available to them. Chinese and Latino workers, for example, reported that they left lower paying jobs than their African American and White counterparts in order to work in IHSS.

Thus, I designed the survey that underlies this study to measure the significance of wages and benefits to recruitment and retention of home care workers, controlling for other factors that will affect their decision, including their attachment to their client, cultural norms about care giving, and their alternative employment opportunities and household income. Because alternative employment opportunities are to some extent based on membership in a particular ethnic group, controlling for education and workforce experience, I used ethnicity as a proxy for both alternative opportunities and cultural norms. Because the racial and ethnic composition varies significantly across counties in California, if the racially linked factors that may mediate

the impact of wages and benefits are important, then the impact of wage and benefit differences on retention and recruitment will vary both by ethnicity and by county.

Variables and Measures

Outcome.—The study measured the probability that wages, or benefits, or any of several other possible motivations, was one of the top three reasons why a provider chose to enter the job or remain in home care. Because the vast majority of people indicated that the main reason they took the job and remained in the job was a commitment to their consumer, simply looking at the most important reason tells us little about the effect of wages and benefits. I transformed the data to measure the percentage of people who ranked a specific reason among the top three reasons why they either took the job or remained in the job. Because there are many reasons, other than the level of compensation, why people would choose to do this job, the question was embedded in a set of reasonable alternatives that were initially defined through a series of focus groups conducted in California in March of 2004. Participants in the survey were asked: (a) What were the three most important reasons you first chose to be an IHSS home care worker? (b) What are the three most important reasons why you keep working as an IHSS home care worker?

Each question had the following set of options from which to choose, as well as an open-ended answer at the end that rendered very little additional information:

- Better *pay* than other jobs you could get
- The job offered *health benefits*
- The job offered *dental benefits*
- You wanted to work *part time*
- You wanted to work *flexible hours*

- You had a close *personal connection* to your client
- You like this job *better than other jobs you can get*
- This was the *kind of job you knew how to do*
- This was the *only job you could get*

Predictors.—There were four principal predictors: the wage rate and benefit level in the county, whether the provider was caring for a family member, the race/ethnicity of the provider, and the household income level of the provider. Given the limited number of wage/benefit variants, I initially treated the wages and benefits as interactive (between wages and benefits) categorical variables (Los Angeles, San Francisco, Yolo, YSSN), where Los Angeles was the omitted category. However, subsequent regressions that included a separate dummy variable for the quality of health care showed similar but more revealing results. Keeslar (2005) provided the wage/benefit data used to construct this variable.

I determined whether the provider was caring for a family member (family = 1) by using the Case Management, Information & Payrolling System (CMIPS) data. The ethnicity/race of the provider was self-reported in the survey. The reported categories were African American, Armenian, Chinese, Latino, Russian, and White (native born); White was the omitted category. The household income level was also self-reported. Respondents stated the total amount of money that the entire household brought in each month. They had the option to select one of six income categories. I collapsed the income categories into low income (<$24,000 annual household income), medium income ($24,000 to <$48,000), and high income ($48,000 and greater); high income was the omitted category.

Results

Variation by County

Table 4 and 5 provide a first impression of what motivates people to enter and remain in this job. Most important, only a small proportion reported that pay or benefits were important to their decision to take the job. Overall, about 25% of the respondents (controlling for intersection) mentioned one or more of wages, health benefits, or dental benefits as among their top three reasons for taking the job. In contrast, 66% reported that their commitment to the consumer was among the top three reasons why they first took the job. In addition, 41% rated wanting a job that was flexible among the top three reasons; 26% rated wanting a part-time job among the top three reasons. Although there was considerable correlation between flexible and part-time responses, 50% of all respondents said that wanting either a part-time or flexible job or both was among the top three reasons why they took the job, making this set of reasons almost as important as commitment.

[Table 4 and 5 about here]

For many of the reasons for taking the job, there was very little variation across counties. Because the principal dimensions along which counties varied in this study were the wage and benefit levels and the ethnic composition of the county, this suggested that the nonvarying reasons (part time and flexible hours) and the last three categories ("prefer the job," "know how to do the job," and "only job you could get") were unvarying with respect to wage and benefit levels or by ethnicity.

However, there was a tremendous difference in the importance of benefits across counties, a slight difference in the significance of wages, and a large difference in the importance of commitment to the consumer, suggesting that these three reasons were sensitive to wage and benefit levels and to ethnicity. Clearly the health benefits in San Francisco, which were available to independent providers who had worked as few as 35 hr per month, were an important factor in the decision to work in IHSS. In all, 48% of respondents in San Francisco cited health insurance, dental insurance, or both as one of the top three reasons why they started working, in contrast to 15% in Los Angeles and 12% in Yolo County, both counties where people had to work 80 hr a month to qualify. In San Francisco, health and dental insurance rivaled commitment as among the three most important reasons why people took the job. Wages in Yolo County, which were $9.60 per hour, were significantly more important than in Los Angeles, where wages were $7.50, though they were also more important than in San Francisco, where hourly wages had been stalled at $10.28 for several years.

