

WOMEN IN HEALTH CARE: AN EXAMINATION OF EARNINGS

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The following faculty members have examined the final copy of this thesis for form and content, and recommend that it be accepted in partial fulfillment of the requirement for the degree of Master of Arts with a major in Sociology.

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ABSTRACT

The purpose of this research is to examine the wage gap that occurs in health care occupations. This project investigates the annual salaries of women who are employed as health care professionals. The secondary data for this research is drawn from the Current Population Survey (CPS) Annual Social & Economic Supplement (ASEC). The final sample size was 16,884. OLS Regression was used to test the hypotheses proposed in this study. The findings indicate that net of other factors, minority women who work in health care occupations earn less annually than their white counterparts, with the exception of Asians.

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1. Introduction

According to the U.S Department of Labor, health care jobs are projected to increase by 25.4% by 2016. Healthcare jobs are in high demand but significant disparities in health care exist as to who occupies the positions with lucrative salaries. For example, in 2008 blacks made up 11% of the employed population, but 34% of health care aides were black. (U.S. Department of Labor, Bureau of Labor Statistics, 2009b). In healthcare, those who provide direct care are disproportionately comprised of minority and immigrant women who live in poverty and possess limited education (Ryosho, 2011). These women are disadvantaged socially and serve family members and friends of those who are privileged. They reside at the bottom of the health care hierarchy, in terms of salary, privilege and status, while white middle-class women monopolize managerial and supervisory positions (Ryosho, 2011). According to the National Assistant Survey, 92% of Certified Nursing Assistants (CNAs) who are employed by nursing homes are female, of them 47% are non-white, and 9% are foreign born (Ryosho, 2011). Women of color and immigrants continue to wrestle to obtain pay equity in healthcare. A study conducted by Mc Ginnis and Moore (2010) found, net of all other variables, African American RN's earned \$3041 less than non-Hispanic white RNs, Hispanic/Latino RNs earned \$2,217 less, and Asian/Pacific Islander RNs earned \$2596 less. The purpose of this research is to examine the wage gap that exists *within* health professions *between* white women and minority women.

To discuss and examine the gap between non-white women and white women, three theoretical perspectives will be identified; the individual- level theoretical perspective, the structural-level theoretical perspective, and the gender-level theoretical perspective which entails the intersections of gender, class and race. The individual-level model can be used to explain

varying degrees of human capital investment. Human capital theory tells us individuals make rational choices about their investment in human capital (Becker, 1993). The varying degrees of human investment capital have an impact on income which represents the individual- level model. The structural-level perspective maintains that the labor market encompasses two sectors; primary and secondary, and income is based on one's location in the market (Wright, 1992). The United States economy is organized by a hierarchy that includes workers, supervisors, and managers. Each position within the hierarchy has a pre-determined range for income, and as a result income is based on position instead of individual attributes. According to the gendered perspective, income inequality is constructed on the job queues/labor queues and the segmentation of labor which intersects with class and race, which argues that women of color are sorted into categories that continue to place them in economically disadvantaged positions in the labor force.

This paper will explore from a sociological perspective, the three types of theories mentioned above by using a model that merges gender and race with individual and structural level rationalizations of income determination and distribution. The rationale for using an alternative model is to demonstrate the critical role that race and gender have on an individuals' ability to acquire human capital and the location of people within the economic structure. The data used in this research is from the 2010 Current Population Survey (CPS).

2. Literature Review

2.1 Individual –Level Model

Human capital theory contends that an individual's income is directly related to the investments he or she makes in gaining knowledge and skill (Becker, 1992). Human-capital theory explains that individuals make rational choices about their levels of investment in human capital, and it is based on the idea of people investing in themselves in various and diverse ways. According to rational choice theory, actors make individual choices based on their intentions and goals; this theory suggests individuals have access to necessary resources to maximize their decisions about occupational options (Ritzer, 2004). Within the framework of this theory, segregation of occupations can be illustrated as a product of individual decisions versus structural limitations (Kaufman, 2002). For example, an individual may acquire additional or advanced education, or they may advocate strongly for themselves in terms of negotiating for the best salary when job seeking. Individuals may relocate in search of better employment opportunities, and all of the above can be perceived as investments (Blau, 1976).

Researchers continue to explore and search for explanations that will explain why, on average, whites typically earn more than minorities and why women continue to earn less than men. Human capital theory has been used by some economists to explain the growing racial gap in occupational attainment. The scope of traditional human capital theory includes and considers factors such as: education, social class, skills, abilities and life experiences that can be used in the production process of human capital (Deng and Zhang, 2008). The theory suggests that workers may have incentives to invest in education and skills that can improve productivity, with the end result being higher economic returns for their investment. Individuals are likely to

continue to pursue their accumulation of human capital because the value of future rewards and incentives outweigh the costs associated with human capital acquisition (Becker, 1964). Job characteristics and human capital differences are factors that affect the wage gap that exist between men and women as well as white and minority workers (Tomaskovic-Dewey, 1993). Per human capital theory, job characteristics and human capital differences are not the only factors of wage determination. Commitment to career advancement, professional credentials and seniority are also determinants of wage increases and promotions.

The U.S. has seen a significant increase in females who participate in the labor force as well as human capital investment by advancing their careers and education. For example, women make up the majority of professional related occupations and service occupations. Women also have been earning more bachelor and master degrees than men since 1982. In 1900, there were 5.1 million working women, in 1950 there were 18.4 million working women, and in 2009 there were 66.2 million women who accounted for 46.8% of the total U.S. labor force (U.S. Department of Labor, Bureau of Labor Statistics, Professional Women Fact Sheet, 2010). In 2005, women made up 11% of medical school deans, and 50% of medical school students were women (Carnes, Morrissey and Geller, 2008).

Training for careers in healthcare varies widely. For example, a home health aide may prepare for one month or receive on the job training. A nursing assistant position usually requires vocational training, but a significant number of nursing assistants have taken college courses to be qualified for specific jobs and/or to prepare for other higher paying healthcare occupations (U.S. Department of Labor, Bureau of Labor Statistics, Professional Women Fact Sheet, 2010). Other healthcare careers such as registered nurse require individuals to obtain an associate's degree or bachelor's degree and pass a state licensure exam (Auerbach, 2007).Health

diagnosing or treating practitioners such as physicians, surgeons, audiologists and optometrists require graduate school completion coupled with many years of training beyond college (U.S. Department of Labor, Bureau of Labor Statistics, 2010-2011). The skills needed in healthcare are becoming more complex and as a result healthcare workers are investing in more training. A common strategy for advancement in healthcare is to hold a job in one area while training for another.

Varying levels of income among health care professionals can be explained by human capital theory. For instance, a dental hygienist will earn more than a dental assistant, due to higher levels of investment in human capital. Educational attainment, experience, skills and competencies as well as personality traits are individual characteristics that are valued in the labor market (McGinnis and Moore, 2010). One study of New York nurses found African American nurses have fewer years of experience compared to white nurses, but were just as likely to have a bachelor's degree or higher as their highest nursing degree. The study found Hispanic nurses also have less experience compared to white nurses and were less likely to have a bachelor's degree in nursing. Asian Pacific Islanders were found to have levels of experience comparable to white nurses and were more likely to have a bachelor's degree in nursing (McGinnis and Moore, 2010). The wage differential that a nurse receives can be a reflection of reward to those with greater skills and knowledge.

Women of today face a number of responsibilities that influence their level of attainment such as the balance of home life and their careers. Black women compared to white women have higher rates of single parenthood. For example in 1994, of those aged 25 to 34, only 29% of black women were married versus 64% of white women. Black women on average, tend to have more children than white women (Reid, 2002). Of those aged 15 to 44, 39% of black women

were childless compared to 45% of white women, and 20% of black women had three or more children compared to 15% of white women (U.S. Census Bureau 2000a). Many black women work while attending school and often have younger children versus white women who often delay childbearing for later years (Ahitu and Tienda, 2004). Mc Elroy (1996) found young black women to have higher rates of childbearing before the age of 18 than young white women. The burden of early birth for young black women has a modest effect on their high school completion, but a more significant impact on their college attendance and completion than for whites (Mc Elroy, 1996).

For instance a survey of 2000 faculty from 24 academic medical centers, found women faculty with children had less secretarial support and fewer research dollars as well as career satisfaction compared to male faculty and other women faculty without children, further women are affected disproportionately as they continue to have the primary responsibility for child care and housework (Carnes, Morrissey and Geller, 2008). Human capital theorists would suggest that a woman's family circumstances are directly related to her participation in the work force, suggesting that black women attain less human capital due to family obligations (Reid, 2002).

2.2 Structural-Level Model

The economy of the United States is organized as a hierarchy of economic positions. Each position in the labor market is associated with a specific hierarchy that has a specific wage associated with the position. The income that an individual receives for a position is established on the position versus individual attributes. Managers, supervisors, and workers are all examples of positions that exist within a hierarchy, and each position has range of income that is pre-determined (Wright, 1992).

In the 1970s, researchers developed theories of structure for wage determination that challenged the then dominant status attainment theory. One variant located processes of wage determination in industry structures, and focuses on the division of industries into core and peripheral sectors (Reid and Rubin, 2003). The economic core has been identified as being composed of monopolistic industries that are large in size, diversified, technology-intensive, and operating in national and international markets (Reid and Rubin, 2003). The economic periphery has been identified as small firms with restricted markets, a small number of employees, and labor-intensive production techniques. Employment outcomes are differentiated by sector. The core is characterized by higher wages, job benefits, career ladders and greater work satisfaction. The economic periphery is characterized by lower wages, lower work satisfaction, small firms, restricted markets, less job benefits, and no potential for advancement (Reid and Rubin, 2003). The core and peripheral sectors approach and reward their labor pools disparately. The core sector industries provide unions, access to job training, lucrative salaries, and the option of advancement (Noyelle, 1987). The peripheral sectors afford external and transient labor pools with low wages, no opportunities for promotion and no access to on the job training (Noyelle, 1987).

The healthcare industry is a service providing industry where large corporations dominate healthcare markets both regionally and nationally, with the end result being core and peripheral markets. Health care in the United States is the consummation of diversification, company and political input. Current health care sectors consist of specialty groups that are for profit and nonprofit organizations (White 2007).

In 1993, hospitals began to consolidate at an unprecedented rate. In 1995, one-third of admissions were to hospitals with at least one local hospital partner. By 2000, that figure had

risen to nearly half (White, 2007). By 2002, for-profit specialty hospitals and physicians had created 48 small hospitals with substantial physician ownership (White, 2007). The role for specialists was strengthened, in the form of multispecialty groups. A period of market-led transformation of American medical care resulted in consolidation of insurers and hospital systems. Large medical systems are the core of the healthcare economy as they dictate employee extrinsic rewards. Small and private medical providers make up the periphery and lack the monopolistic power to compete. In the United States, the number of organizations that own hospitals, nursing homes, and other specialty facilities are scarce, which results in practitioners negotiating an affiliated status or working directly for the health system (White, 2007).

A second theory was introduced from a structuralism perspective and it relates to wage inequality. This idea can be explained by dual economy theory as the United States is comprised of different economic sectors. There are two existing markets, primary and secondary. Dual economy theory explains the higher earnings of those in the primary sector are associated with the highest levels of financial resources within the organization (Kalleberg, Wallace and Althaus, 1981). The primary sector is controlled by large conglomerates that hold the necessary resources for production. The secondary market is comprised of smaller organizations that have fewer resources for production. Basically, the larger companies dominate the economy and the smaller companies compete in the economic margins (Baron and Bielby, 1984). The primary labor market consists of positions or jobs where formal education, skills, and training are required. This market is characterized by career advancement opportunities and stable job security. The secondary market is one of which few skills or little education is required to hold the position. This market offers the worker little or no opportunity for career growth and advancement nor job stability (Reid and Rubin, 2003).

In health care occupations, the establishment of a structural hierarchy evolved due to the global economy and the advancement of technology. Levels of occupational prestige for health care workers is a direct reflection of the value society places on specific occupations. For example, a physician is conferred a higher level of prestige than a physician assistant. Medical and technological advances are responsible for higher degrees of specialization among providers, which resulted in the restructuring of divisions of labor within occupational groups (Zetka, 2001). Historically, surgeons held an inferior position in Western medicine, but after careful documentation of their successes they were able to carve out a viable market niche for themselves, thus elevating their occupational prestige (Zetka, 2001).

Segmented labor market theory categorizes jobs into two categories: primary or secondary. Jobs in the primary market offer more opportunities for career advancement and job security, while jobs in the secondary labor market offer no job security and no room for growth. Women are more likely to be employed in the secondary labor sector or the lower levels of the primary sector. The variation in levels of job stability is explained by the internal and external labor markets (Hodson & Kaufman, 1982). The primary sector consists of internal labor markets that have a hierarchy of positions, and those positions are filled from within. Those who work in the external labor market are unable to gain entry to these same positions. The secondary sector selects workers' from the external labor market to fill positions and selection from the external labor market creates an environment of job instability which results in worker high turn-over rates (Hodson & Kaufman, 1982). The lack of mobility between primary and secondary sectors can be explained by segmented labor market theory. Individuals who are employed in the secondary labor market are often unable to later find work in the primary market due to their

unstable work histories, which equates to being an undesirable prospect for an employer in the primary labor sector (Hodson & Kaufman, 1982).