Variation by Ethnicity

Table 5 shows significant variation in responses by ethnicity. For example, Chinese workers were more than 3 times as likely to say that wages were an important attractor, and Chinese and Russian workers were much more likely to say that benefits were important than were White workers. There was not very much variability by ethnicity in most of the other categories with the exception of commitment, which African Americans, Latinos, and Whites were far more likely to cite than Russians, Chinese, and Armenians. Finally, Russians were much more likely than other workers to say that this was the only job they knew how to do or that they could get. Tables 5 and 7 indicate that there was very little difference by ethnicity in the reasons

why people remained in the job, compared to why they took the job. The exceptions were that Armenians and Russians, who were least likely to have taken the job because of commitment, cited commitment as a somewhat more important reason for staying in the job. Flexibility was more important to Russians as a reason for staying in the job than it was for taking the job.

[Tables 6 and 7 about here]

Regression Analysis

Some of the variation in the importance placed on health benefits across counties may have been explained by factors other than the difference in the level of the benefit. For example, Russian and Chinese providers, who put so much more weight on health insurance than other groups, compose 54% of the San Francisco workforce compared to 12% of the workforce statewide. It is also true that a far larger proportion of Chinese workers, again heavily represented in San Francisco, cited wages as being more important than other ethnic groups. To parse out the significance of the wage and benefit level relative to other explanatory factors, including ethnicity, income, and being a family provider, I ran a set of logit regressions to analyze variance in the probability of a worker citing each of the possible categories as among his or her top three reasons for entering and remaining in the job. (Prior to performing regressions, I conducted factor analysis in order to see if there was any natural grouping that would reduce the dimensions of the reasons for taking the job. Because the factor analysis did not add new information but rather obscured some useful information, I did the regressions on each of the reasons rather than on the reduced dimension factors.) Table 8 reports the odds ratios of various factors explaining why workers cited any of their top three reasons. The results

showed that, after controlling for ethnicity (Chinese workers were almost 9 times as likely to cite wages than were White workers, the omitted category) and income, the odds of someone who worked in the high-wage/good-benefit county (San Francisco) saying that wages were an important reason for taking the job were only half those of someone from Los Angeles, where wages were much lower. This was strong evidence that wages at their current level, which have not changed significantly in 4 years, were not an important attractor in San Francisco, except for Chinese workers. In contrast, workers in Yolo County, where wages were much higher than in Los Angeles but somewhat lower than in San Francisco, and much higher than they were 4 years ago, were more than twice as likely to cite wages as were home care workers in Los Angeles, after I controlled for ethnicity and income. Clearly wages were attracting workers in Yolo County.

[Table 8 about here]

Moving to health insurance, workers in San Francisco were 2 to 3 times more likely to cite health and dental benefits than were Los Angeles workers, even after I controlled for the fact that the large Chinese and Russian populations were many times more likely to cite these benefits among their top three reasons for taking the job.

Looking at the result through the lens of family versus non-family caregivers revealed that family caregivers were much more likely to do the job out of commitment to their client than were non-family caregivers and were much less likely to say they were looking for a part-time or temporary job, or that they preferred the job or that it was the only job they could get. In other words, they had other choices and would not have chosen the job but for the fact that they had a

commitment to their family care recipient. However, also extremely important was that although family providers were definitively not attracted to the job for many of the reasons that other groups were, they were not significantly different from non-family caregivers with respect to either wages or benefits.

Shining an ethnic light on this analysis revealed that Armenian, Russian, and Chinese workers were less likely to be doing it out of commitment than Whites, African Americans, or Latinos. Again, the Russians and Chinese were, relative to the other groups, motivated by health and dental insurance, and the Chinese by wages. All three of these groups, as well as Latinos, were more likely than Whites to say it was the only job they could get.

Low-income workers were less likely to be doing it for love than high-income workers. Low-income workers were also less likely than high-income people to be looking for part-time work and vastly more likely to be doing it because it was the only job they could find. Table 9 shows the regression results for why people remain in the job. Most of the same patterns held. However, the results did indicate that both low- and medium-income workers, neither of which were more likely to say they took the job originally for health insurance, were now vastly more likely to say they remained in the job for the health insurance. Consistent with the analysis of why they entered, low-income people were less likely to stay in the job for flexibility or commitment but more likely to be doing it because it was the only job they could find.

[Table 9 about here]

One problem with this set of regressions was that the county dummy variables were functioning as the measure of differences in wages and benefits combined, which made it

difficult to see how important wages were relative to benefits. I ran another set of regressions that focused only on whether people stated that wages or health insurance was among the top three reasons to take the job. Model 1 in Table 10 reports the results from Table 8 for comparison. Model 2 reports results when I added a dummy variable that indicated whether the individual had enrolled in the program. Model 3 reports both whether the individual had enrolled and whether the county made IHSS insurance available, raising possible multicollinearity problems, especially given the high enrollment rate in San Francisco County. Model 4 reports the same two additional indicators for health insurance but drops the county indicators. Model 5 added the county indicators back but used two health insurance indicators that measured whether a person had enrolled in a good health insurance program (for which people who had worked only 35 hr in a month were eligible) or an OK health insurance program (for which people were eligible only if they had worked 80 hr per month). The final columns (Model 6) uses these same two indicators for health insurance and drops the county variables. Because 66% of workers in San Francisco county enrolled in the good health insurance program there, there was a very high correlation between the San Francisco dummy variable and the good health insurance dummy variable.