In the health care industry, primary positions are those that require degrees, specialized training and credentialing. Occupations such as physicians, surgeons, dentists and diagnostic practitioners are all examples of primary positions in healthcare that offer lucrative salaries, and unfortunately remain underrepresented by women, blacks and Hispanics (Queneau, 2006). For example, African Americans, Hispanics, and Native Americans constitute less than 9 percent of nurses, 6 percent of physicians, and 5 percent dentists. Similar disparities exist among health professional school faculty. For example, minorities make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent dental school faculties and 4.2 percent of medical school faculties (Sullivan, 2004). In health care, physician earnings are influenced by a variety of characteristics. One important determinant of physician's earnings is the area of specialty. Physician specialties can be categorized by the types of patients a physician treats (pediatrics), a specific region of the body treated (otolaryngology), or by the type of technique that is used in treatment (anesthesiology). Advancements in medicine have facilitated higher degrees of specialization, thus creating a reorganization of division of labor within occupational groups (Zetka, 2001).

Secondary positions in the medical field are those characterized by low wages, low occupational skill, high turnover rates, and high segregation of workers by gender and race. Examining gender and race from a structuralist perspective, black women are more likely to be less educated than white women which partially explains their overrepresentation in the secondary labor market (Dodoo, 1995). Research reveals women and minorities are the most likely groups of people to be employed in secondary positions where the development of new

skills and opportunities for advancement do not exist (Reid and Rubin, 2003). Evidence suggests that the healthcare industry is no exception. In healthcare, the secondary job market is primarily made up of paraprofessional workers who hold positions such as nursing assistants, orderlies and attendants. Nursing assistants, orderlies, and attendants provide basic patient care under the supervision of licensed or skilled staff (Watson, 2007).

These positions in the secondary labor market are ranked lowest in terms of occupational skill and pay the workers low wages. In the elder care industries, nursing assistants earn a mean hourly wage of \$10.67, home health aides mean hourly wage is \$9.34 and personal care aides earn a mean hourly wage of \$8.52 (Watson, 2007). Over the past two decades, the occupational composition of elder care industries has grown tremendously, for instance, home health care service employment increased by 183% between 1990 and 2005, 29% between 2000 and 2005, and employment in the home health care sector is projected to increase about 70% between 2004 and 2014 (Watson, 2007). The home health care sector is largely comprised of service providers and health care aides account for 86% of service providers in the home health care sector. Service and support providers comprise 65% of occupational groups in community and nursing care facilities (Watson, 2007). Health care practitioners such as registered nurses account for 56%, and an additional 25% is made up by licensed practical nurses (Watson, 2007).

2.3 Gender-Race Intersection Model

This model encompasses the intersection of gender, class, and race. Theories of intersectionality are usually referred to multiracial feminism, multicultural feminism or post colonial feminism (Zinn and Dill, 1996). This viewpoint challenges the ideas and theories that were constructed around the lives of white middle-class women. These theories were established

by women of color which includes African Americans, Latinas, Asian Americans, and Native Americans. Multiracial feminist theorists argue that race and gender are socially constructed, and the two shape identities and provide principles of organization in the social system (Collins 1999, cited in Browne and Misra, 2003).

Moreover, these categories produce and maintain social hierarchy, which is referred to by Collins (1990) as the “matrix of domination.” This matrix explains how an individual can hold different social locations through combined statuses of gender, race, and class, for instance a middle-class black lesbian. Within this system, white women are privileged by race and penalized by gender. Further, depending on the context, an individual may be an oppressor, hold membership in an oppressed group, or concurrently be oppressor and oppressed (Collins, 1990). Traditionally, this account purports power as domination operates from the top down by forcing and controlling unwilling victims to bend to the will of the more powerful superiors (Collins, 1990).

One approach that can be used to explain the gender and racial inequalities that occur during the hiring process is job queues and labor queues. Employers seek to hire from as high in the labor queue as possible, and workers accept the best jobs available to them. The end result is that the better jobs are offered to the most desirable candidates and the lower, menial jobs are given to those who are positioned low on the labor queue. When considering job and labor queues there are three structural approaches that characterize the queues: (a) the ordering of their elements, (b) the existence of overlap in the elements, and (c) the shape of the elements (Reskin and Roos, 1990). In reference to job queues and labor queues, elements are the groups of potential workers or jobs. Ordering of the elements entails the order workers classify potential

jobs and the ranking of possible workers by employers. The shape of the queue is determined by the number of workers (Reskin and Roos, 1990).

White men are ranked highest in the labor queues. This potentially means an employer may choose a less qualified white worker over a black worker who is more qualified (Reskin and Roos, 1990). White collar workers tend to have higher wages and more lucrative job characteristics therefore white collar jobs are usually more desirable. White women account for 66% of white collar jobs compared to 50% of minority women (Dodoo, 1995). White women tend to be employed in female occupations that pay well. White women are distributed across more occupations and are usually the first to enter integrating occupations (Cotter, Hermsen and Vanneman, 2003).

Robert Kaufman (2002) maintained that jobs carry a race label that is based upon the job description as “appropriate or “inappropriate” for minority workers. In sum, employers rank minorities lower than whites in the labor queue for positions that require skill and authority, and unfortunately jobs that are associated with extrinsic rewards. The jobs that are deemed “appropriate” for minorities are the dead-end low paying jobs with poor working conditions and low occupational prestige (Kaufman, 2002). Proponents of comparable worth and status composition argued that when positions become filled with marginalized groups the pay scales are lowered and the lowered pay results from the under-valuing of subordinate work (Kmec, 2003).

Devaluation theory argues that a positions pay will deteriorate once a woman or racial minority enters the position (Kmeck, 2003). Tomaskovic-Devey (1993) found in his North Carolina sample evidence of devaluing work performed by racial minorities. He found white

workers in black jobs were paid wages consistent with their jobs, instead of race. From a feminist intersectional approach, one assumes discrimination operates in the workplace as employers make decisions about training, wages, hiring practices, and promotions based on a worker's race and gender (Weber as cited in Browne and Misra, 2003). One study found employers hired blacks and whites into lower occupational prestige jobs at similar rates. However, whites were offered machine operating jobs that allowed for advanced training while blacks were offered physical labor jobs (Kmec, 2003).