[Table 10 about here]

The Wages column in Model 1 and the Health column in Model 6 provide probably the best account of why people cited wages or health benefits as among the most important reasons that they took the job. I reported the results for Model 1 in the discussion of Table 8. The Health column of Model 6 indicated that people who enrolled in the good health insurance program in

San Francisco were 5 times more likely to cite health insurance as a reason for taking the job than were people in counties where health insurance was not yet available. More important, people in the good health insurance county were 40% more likely to cite health insurance than people in OK health insurance counties, even when I controlled for ethnic preferences. Similar but stronger results were reported as a reason for staying in the job. Table 11 shows that people in good health insurance counties were almost twice as likely to report health insurance as were people in OK health insurance counties.

[Table 11 about here]

Discussion

Do wages and benefits attract workers to the job and help retain them? Why are workers in San Francisco, which pays the highest wages, less likely to cite wages than workers in Yolo County, where wages are lower? Why, after controlling for ethnic and income differences, are San Francisco workers half as likely as Los Angeles workers to cite wages as important? Analysis of this survey data both confirms the importance of benefits paid for part-time work and raises some questions about under what conditions wages are important.

Without question, the results of the survey suggest that with low enough eligibility thresholds (i.e., making it available to very part-time workers), health insurance is one of the major reasons why workers take the job and, even more important, why they remain in the job. Almost half of workers in San Francisco— where eligibility criteria are much lower than for other counties—said that health insurance is a very important reason why they took the job and remain in the job. Because 63% enrolled in the IHHS health insurance program (and 22%

already had health insurance from another source), this means 81% of those who needed health insurance enrolled. In contrast, in Los Angeles, only 22% enrolled. Forty percent already had insurance, but that means only 37% of those who needed it enrolled, either because they were not eligible (16%), could not afford it (10%), or did not believe it was available when it was (16%). Although there are some ethnic groups for which the benefits are more important (i.e., Russians and Chinese), even controlling for that effect, San Francisco workers were twice as likely to take the job for health insurance as were Los Angeles workers.

Why are health insurance benefits so important to Chinese and Russian workers? When workers were asked whether they had taken the IHSS insurance, 48% and 50% of Chinese and Russians, respectively, compared to 26% for the entire sample, reported yes. When those who reported that they had not taken the insurance were asked why they had not taken it, only 21% and 29% of Chinese and Russians, respectively, reported having insurance through another source, compared to the overall average for the sample of 37%. Anecdotal evidence collected from conversations with people working in social service agencies that serve these communities suggests that Chinese workers have access to very few jobs that provide health insurance, unlike many African American and native-born White workers (Howes, 2002). Many of the Russian workers are new immigrants who do not speak English, who are trying to retrain for jobs in the United States, and who are in the meantime eligible for refugee assistance and Medicaid insurance as long as they do not work too many hours. The IHSS job was one of the very few jobs they could do—note their propensity to say that this was the only job they could get—that also provided the health insurance they would otherwise have had to give up (Howes, 2002). It is interesting that Latinos, who were equally unlikely to have health insurance from another source (31%), were among the least likely to take IHSS insurance: 32% reported that there was none

available, which is untrue because the majority worked in Los Angeles County, where there was health insurance. This suggests that Latinos are not aware that they can get health insurance through IHSS.

Although the results seem to suggest that wages are not a significant attractor, it is important to note that for one county—Yolo—and for one ethnic group—the Chinese—wages were relatively more important. Yolo County received a large wage increase within the 2 years preceding the survey. Many of the workers entered just as the wage was going up, and the rest experienced a wage increase in the recent past. In contrast, in San Francisco, which had the highest wages but also the highest cost of living, the wage had not increased for 4 years prior to the survey. The fact that the wage was still very important to Chinese workers, for whom the other options were jobs in garment factories and food service, suggests that $10.28 an hour is still a very competitive wage. For many of the other ethnic groups, $10.28 an hour in San Francisco and lower wages in other counties were probably not competitive wages. So it is not possible to conclude from this study that wages are not important, but it is possible to conclude that as long as they are stagnant or remain below a wage that is competitive with the other low-wage jobs available to this group of people, it is unlikely that wages alone will attract or retain workers.

Turning to the other factors that attract workers to the job, note that flexibility and, to a lesser extent, part-time work were extremely important, regardless of wage and benefit levels and regardless of ethnicity. But also note that low-income workers and non-family providers were not looking for part-time jobs, but they were looking for flexible jobs. As reported in Table 1, a significant proportion of people in this workforce worked at second and third jobs, probably because they were too poor to make it on one low-wage job. In addition, 48% worked more than

40 hr per week. So although it is true that there are a fair number of people looking for part-time and flexible work, for the low-income workers who are doing this as a primary job, and not primarily because they are caring for a family member, flexible is what is important, not part-time work.

Particular attention needs to be paid to the importance of commitment in attracting and retaining providers. Of the respondents, 66% reported that commitment was one of the three most important reasons why they took the job and also why they stayed in the job. But for Yolo County, where the wages had gone up the most and most recently, the proportion of people who said they *stayed in* the job out of commitment went up relative to the proportion who *took* the job out of commitment. And the two ethnic groups that were least likely to cite commitment as a reason for taking the job were far more likely to report that they stayed because of commitment. These two facts provide evidence that regardless of the reason people take the job, once they are in the job they become more attached to it through their attachment to their consumer and because the wage and benefit improvements matter.

Permitting family members to provide care is thus an obvious way to attract more workers into the field. As Benjamin (2006) reported, many family providers say they would be willing to care for a non-family consumer. I must note, furthermore, that although family providers are far more likely to enter the field because of commitment than non-family providers, they express no less interest in wages and benefits as a reason for taking the job. The fact that family caregivers are half as likely to do the job because they like it as are non-family caregivers suggests that many of them may feel like they have little choice. (This interpretation is consistent with the findings of National Alliance for Caregiving (NAC) and AARP 2004, which found that a very large proportion of family caregivers felt they had little choice in whether to

provide care for a family member.) Thus, it is important to see family providers as people who could be continuing members of the workforce if only they received the resources that they, like other workers, needed.

From these results a number of recommendations about how to increase recruitment and retention of consumer-directed home care workers emerge:

1. Allow family, neighbors, and friends to be caregivers. They are the first to respond to caregiving needs, and, once they enter the workforce, they may become interested in the job beyond the need to care for a friend or relative. But recognize that they are not doing it just for love; they are just as likely to cite health insurance as a reason for taking and remaining in the job as are non-family providers.
2. Make health insurance benefits available to very part-time workers—those working as few as 8 or 9 hr per week. This is the single most important factor after commitment to the consumer that attracts and retains workers.
3. Recognize that in order to attract and retain workers from a broad range of ethnic groups, wages must be competitive with the wages paid for other low-wage jobs in that community. If in San Francisco $10.28 an hour is important only to Chinese workers, wages need to be considerably higher to serve as an attractor in other ethnic communities.
4. Jobs should be flexible, but they need not necessarily be part time. In fact, it may be harder to attract particularly low-income workers to part-time work.

Making home care the centerpiece of our long-term-care policy in this country will be an important part of a strategy to secure an adequate workforce and provide quality long-term care for the coming decades. But, as this article argues, direct care workers, especially home care

workers, must be paid a decent wage and provided with health insurance benefits for very part-time employment. (Making home care the centerpiece of a long-term-care strategy in the United States will also require reversing the bias in the Medicaid-funded long-term-care system that favors facility-based over home-based care; Howes, in press.)

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Table 1. Demographics of IHSS Workforce by County, 2004, Based on Weighted Sample

Variable	Total Sample	Los Angeles	San Francisco	Yuba/Sutter	Yolo	Sierra/Nevada
n	2,260	924	796	181	272	87
Race/ethnicity of caregiver						
Latino	24	26	9	10	19	10
Chinese	8	5	36	0	1	0
Russian	4	2	18	0	11	0
Armenian	10	12	0	5	4	2
African American	18	19	12	2	4	0
White	21	20	13	69	52	81
Foreign born	58	58	76	17	27	4
Caring for family	68	70	56	61	52	55
Family/friend as first client	84	86	72	68	71	84
Family/friend as current client	84	86	73	68	71	76
Living with client	43	45	28	40	34	56
Female	79	79	71	86	83	89
Marital status						
Married/cohabiting	52	51	60	58	60	51
Widowed/separated/divorced	27	27	21	29	20	25
Never married	21	22	20	12	19	24
Educational attainment						
Less than high school	25	25	27	24	22	13
High school	29	29	29	35	26	34
Some college/technical school	30	31	22	37	35	45
College graduate	10	10	15	3	11	3
Graduate school or more	5	5	7	2	7	5
Have other job	37	37	41	27	45	52
Total paid hours per week in all jobs						
Less than 20 hr	15	15	18	19	11	22
20–40 hr	38	39	36	40	35	36
More than 40 hr	46	46	47	40	54	42
Annual household income						
Less than $12 K	19	20	14	21	14	10
$12 to <24K	33	34	27	32	26	30
$24 to <36K	23	23	28	24	20	23
$36 to <48K	14	14	18	14	21	19
$48K or more	11	11	14	8	13	16
Satisfied/very satisfied with job	86	85	92	77	94	86
Wages (08/2004)		$7.50	$10.28	$6.75	$9.60	$7.11
Health insurance (08/2004)[a]		80/2	35/2	None	80/3	None

Note: Data are percentages, unless otherwise specified. IHSS = In-Home Supportive Services program.

[a]Data show hours/months for eligibility.

Table 2. Ethnic Distribution of California IHSS Population, Survey Population, Sample, and Respondents

	California, 12/2003	Eight Counties, 06/2004		
Ethnicity	IHSS Population	IHSS Population	Sample	Respondents
Latino	23	25	20	22
Chinese	5	8	15	17
Russian	3	4	13	14
Armenian	4	10	4	5
African American	16	19	13	12
White	35	21	24	23
Other Asian	13	11	8	7
Other	1	1	1	1
Total	100	100	100	100
n	284,700	119,574	5,022	2,260

Note: Data are percentages, unless otherwise specified. IHSS = In-Home Supportive Services program.
Source: Case Management, Information and Payrolling System, December, 2003; Case Management, Information and Payrolling System, June 2004; survey results.