In the U.S health care system, there are approximately 2.2 million nurses, 600,000 physicians, and 153,000 dentists. African American, Hispanics, and American Indians are underrepresented in medicine, nursing and dentistry (Sullivan, 2004). African Americans, Hispanics, and American Indians represent approximately 25 percent of the U.S population; however, less than 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists are from these groups (Sullivan, 2004). In healthcare, minority men and women account for 39% of service workers and 16% of diagnostic and support workers (U.S. Department of Labor, Bureau of Labor Statistics, 2009).

With the exception of Asians, minorities comprise approximately 20% of medical matriculants and about 50% of medical students are women (AAMC Report, 2008; Weeks and Wallace, 2006). Despite the increases in medical school admittance of minorities, a significant gap remains between whites and ethnic minorities. According to Gabard (2007) black physicians make up between 3% and 5% of the U.S. physician workforce. Data on race and ethnicity of healthcare providers from the 2000 Census revealed 73.6 % of physicians are white, 5.1% are Hispanic, 4.4% are black, 14.9% are Asian, and Native Americans accounted for only 0.2% (Gabard, 2007). Between 1983 and 2002 racial composition of careers in the health care sector

experienced an increase in terms of integration, however the distribution is not representative of the population (Queneau, 2006).

Clustering of minorities into a few schools has been noted in the area of pharmacy and physical therapy. For example, the majority of new minority graduates in pharmacy came from schools that have a history of serving minority populations, such as Howard University, Florida A&M University, and Xavier University (Gabard, 2007). Despite the affirmative action programs that were launched in the 1960s and 1970s by medical schools, the proportion of African American physicians has barely changed in the United States (Rao and Flores, 2007). In 1990, the Association of American Medical Colleges initiated Project 3000 to increase the number of underrepresented minorities in medicine by the year 2000. In fact underrepresented minorities totaled 1700 in U.S. medical schools in 2000 (Rao and Flores, 2007). An appropriate and proportionate ratio of African American physicians to the overall population would be 218 per 100,000, currently the ratio remains at 73 per 100,000 (Rao and Flores, 2007).

Today the racial bias in nursing is demonstrated in the small numbers of black registered nurses, and black nursing students as well as the scant representation of black nurses' contributions to nursing in the medical literature (Barbee, 1993). Institutional racism refers to a practice of intentional and unintentional policies that restrict opportunities, distribute resources unequally which are reinforced in daily interactions and practices (Barbee, 1993). In nursing, both the educational and employment opportunities have been systemically affected by racial discrimination and for many black nurses these discriminatory practices have resulted in lower wages and no promotions (Spratlen, 1998).

The intersection of occupational and gender/racial queues are explained in Bergmann's (2006) examination of the U.S. nursing shortage. Current wages for nurses are stagnant compared to males with the same educational level. For example, in 2004, RNs with a bachelor's degree who worked full-time averaged \$904 a week. Men with the same educational levels averaged \$1042 a week (Bergmann, 2006). Bergmann (2006) suggest socially conditioned attitudes of hospital administrators and nurses themselves play a role in what is considered a generous wage for a woman which perpetuates the failure of wages to increase, and makes retaining nurses difficult. Instead of increasing the wages a nurse earns, the job queue has been shifted down from a white woman to foreign born nurses and minority women (Brush, Sochalski, and Berger, 2004).

As for physicians who are from racial/ethnic minority groups, literature has supported the presence of discrimination for many years in academic institutions as well as in postgraduate training programs for black, Hispanic and Native Americans (Coombs and King, 2005). A study conducted by Coombs and King (2005), found 54% of the physician respondents in their study had experienced discrimination in the academic setting, and 63% of the physicians reported having experienced some form of discrimination and the majority experienced more than one form of discrimination.

White and black doctors are concentrated differently regarding specialty, and Kornich (2009) found more white physicians work in surgical specialties and slightly more black physicians work in lower paying specialties such as pediatrics or internal medicine. Weeks and Wallace (2006) conducted a study of physician annual incomes. The study found white female physicians in 2004 to have mean annual incomes of \$135,531 and black female physicians to have mean annual incomes of \$107,733. This study also found minority physicians are more

likely to work in communities that serve the underprivileged which affects income potential versus working in private or areas of specialization (Weeks and Wallace, 2006). Another study investigated the ratio of black to white earnings among physicians in 2000 found black earnings as a percentage of white earnings to be 72.5% (Cornish, 2009). Having more black patients can potentially lower a physician's earnings as black patients tend to be low income and more likely to be underinsured or uninsured. Black patients are also more likely to rely on Medicaid and Medicare, thus affecting physician's earnings (Kornich, 2009).

Minority and immigrant CNAs also have experienced institutional racism, cultural insensitivity and disrespectful attitudes from supervisors and coworkers (Ryosho, 2011). A study conducted by Dodson and Zinbavage (2007) reported that black CNAs perceived their heavier workloads compared to white CNAs as racism. Further research describes subtle remarks made by supervisors posed as compliments but consistent with historical stereotypes surrounding race and work (Ryosho, 2011).

The gap in healthcare wages by gender and race represents facts about the U.S. economy that will be explored. Three broad possible explanations will be considered: differences in individual preferences and skills (human capital argument), differences in labor market position (occupation, industry, firm and region) and institutional discrimination (Browne and Misra, 2003).

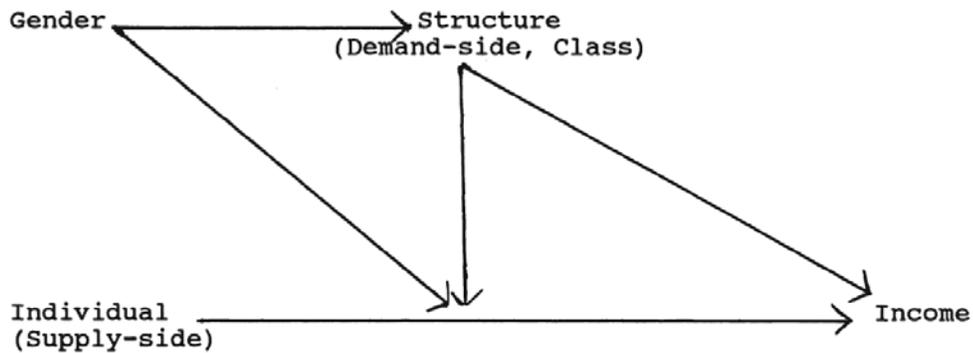


Figure 3.3

Structural/Gender Determination Models

Individual-Level Model

Human capital theory is based on the investment one decides to make pertaining to self. The first perspective of this theory is that education increases the likelihood for improved socio-economic status and one's earning potential. Human capital theory can be used to explain the varying levels of income among individuals. For example, human capital theory can be used to explain why a physician earns a higher wage than a physician assistant. In this model we can see investment in human capital impacts income. Three commonly used variables pertaining to wage gap differences are age, education, and experience. Age is a variable that can affect one's earnings and age can be used to discriminate against the young or the old. Age is used as a proxy for experience. Education affects age earnings as it is a predictor of income, and experience has the ability to drive wages up or down.