Table 3. Response Rate by County and Ethnicity: Gross and Net of Sample Observations With Bad Contact Information

	Los Angeles		San Francisco		Yolo		Yuba/Sutter		Sierra/Nevada		Total	
Ethnicity	Total	Net	Total	Net	Total	Net	Total	Net	Total	Net	Total	Net
Latino	0.49	0.72	0.54	0.64	0.39	0.45	0.49	0.59	1.00	1.00	0.48	0.63
Chinese	0.55	0.66	0.50	0.52							0.51	0.55
Russian	0.34	0.46	0.51	0.57	0.53	0.53					0.46	0.53
Armenian	0.48	0.61									0.48	0.61
African American	0.39	0.65	0.49	0.64							0.42	0.63
White	0.31	0.49	0.45	0.55	0.49	0.61	0.55	0.58	0.43	0.46	0.42	0.53
Other Asian	0.34	0.49	0.30	0.34			0.52	0.53			0.36	0.45
Other	0.17	0.29	0.19	0.27			0.31	0.31	0.50	0.50	0.22	0.30
Total	0.41	**0.60**	0.49	**0.55**	0.45	**0.52**	0.51	**0.57**	0.44	**0.47**	0.45	**0.56**

Note: Bold figures indicate average response rate by county, net of observations with bad contact information.

Table 4. Percent Reporting That Reason Was One of Top Three Reasons Why They Took the Job, by County

Reason	Los Angeles[a]	San Francisco	Yolo	YSSN	Total	*p*
Wages better	8	11	15	3	8	.01
Health insurance	14	43	12		16	.00
Dental insurance	6	28	5		8	.00
Part-time job	25	20	25	23	26	.01
Flexible hours	42	35	45	42	41	.01
Commitment	68	51	67	81	66	.00
Prefer this job	16	16	22	18	16	.43
Knew how to do	23	21	25	32	23	.04
Only job you could get	9	12	8	9	9	.14
n	896	761	266	262	2,185	

Note: YSSN = Yuba, Sutter, Sierra, Nevada, and Plumas counties.
[a]Omitted category for econometric analysis.

Table 5. Percent Reporting That Reason Was One of Top Three Reasons Why They Stayed in the Job, by County

Reason	Los Angeles[a]	San Francisco	Yolo	YSSN	Total	*p*
Wages better	9	11	12	2	9	
Health insurance	15	48	17	3	18	.00
Dental insurance	9	34	7	1	11	.00
Part-time job	27	18	24	24	26	.00
Flexible hours	42	35	47	44	42	.01
Commitment	67	53	73	86	66	.00
Prefer this job	18	16	16	17	17	.80
Knew how to do	22	20	27	31	22	.05
Only job you could get	7	9	5	5	7	.13

Note: YSSN = Yuba, Sutter, Sierra, Nevada, and Plumas counties.
[a]Omitted category for econometric analysis.

Table 6. Percent Reporting That Reason Was One of Top Three Reasons Why They Took the Job, by Ethnicity

Reason	African American	Armenian	Chinese	Latino	Russian	White[a]	Total	*p*
Wages better	6	4	29	5	4	6	9	.00
Health insurance	13	9	55	13	38	13	16	.00
Dental insurance	6	2	27	4	26	8	8	.00
Part-time job	28	29	20	23	25	28	26	.75
Flexible hours	37	36	42	44	42	37	41	.24
Commitment	70	41	44	72	50	78	66	.00
Prefer this job	19	9	15	21	8	14	16	.03
Knew how to do	25	23	17	21	39	24	23	.17
Only job you could get	8	7	12	12	20	5	9	.08

Note: All reported *p* values statistically significant at the 1% level.
[a]Omitted category for econometric analysis.

Table 7. Percent Reporting That Reason Was One of Top Three Reasons Why They Stayed in the Job, by Ethnicity

Reason	African American	Armenian	Chinese	Latino	Russian	White[a]	Total	*p*
Wages better	5	3	29	7	0	10	9	.00
Health insurance	15	10	55	14	47	15	18	.00
Dental insurance	10	4	32	7	31	9	11	.00
Part-time job	28	29	19	25	22	26	26	.37
Flexible hours	40	39	38	44	50	38	42	.68
Commitment	69	47	43	71	55	77	66	.00
Prefer this job	15	10	14	26	11	16	17	.01
Knew how to do	26	20	18	22	35	22	22	.44
Only job you could get	7	6	11	8	9	3	7	.13

Note: All reported *p* values statistically significant at the 1% level.
[a]Omitted category for econometric analysis.