The following hypotheses are based on the individual model.

- 1a. Net of other factors, higher levels of education will yield higher earnings.

1b. Net of other factors, an increase in age will yield an increase in income.

Structural-Level Model

The U.S. economy is organized by categories or a hierarchical system. Each hierarchy has a dollar amount attached to it. In any given field or industry there will be individuals toward the top of the hierarchy, the middle, and those who occupy the bottom of the hierarchy. The large corporations control the market and their power is maintained through the size of the organization along with the organization's resources. Variables that are associated with structure are: occupation, company size, public or private organization, and geographical region.

The following hypotheses are based on the structural model.

2a. Net of other factors, increases in occupational status will result in increases in earnings.

2b. Net of other factors, the larger the company the more the worker will earn in wages.

2c. Net of other factors, urban healthcare workers will earn more than rural workers.

Gender/Race- Level Model

The gender model says that variances in human capital and positions in the labor market are due to women being sorted into positions based on their gender and further sorted based upon their race and ethnicity. This model will use the intersection of gender and race as two systems of oppression used to subordinate women of color.

The following hypotheses are based on the gender/race model.

3a. Net of other factors, white women will earn more than non-white women.

3b. Net of other factors, women with children younger than six will earn less than women with children over the age of six.

3c. Net of other factors, immigrant women will earn less than non-immigrant women.

3. Methods

3.1 Data

The data for this research uses the Current Population Survey (CPS) and the Annual Social and Economic (ASEC) Supplement for combined years of 2008-2010 (Bureau of the Census for the Bureau of Labor Statistics, 2010). The CPS data are obtained through a national probability sample of approximately 60,000 civilian households living within the United States, which includes telephone interviews and surveys. For the purposes of CPS, approximately 112,000 individuals 15 years of age and older are surveyed. The CPS provides government statistics regarding employment, unemployment, annual earnings, hours worked, demographic factors and economic status.

The original CPS data used in this study has had specific sample restrictions applied to target the desired population of interest. Sample restrictions are applied to the 2008-2010 CPS data to select only women working within health care professions. The data set is restricted to women between the ages of 18 to 65. The decision to select only individuals between the ages of 18 and 65 was made to eliminate the possibility of subsidized training wages of those under 18 years of age and the effect that retirement has on wages of those 65 and older. The data set is restricted to non- military workers, and veterinarians were excluded from the sample. After the restrictions are applied, the final sample population was 16,884. Additionally, the sample was restricted to those with annual incomes of \$5,000 or more.

The CPS is a national probability sample that provides a standard weight variable that is used to generalize the CPS sample to the U.S. population. Applying the relative weight to the data set helps to ensure the distribution of the sample to be reflective of the target population. The relative weight was obtained by dividing the standard weight by its mean.

3.2 Variables

3.2.1 Dependent Variable

The dependent variable in this study is annual income which is an interval level measurement of income in dollars. Income is often measured through hourly, weekly, or monthly earnings. Measuring income through hourly, weekly, or monthly earnings does not include overtime pay. This study uses annual earnings in dollars to measure income which includes overtime pay. The income range for this study is \$5,000 to \$200,000.

3.2.2 Independent Variables

3.2.2.1 Individual Model

The individual level variables used in this study are as follows: age, age centered squared, education, region, and rural location. Age is an interval- level variable that ranges from 18 to 65. Age is measured in years and is used as a proxy for experience since there is not an existing measurement for work experience. Age centered squared allows one to take into consideration non-linear relationships like lower earnings at the beginning and end of a career. Originally, education was a 17- item category that was recoded to a four level ordinal variable. Having attained a high degree or less was coded 1. Some college which includes an Associate degree was coded 2, a college degree such as a Bachelor's degree was coded 3, advanced degrees such

as a Master's degree, or a Doctoral degree was coded 4. Final variables were coded into binaries. High school degree or less was coded 1 and all others were coded 0. The variable some college was coded 1, and all others received a code of 0. Bachelor's degree was coded 1, and all others received a code of 0. If respondents had completed an advanced degree, they were coded 1 and all others were coded 0. Region is a nominal level variable that was measured based upon whether a respondent resided in the Midwest, South, Northeast, or the West region of the United States. A Midwest dummy variable was created and coded 1, the remaining regions were all coded 0. Based on preliminary analysis, it was determined that the Midwest was the lowest income region for those in healthcare. Therefore, it is expected that health professionals living in the Midwest will earn lower annual wages compared to those in other regions of the United States. Rural is a nominal level variable that was recoded and dummy variables were created to distinguish those living in rural areas. Rural was coded as a 1, and urban was coded as a 0.

3.2.2.2 Structural Models

The independent structural level variables used in this research include: annual hours, government worker, self-employed, small business, medium business, large business, and medical occupational groups. The number of hours worked per year is an interval level measure rating hours worked per year. It is expected that individuals who work more hours annually will earn more. Government and self-employed workers are nominal level variables. Dummy variables were created for both categories, government workers were coded as a 1 and non-government workers were coded as 0. Self-employed workers were assigned a value of 1 and non self-employed workers were coded 0. The number of employees was an interval-level variable that was recoded into an ordinal level variable to represent company size in which respondents worked. Companies that employed 1-99 employees were categorized as small with a

code of 1, companies with 100-499 employees were considered medium and coded as 2, companies with 500 or more employees were large and assigned a value of 3. Dummy variables were created later for final analysis and received codes of (1) or (0). Small business was coded 1 and others received a code of 0. Medium business was coded 1 and all others assigned 0. Large businesses were coded 1, and others coded 0.

Occupational prestige was an interval level variable that represented the prestige of each occupation based on a scale of 0 to 100. In this study, occupational prestige was recoded into a four level ordinal variable named medical occupational groups, which included the following categories: direct, direct assist, indirect and indirect assist. Health care professions were disaggregated into four groups to represent the hierarchy that exists within health professions. Positions in the direct category include the following providers: chiropractors, dentists, optometrists, pharmacists, physicians, surgeons, podiatrists, and audiologists. The above occupations were recoded from occupational prestige categories to medical occupational groups and were coded as 1, and all others were coded 0. Direct assist positions were as follows: physician assistants, registered nurses, and dental hygienists. These occupations were coded 1, and all others were coded 0. Dietitians/Nutritionists, occupational therapists, and other therapists, health diagnosing practitioners, laboratory technicians, diagnostic related technologists, and other healthcare practitioners comprised the medical indirect occupations, and were coded 1 while all others were coded 0. Indirect assist providers were individuals who worked as nursing home health aides, occupational therapist assistants, massage therapist, dental assistants, medical assistants, and other healthcare support occupations. Dummy variables were created with indirect assist coded as 1 and all others coded 0. It is expected that direct medical occupations will earn more than direct assist, indirect and indirect assist medical occupations.

3.2.2.3 Gender Race Model

The race model includes race and ethnicity, occupational sex segregation, marital status, children under six years of age, and immigrant. Race is a five-level nominal variable that includes white non-Hispanic, black non-Hispanic, Asian non-Hispanic, and other non-Hispanic. Dummy variables were created for race and ethnicity for the final analysis. White non-Hispanic was coded 1 and all other races were coded 0. Black non-Hispanic received a code of 1 and all other races received a code of 0. Hispanics was coded 1 and all others were coded 0. Asian non-Hispanic received a code of 1, and the other races were coded 0. Other non-Hispanics was coded 1, and all other races received a code of 0. It is expected that white non-Hispanics will earn more than black non-Hispanic, Asian non-Hispanic and other non-Hispanic. Occupational sex segregation was an interval-level variable. Marital status was a nominal level variable that was recoded to represent three categories: (1) married, (2) ever married, and (3) never married. Married was coded 1 and others coded 0. Ever married received a code of 1, and all others were coded 0. Never married was coded 1 and others received a code of 0. A dummy variable was created for respondents who had children under six years of age. Respondents who had children under six were assigned a value of 1, and all others were assigned a value of 0. Immigrant status of respondents was recoded, immigrants were coded 1, and non-immigrants were coded 0.

4. Results

4.1 Univariate Results

Table 1 is comprised of univariate results for the full sample of women in health care. The full weighted sample size for women in health care is 16,884. The average annual earnings for the full sample of women in health care was \$40,283. The range for annual earnings of women in health care was \$5,000-\$200,000. The standard deviation for annual income

was \$26,229.41. The average age of a female health care worker in this sample was 40 years. The standard deviation was 11.96. The frequency distribution of educational attainment for women in healthcare is displayed in table 1. A total of 3,515 respondents reported having a high school degree or less which accounted for 21.4% of the sample. The majority of this sample (41.9%) had some college. Of the sample, 24.4 % had a bachelor's degree (N = 4,121). Respondents who had advanced degrees totaled 2,071.

The majority (83.4%) of health care workers in this study resided in urban communities. There was total of 1,838 respondents who reported working for the government, which accounted for 10.9% of the sample. Self-employed workers accounted for 3% of the sample. The majority of respondents (52.6%) worked for large companies. Respondents who were employed by small companies totaled 5,251, accounting for 31.1% , and those who worked for medium-sized companies made up 16.3 % which totaled 2,754 of the full sample. Of the full sample, 3.9% of health care workers were employed in direct medical occupations. Direct assist providers accounted for 32.5%. There were 5,016 respondents who reported working as indirect assistants (29.7%). Finally, a total of 5,717 workers reported working in the indirect assist category, which accounted for 33.9%.

The majority of respondents were non-Hispanic white. The total number of non-Hispanic whites was 11,407 which comprised 67.6% of the full sample. Non- Hispanic blacks made up 16.1% which totaled 2,721. Individuals who classified themselves as Hispanic totaled 1,487 and accounted for 8.8% Asians comprised 5.6 % of the sample which totaled 948. The final racial/ethnic category was other non –Hispanic, which totaled 322 making up only 1.9% of the full sample. A total of 9,867 individuals reported being married which accounted for 58.4% of the sample. A total of 3,711 respondents reported never being married which comprised 22.0 %

of the full sample. Individuals with children under six made up 20.3% of the sample. The majority (85.5%) of the sample were non-immigrants.

4.2 Multivariate

Multiple regression was performed to assess how well independent variables used in the model would predict the annual income of respondents. A one unit increase in age increases income by \$269. Individuals who had some college received income increases of \$942 compared to those with a high school degree or less. Respondents with a bachelor's degree received an increase in annual earnings by \$6,637 compared to those with a high school degree or less. Professionals with an advanced degree had an income increase of \$15,782, compared to those with a high school diploma or less.

Living in the Midwest region has a negative impact on annual income. Living in the Midwest decreases income by \$1,952, when compared to those living in other geographical locations. Residing in rural communities also was found to have a negative impact on income. Residing in rural communities versus urban communities decreases income by \$3,958. A one unit increase in annual hours worked increased income by \$16. Government workers experienced a \$1,360 decrease compared to non-government workers. Self-employed workers received an increase of \$3,396 compared to the non-self-employed. Working for a small business impacted income negatively compared to those who are employed by medium-sized businesses. Small business employees experienced a decrease of annual earnings by \$2,078 compared to those employed by medium-sized companies. Those employed by large companies received an income increase of \$3,143 compared to individuals who are employed by medium-sized companies. Direct medical occupations category received the largest increase in income, which totaled \$46,894 compared to medical indirect occupations. Health care workers who worked in

direct assist medical occupations earned \$21,303 more a year compared to medical indirect assist. Health care workers in indirect medical occupations earned \$8,463 more a year compared to those in indirect assist medical occupations.

Being black had a negative impact on income as black respondents in this study received an income decrease of \$4,132 compared to their white counterparts. Being Hispanic decreased income by \$2,591 compared to whites, and other non-Hispanics received income decreases of \$2,476. In this model being Asian non-Hispanic was the only race variable that experienced an increase, which was \$2,635 more a year than whites. Occupational sex segregation index impacts income negatively. A one unit increase in sex segregation decreased annual earnings by \$3,629. The coefficients for married, having children under six, and immigrant status were not statistically significant. The coefficient for never married was statistically significant.

The results of this analysis conclude that the medical occupational category a healthcare worker chooses has a great impact on annual earnings. A direct assist medical provider received an annual increase of \$21,303 and the beta was .38. The adjusted R square was .570 which means 57% of the variation in income can be explained by the independent variables in this model.

The model was partitioned into three segments, individual, structural, and gender. The adjusted R square was 0.570 ($p < .001$). When the individual segment was removed, R square variance decreases to .523 ($p < .001$). This means individual variables explain 4% of the dependent variable. When the structural segment is removed, the R square decreases to .307 ($p < .001$), meaning structural variables explain 26% of the model and have a greater effect on wages than the individual and race segments. When the race segment is removed, the R square changes to .565 ($p < .001$), so it explains less than 1% of the model.