Table 8. Odds Ratio That Factor Affected Reason for Taking the Job

Factor	Wages Better	Health Insurance	Dental Insurance	Part-Time Job	Flexible Hours	Committed	Prefer This Job	Knew Job	Only Job You Could Get
San Francisco	**0.535****	**2.109****	**3.037****	**0.688***	**0.626****	**0.636****	**1.230**	**0.804**	**1.078**
	(2.86)	**(4.91)**	**(5.55)**	**(2.31)**	**(3.38)**	**(3.23)**	**(1.16)**	**(1.34)**	**(0.36)**
Yolo	**2.471***	**0.776**	**0.867**	**0.873**	**1.197**	**0.730**	**2.145****	**0.997**	**1.026**
	(2.45)	**(0.83)**	**(0.32)**	**(0.55)**	**(0.84)**	**(1.33)**	**(2.77)**	**(0.01)**	**(0.09)**
YSSN	**0.400**	**0.082****	**0.023****	**0.671**	**1.131**	**1.218**	**1.523**	**1.531**	**2.288***
	(1.50)	**(3.48)**	**(3.51)**	**(1.44)**	**(0.51)**	**(0.69)**	**(1.29)**	**(1.56)**	**(2.01)**
Family	**0.677**	**0.858**	**0.754**	**0.645***	**0.522****	**2.619****	**0.508****	**0.720**	**0.446****
	(1.39)	**(0.74)**	**(1.01)**	**(2.38)**	**(3.99)**	**(5.60)**	**(3.36)**	**(1.74)**	**(3.48)**
African American	**0.920**	**1.014**	**1.504**	**0.841**	**1.072**	**0.625**	**1.737**	**1.191**	**2.838**
	(0.13)	**(0.03)**	**(0.73)**	**(0.54)**	**(0.23)**	**(1.34)**	**(1.36)**	**(0.51)**	**(1.74)**
Latino	**1.062**	**0.926**	**0.637**	**0.785**	**1.538**	**0.659**	**1.933**	**0.956**	**3.997***
	(0.11)	**(0.21)**	**(0.81)**	**(0.83)**	**(1.60)**	**(1.31)**	**(1.75)**	**(0.14)**	**(2.55)**
Russian	**0.656**	**2.658****	**3.186***	**0.816**	**1.681**	**0.308****	**0.397**	**1.897***	**7.766****
	(0.61)	**(2.63)**	**(2.47)**	**(0.62)**	**(1.78)**	**(3.66)**	**(1.92)**	**(1.99)**	**(3.70)**
Armenian	**0.696**	**0.644**	**0.468**	**1.198**	**1.148**	**0.138****	**0.655**	**1.227**	**3.459***
	(0.51)	**(0.91)**	**(0.96)**	**(0.54)**	**(0.43)**	**(5.50)**	**(0.84)**	**(0.56)**	**(2.05)**
Chinese	**8.912****	**6.217****	**4.938****	**0.734**	**1.580**	**0.174****	**1.294**	**0.749**	**4.427****
	(4.17)	**(5.21)**	**(3.50)**	**(1.02)**	**(1.64)**	**(5.58)**	**(0.67)**	**(0.87)**	**(2.74)**
Low income	**1.373**	**1.179**	**0.598**	**0.529***	**0.809**	**0.338****	**1.538**	**0.739**	**2.799***
	(0.69)	**(0.41)**	**(1.05)**	**(2.22)**	**(0.79)**	**(3.36)**	**(1.21)**	**(0.98)**	**(2.16)**
Medium income	**1.464**	**1.307**	**0.661**	**0.650**	**0.784**	**0.632**	**1.236**	**0.937**	**1.652**
	(0.81)	**(0.66)**	**(0.90)**	**(1.47)**	**(0.89)**	**(1.45)**	**(0.57)**	**(0.21)**	**(1.06)**

Note: t statistics are in parentheses. YSSN = Yuba, Sutter, Sierra, Nevada, and Plumas counties. Observations = 1,885.

*$p < .05$; **$p < .01$.

Table 9. Odds Ratio That Factor Affected Reason for Remaining in the Job

Factor	Wages Better	Health Insurance	Dental Insurance	Part-Time Job	Flexible Hours	Commitment	Prefer This Job	Knew Job	Only Job You Could Get
San Francisco	0.587*	2.320**	2.696**	0.555**	0.715*	0.809	1.151	0.796	1.181
	(2.36)	(5.47)	(5.55)	(3.47)	(2.42)	(1.48)	(0.82)	(1.40)	(0.67)
Yolo	1.321	1.024	0.774	0.773	1.264	1.153	1.078	1.419	0.925
	(0.73)	(0.08)	(0.65)	(1.00)	(1.08)	(0.60)	(0.25)	(1.44)	(0.25)
YSSN	0.199**	0.171**	0.125*	0.695	1.187	2.226*	1.129	1.649	2.282*
	(2.72)	(3.28)	(2.49)	(1.26)	(0.70)	(2.57)	(0.37)	(1.72)	(2.00)
Family	0.610	0.551**	0.695	0.608**	0.598**	2.489**	0.548**	0.660*	0.611
	(1.74)	(2.92)	(1.49)	(2.64)	(3.07)	(5.11)	(2.89)	(2.19)	(1.77)
African American	0.323*	1.144	1.683	0.771	0.981	0.708	1.187	1.648	4.550**
	(2.07)	(0.34)	(1.08)	(0.76)	(0.06)	(0.99)	(0.40)	(1.41)	(2.88)
Latino	0.502	0.902	0.974	0.969	1.339	0.815	2.300*	1.159	7.526**
	(1.57)	(0.28)	(0.06)	(0.10)	(1.07)	(0.64)	(2.16)	(0.45)	(4.83)
Russian	0.038**	3.265**	2.903*	0.704	1.552	0.423**	0.666	1.943	7.727**
	(3.40)	(3.21)	(2.42)	(1.02)	(1.51)	(2.61)	(0.95)	(1.94)	(4.08)
Armenian	0.236*	0.460	0.443	1.227	1.020	0.214**	0.836	0.996	6.726**
	(2.19)	(1.53)	(1.14)	(0.59)	(0.06)	(4.28)	(0.37)	(0.01)	(3.62)
Chinese	3.864**	5.771**	4.451**	0.751	1.155	0.188**	1.011	0.911	10.053**
	(3.51)	(4.95)	(3.41)	(0.90)	(0.52)	(5.31)	(0.03)	(0.27)	(5.20)
Low income	2.124	2.260*	0.939	0.524*	0.844	0.220**	1.070	0.842	4.924*
	(1.44)	(2.12)	(0.14)	(2.20)	(0.59)	(4.26)	(0.18)	(0.54)	(2.16)
Medium income	1.267	2.245*	1.062	0.688	0.884	0.406*	0.782	0.927	3.504
	(0.44)	(2.08)	(0.13)	(1.26)	(0.43)	(2.56)	(0.62)	(0.23)	(1.70)