A one sample Kolmogorov- Smirnov test was conducted to test whether the distribution of the sample is normal. Results of the Kolmogorov-Smirnov test are statistically significant. Therefore the null hypothesis was rejected. Although the dependent variable was not normally distributed, there were over 16,000 cases, and the plots of the residuals suggested that there was not a departure from normality. Tolerance and VIF tests were done to check for multicollinearity. Two diagnostic statistics were performed to determine whether outliers affected the regression results. The Mahalabnobis distance maximum was 121 and the largest observation for Cook's distance was .005. The outliers of the sample were removed and the model was computed again. These observations did not substantively influence the results, and so a decision was made to leave outliers in the model.

5. Conclusion

5.1 Discussion

Hypothesis 1a predicts that higher levels of education will yield higher earnings. As expected regression analysis revealed health care workers with some college earn \$942 more per year than those with a high school degree or less. Individuals with a Bachelor's degree earned \$6,637 more per year than those with a high school degree or less and individuals with advanced degrees earned \$15,782 more annually than individuals with a high school degree or less. This finding is consistent with human capital theory, that individuals who invest more in education will earn more income (Becker, 1992). Hypothesis 1b predicts that net of other factors, an increase in age will yield an increase in income. Hypothesis 1b was validated as regression analysis illustrates that health care workers earned \$269 more per year with each year of age. Age was used as a proxy for experience in this study.

Hypothesis 2a predicts, that net of other factors, an increase in occupational status will result in increases in earnings. As predicted, hypothesis 2a was validated as regression analysis revealed individuals employed in direct medical occupations earned \$46,894 more annually than those employed in medical indirect assist occupations. Health care workers who work in direct assist medical occupations earned \$21,303 more per year than individuals employed in medical indirect assist occupations. Health care workers who work in indirect medical occupations earned \$8,463 more per year than individuals who worked as indirect medical assist occupations.

The varying levels of income among health care workers can be explained with segmented labor market theory. Segmented labor market theory categorizes jobs into two categories; primary and secondary. In the health care industry, primary positions are those that require degrees, specialized training and credentialing which justifies earning a higher income. Secondary positions in the medical field are made up of paraprofessional workers with low occupational skills which justifies lower earnings.

Analysis supported hypothesis 2b, that net of other factors, those who are employed in larger companies will earn higher wages. More than half of the full sample was employed by a large company. Health care workers employed in large organizations earned \$3,143 more annually than those employed in medium sized organizations. The economic core and periphery help to explain the income differences between individuals who are employed by large companies versus small companies. The economic core consist of monopolistic industries that are large in size and influence. Core positions offer higher wages, job benefits and career ladders (Reid and Rubin, 2003). The economic periphery consist of small firms, restricted markets, less job benefits, and no potential for advancement (Reid and Rubin, 2003). This finding is consistent with (Noyelle, 1987) which concludes that core sectors reward their labor pools disparately than

peripheral sectors. Large conglomerates have the necessary financial resources to pay competitive wages. Basically, the larger companies dominate the economy, and many of these companies are the national health care systems that are discussed and identified by (White, 2007). Hypothesis 2c predicts, net of other factors, urban health care workers will earn more than rural health care workers. Hypothesis 2c is supported as rural health care workers earned \$3,958 less per year.

Hypothesis 3a predicts, net of other factors, white women will earn more than non-white women. This hypothesis is supported with the exception of Asian health care workers. Regression analysis revealed being a Black non-Hispanic decreased income by \$4,132, compared to white women. Hispanics experienced a decrease in earnings of \$2,591, compared to white women and other non-Hispanics received a \$2,476 decrease in earnings compared to white women. These findings are consistent with previous documented research regarding racial income inequalities in health care occupations (Duffy, 2007; Gabard, 2007; McGinnis and Moore, 2010; Queneau, 2006; Sullivan, 2004; Weeks and Wallace, 2006). For example, McGinnis and Moore (2010) found net of all other variables, African Americans earned \$3,041 less than non-Hispanic white RNs, Hispanic/Latino RN's earned \$2,217 less than white RNs and Asians earned \$2,596 less than white RNs. Another example of income inequalities was discussed in Weeks and Wallace (2006), which found white female physicians to have annual mean incomes of \$135,531 and black female physicians with annual mean incomes of \$107,733. Hypothesis 3b was not supported as there were no differences in earnings among women with children under six and women without children under six. Hypothesis 3b was formulated based on women having the primary responsibility for child care and housework (Carnes, Morrissey and Geller, 2008). Women of today face a number of responsibilities and human capital theorists

suggest that a woman's family circumstances are directly related to her participation in the workforce (Reid, 2002). Hypothesis 3c was also not supported as there were no differences in earnings among immigrant and non-immigrant women. A possible explanation for this finding may be that immigrant respondents were employed in direct occupations instead of indirect assist occupations, which was not considered when the hypothesis was formulated.

5.2 Limitations

CPS data is unable to disaggregate specific health care occupations into sub-specialty groups. Among physicians, there are a number of specialty areas and depending on the area of specialization, physician's annual earnings will vary. For example, a cardiologist will earn more than a family physician. The occupational health care worker categories is another limitation of this study as some individuals have been "grandfathered" into positions, and CPS does not have the capability of capturing this information. CPS data is cross-sectional and limited information is available about the context of the variables. In addition, this research is limited as the CPS data regarding length of employment, promotions, on the job training, and management experience are not available, and earnings can be influenced by all these factors.

5.3 Policy Implications

The health professions are composed of dentists, nurses, physicians, public health workers, pharmacists, physical therapists, and many others. Collectively, these professionals are vital to the health care delivery system (Sullivan, 2004). Equal access to a solid education determines the means for an individual to pursue a career in the health professions. In theory, a pipeline from primary to secondary to postsecondary education, and finally to professional training, directs the flow of a diverse stream of individuals into the health care system (Sullivan,

2004). However, in reality, the flow is not equal through the health care professional pipelines as educational institutions continue to struggle with recruitment and retention of minority students in health care programs (Sullivan 2004; Queneau, 2006; Gabard, 2007). The social markers of race and ethnicity can impact an individual's access and forward progression at each of the three key stages of the pipeline: (1) primary and secondary education, (2) college years, and (3) health professions education and leadership development. Typically, racial and ethnic minorities receive lower scores on standardized tests, are less likely to successfully complete high school or college, and generally receive a lower quality of education than their white counterparts (Sullivan, 2004). However, minorities who successfully complete high school and gain admission to health profession training programs continue to experience road blocks to academic success (Gabard 2007; Sullivan, 2004). The following are initiatives outlined by Sullivan (2004) that will aim to increase minority representation in the health professions: (1) U.S. Public Health Service, state health departments, colleges and health professions schools should produce public awareness campaigns to encourage minorities that are underrepresented in health care occupations, (2) colleges and universities should support college students who are disadvantaged and have an interest in health careers by providing students with mentoring, test-enhancement skills, counseling regarding the application process and interviewing skill, (3) health professional schools, hospitals and other organizations should partner with businesses, as well as public school systems to provide students with opportunities in the classroom for enrichment in the sciences. The recruitment of underrepresented minorities in health professions, is what determines their overall representation in the workforce as well as their influence on the educational process (Cohen, Gabriel and Terrell, 2002).