Note: t statistics are in parentheses. YSSN = Yuba, Sutter, Sierra, Nevada, and Plumas counties. Observations = 1,806.

*$p < .05$; **$p < .01$.

Table 10. Odds Ratio That Factor Affected Reason for Taking the Job, Wages and Benefits Only

	(1)		(2)		(3)		(4)		(5)		(6)	
Factor	Wages	Health	Wages	Health	Wages	Health	Wages	Health	Wages	Health	Wages	Health
San Francisco	0.535**	2.109**	0.650	1.543*	0.650	1.543*			0.333**	1.519		
	(2.86)	(4.91)	(1.73)	(2.36)	(1.73)	(2.36)			(3.03)	(1.72)		
Yolo	2.471*	0.776	2.115*	0.730	2.115*	0.730			2.124*	0.731		
	(2.45)	(0.83)	(1.99)	(1.00)	(1.99)	(1.00)			(1.99)	(1.00)		
YSSN	0.400	0.082**	0.389	0.137**					0.377	0.142**		
	(1.50)	(3.48)	(1.56)	(2.75)					(1.62)	(2.70)		
Family	0.677	0.858	0.663	0.968	0.663	0.968	0.669	0.944	0.670	0.969	0.673	0.974
	(1.39)	(0.74)	(1.42)	(0.15)	(1.42)	(0.15)	(1.40)	(0.26)	(1.38)	(0.14)	(1.38)	(0.12)
African American	0.920	1.014	0.975	1.081	0.975	1.081	0.964	1.066	0.992	1.082	1.008	1.136
	(0.13)	(0.03)	(0.04)	(0.18)	(0.04)	(0.18)	(0.06)	(0.15)	(0.01)	(0.18)	(0.01)	(0.30)
Latino	1.062	0.926	1.081	1.036	1.081	1.036	1.070	1.029	1.069	1.036	1.114	1.072
	(0.11)	(0.21)	(0.14)	(0.09)	(0.14)	(0.09)	(0.12)	(0.07)	(0.12)	(0.09)	(0.20)	(0.18)
Russian	0.656	2.658**	0.683	2.754**	0.683	2.754**	0.606	3.219**	0.682	2.753**	0.631	3.023**
	(0.61)	(2.63)	(0.55)	(2.62)	(0.55)	(2.62)	(0.70)	(2.93)	(0.54)	(2.62)	(0.66)	(2.86)
Armenian	0.696	0.644	0.725	0.733	0.725	0.733	0.723	0.714	0.714	0.732	0.753	0.755
	(0.51)	(0.91)	(0.45)	(0.61)	(0.45)	(0.61)	(0.46)	(0.66)	(0.47)	(0.61)	(0.40)	(0.56)
Chinese	8.912**	6.217**	7.899**	5.887**	7.899**	5.887**	6.891**	6.717**	7.732**	5.883**	7.162**	6.430**
	(4.17)	(5.21)	(3.82)	(4.70)	(3.82)	(4.70)	(3.55)	(5.04)	(3.76)	(4.70)	(3.80)	(5.00)
Individual enrolled in IHSS			0.729	3.444**	0.729	3.444**	0.667	3.677**				
			(0.88)	(5.37)	(0.88)	(5.37)	(1.17)	(5.97)				
Health insurance available in county					2.568	7.285**	2.602	7.371**				
					(1.56)	(2.75)	(1.60)	(2.77)				
Individual enrolled in good health insurance program									1.816	3.516**	0.684	5.148**
									(1.69)	(5.73)	(1.47)	(8.85)
Individual enrolled in OK health insurance program									0.618	3.430**	0.668	3.391**
									(1.04)	(4.63)	(0.89)	(4.69)
Low income	1.373	1.179	1.364	1.288	1.364	1.288	1.387	1.260	1.350	1.287	1.388	1.264
	(0.69)	(0.41)	(0.68)	(0.63)	(0.68)	(0.63)	(0.71)	(0.59)	(0.66)	(0.63)	(0.72)	(0.59)
Medium income	1.464	1.307	1.448	1.587	1.448	1.587	1.456	1.577	1.428	1.586	1.455	1.562
	(0.81)	(0.66)	(0.78)	(1.14)	(0.78)	(1.14)	(0.79)	(1.14)	(0.75)	(1.14)	(0.79)	(1.11)
Observations	1,885	1,885	1,790	1,790	1,790	1,790	1,790	1,790	1,790	1,790	1,790	1,790

Notes: t statistics are in parentheses. YSSN = Yuba, Sutter, Sierra, Nevada, and Plumas counties; IHSS = In-Home Supportive Services program.
*$p < .05$; **$p < .01$.

Table 11. Odds Ratio That Factor Affected Reason for Remaining in the Job, Wages and Benefits only

	(1)		(2)		(3)		(4)		(5)		(6)	
Factor	Wages	Health	Wages	Health	Wages	Health	Wages	Health	Wages	Health	Wages	Health
San Francisco	0.587*	2.320**	0.807	1.633**	0.807	1.633**			0.363**	1.480		
	(2.36)	(5.47)	(0.86)	(2.63)	(0.86)	(2.63)			(2.73)	(1.62)		
Yolo	1.321	1.024	1.256	1.139	1.256	1.139			1.253	1.139		
	(0.73)	(0.08)	(0.58)	(0.44)	(0.58)	(0.44)			(0.58)	(0.44)		
YSSN	0.199**	0.171**	0.179**	0.237*					0.171**	0.244*		
	(2.72)	(3.28)	(2.81)	(2.47)					(2.89)	(2.41)		
Family	0.610	0.551**	0.559*	0.613*	0.559*	0.613*	0.562*	0.598*	0.565	0.614*	0.574	0.616*
	(1.74)	(2.92)	(1.97)	(2.18)	(1.97)	(2.18)	(1.96)	(2.31)	(1.92)	(2.18)	(1.90)	(2.18)
African American	0.323*	1.144	0.336	1.221	0.336	1.221	0.335*	1.192	0.343	1.226	0.361	1.269
	(2.07)	(0.34)	(1.95)	(0.48)	(1.95)	(0.48)	(1.97)	(0.43)	(1.90)	(0.49)	(1.83)	(0.59)
Latino	0.502	0.902	0.469	0.973	0.469	0.973	0.469	0.959	0.462	0.971	0.497	0.995
	(1.57)	(0.28)	(1.70)	(0.07)	(1.70)	(0.07)	(1.71)	(0.11)	(1.73)	(0.08)	(1.60)	(0.01)
Russian	0.038**	3.265**	0.040**	3.589**	0.040**	3.589**	0.038**	4.257**	0.040**	3.584**	0.038**	3.928**
	(3.40)	(3.21)	(3.35)	(3.51)	(3.35)	(3.51)	(3.39)	(3.86)	(3.36)	(3.50)	(3.43)	(3.77)
Armenian	0.236*	0.460	0.240*	0.515	0.240*	0.515	0.241*	0.495	0.235*	0.514	0.256*	0.524
	(2.19)	(1.53)	(2.14)	(1.21)	(2.14)	(1.21)	(2.14)	(1.29)	(2.17)	(1.22)	(2.06)	(1.20)
Chinese	3.864**	5.771**	3.391**	5.770**	3.391**	5.770**	3.181**	6.617**	3.283**	5.749**	3.168**	6.172**
	(3.51)	(4.95)	(3.10)	(4.78)	(3.10)	(4.78)	(2.94)	(5.18)	(2.99)	(4.77)	(3.02)	(5.07)
Individual enrolled in IHSS			0.572	4.101**	0.572	4.101**	0.547	4.397**				
			(1.54)	(6.23)	(1.54)	(6.23)	(1.72)	(6.88)				
Health insurance available in county					5.596**	4.219*	5.600**	4.321*				
					(2.81)	(2.47)	(2.83)	(2.52)				
Individual enrolled in good health insurance program									1.727	4.689**	0.710	6.672**
									(1.52)	(6.77)	(1.29)	(10.05)
Individual enrolled in OK health insurance program									0.462	4.009**	0.502	3.971**
									(1.60)	(5.29)	(1.45)	(5.37)
Low income	2.124	2.260*	2.131	2.973**	2.131	2.973**	2.150	2.847**	2.087	2.966**	2.165	2.908**
	(1.44)	(2.12)	(1.46)	(3.93)	(1.46)	(3.93)	(1.47)	(3.71)	(1.42)	(3.92)	(1.50)	(3.81)
Medium income	1.267	2.245*	1.130	3.272**	1.130	3.272**	1.134	3.202**	1.107	3.266**	1.133	3.221**
	(0.44)	(2.08)	(0.23)	(4.18)	(0.23)	(4.18)	(0.23)	(4.03)	(0.19)	(4.16)	(0.23)	(4.06)
Observations	1,806	1,806	1,712	1,712	1,712	1,712	1,712	1,712	1,712	1,712	1,712	1,712

Notes: t statistics are in parentheses. YSSN = Yuba, Sutter, Sierra, Nevada, and Plumas counties; IHSS = In-Home Supportive Services program.
*$p < .05$; **$p < .01$.

Figure 1. In-Home Supportive Services program wage trends, by county. Sierra, Nevada, and Plumas counties surveyed in August 2005. SF = San Francisco; LA = Los Angeles.