The importance of minority representation in health care occupations has been recognized by policy makers as well as the direct link between poorer health outcomes for minorities and the shortage of minority health care providers (Sullivan, 2004). The racial and ethnic disparities in health and health care services that exist are well documented and their eradication is important. Abundant data reveals that African Americans have lower life expectancy than whites and are more likely to die from stroke, cancer and diabetes mellitus (Cohen, Gabriel and Terrell, 2002). Increasing diversity in the health care professions will assist in improving health care access and quality for minority patients as well as assuring a sound health care system for citizens of our nation (Sullivan, 2004). Creating a diverse health care workforce begins with ensuring a diverse student body, as well as faculty within U.S health professions schools (Cohen, Gabriel and Terrell, 2002). Another reason to increase minority representation in health care is to broaden the research agenda. As noted above the United States has health disparities that disproportionately affect minority populations. It is reasonable to conclude that finding solutions to our nation's most recalcitrant health issues will require a workforce that is more racially and ethnically diverse (Cohen, Gabriel and Terrell, 2002). Research has documented that patients and communities benefit when health care providers are culturally competent of the populations they serve (Cohen, Gabriel and Terrell, 2002; Gabard, 2007; Sullivan, 2004). Cultural competency denotes the knowledge, skills, attitudes and behaviors that are required of health professionals to provide optimal health care services to persons of diverse cultures (Cohen et al, 2002). To practice cultural competency effectively, a health care practitioner must have an understanding of different belief systems, cultural biases, family structures, and a host of other culturally determined factors that influence how individuals perceive and experience illness (Cohen et al, 2002). Cultural competence is essential to the

communication process between providers and patients, which enables practitioners to collect a more thorough patient history (Sullivan, 2004). A diverse health care workforce is critical and demands immediate large-scale change as well as contributions of people from a myriad of diverse backgrounds to protect the future health of the nation.

This study examined the income inequalities of women in health care. The following hypothesis were supported: 1a, 1b, 2a, 2b, 2c. Hypothesis 3a was partly supported as Asian women earned more annually than their white counterparts. Hypothesis 3b and 3c were not supported. This study contributes to the existing body of literature on the effects and importance of a diverse health care workforce. In the future, research should continue to examine the inequalities in annual earnings and the occupational segregation of healthcare workers that is directly associated with race, class, and gender.

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APPENDIX

Table 1: Independent and Dependent Univariate Analysis

Annual Earnings		
	Minimum	\$5,000
	Maximum	\$200,000
	Mean	\$40,283
	Standard Deviation	26229.41
Annual Hours Worked		
	Minimum	1
	Maximum	5148
	Mean	1837.98
	Standard Deviation	565.01
Race and Ethnicity		
	Non-Hispanic White	67.6%
	Non-Hispanic Black	16.1%
	Hispanic	8.8%
	Asian	5.6%
	Non Hispanic-Other	1.9%
Occupational Sex Segregation		
	Minimum	0.35
	Maximum	2
	Mean	1.83
	Standard Deviation	0.29
Age		
	Minimum	18
	Maximum	65
	Mean	40
	Standard Deviation	11.96
Education		
	High School Degree or Less	3,515
	Percentage	21.4%
	Some College	7,078
	Percentage	41.9%
	Bachelor's Degree	4121
	Percentage	24.4%
	Advanced Degree	2,071
	Percentage	12.3%
Region		
	Midwest	4112

	Percentage	24.4%
	Northeast/South/West	12,772
	Percentage	75.6%
Rural Residence		
	Rural Residence	2,804
	Percentage	16.6%
	Urban	14,080
	Percentage	83.4%
Worker Status		
	Government Worker	1,838
	Percentage	10.9%
	Self-Employed Worker	509
	Percentage	3%
Company Size		
	Small Business	5,251
	Percentage	31.1%
	Medium Business	2,754
	Percentage	16.3%
	Large Business	8,878
	Percentage	52.6%
Medical Occupational Groups		
	Direct	662
	Percentage	3.9%
	Assist Direct	5,488
	Percentage	32.5%
	Indirect	5,016
	Percentage	29.7%
	Indirect Assist	5,717
	Percentage	33.9%
Marital Status		
	Married	10,315
	Percentage	61.1%
	Ever Married	3,207
	Percentage	19.0%
	Never Married	3,362
	Percentage	19.9%
Parental Status		
	Child Under Six	3,426
	Percentage	20.3%

Immigrant status	
Immigrant	2,452
Percentage	14.5%
Non-Immigrant	14,432
Percentage	85.5%

Table 2. Regression Analysis of Annual Income and Independent Variables

Variables	B	Sig.	Std E	Std B
Constant	-7240.82	***	1701.93	
Age in years	269.428	***	13.446	0.123
Age Centered Squared	-9.331	***	1.001	-0.05
Some college	942.669	*	390.44	0.013
Bachelor's degree	6637.419	***	362.53	0.109
Advanced degree	15782.23	***	493.448	0.197
Midwest region	-1952.193	***	317.377	-0.032
Rural residence	-3958.11	***	370.787	-0.056
Annual hours worked	16.251	***	.240	0.35
Government worker	-1360.03	**	441.958	-0.016
Self-employed worker	3396.661	***	817.096	0.022
Small business	-2078.23	***	416.316	-0.037
Large business	3143.373	***	384.414	0.06
Direct medical group	46894.67	***	1139.12	0.347
Direct assist medical group	21303.58	***	391.754	0.38
Indirect medical group	8463.251	***	382.728	0.147
Black non-Hispanic	-4132.78	***	400.336	-0.058
Hispanic	-2591.52	***	516.106	-0.028
Asian non-Hispanic	2635.654	***	684.65	0.023
Other non-Hispanic	-2476.57	*	977.42	-0.013
Occupational Sex Segregation	-3629.81	***	760.195	-0.04
Married	514.554	—	357.119	0.01
Never married	939.752	*	456.638	0.015
Children und 6	644.157	—	362.426	0.01
Immigrant	380.875	—	459.526	0.005
Ad. R squared	0.57			
F	932.4***			
N	16884			

Note: ***p<.001; **p<.01; *p<.05