

Health Care Occupations: Road to Success or Path to Dead End?

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Abstract. Health care provides an attractive career choice for individuals seeking employment in a growing field with livable wages and quality benefits. Jobs in health care services are projected to increase rapidly in the coming decades. Like other skilled professions, significant disparities exist regarding who works in the positions that are highest paying and often most rewarding. This project investigates the representation and incomes of minorities in health care professions. Using secondary data, a sample of 19,693 health care workers were used for this study. The findings of this research indicate that net of other factors, minority health care workers earn \$3,026 less annually than non-minorities. Additionally, minorities are disproportionately concentrated in lower compensating occupations.

1. Introduction

A broad field like the health care sector provides an opportunity to assess series of jobs and positions that are clearly defined and segmented. Differences in the credentials necessary to work in a specialized job, such as a nurse or radiology technician, make tracing the qualifications of applicants relatively easy. Queneau (2006) found that despite years of job proliferation and growth in the health care sector, the labor market is still gender/racially segregated. Between the years 1983 and 2002 racial composition of occupations within health care became more integrated, but distribution is not representative of the population [1]. Minority enrollment in professional programs has increased in the last 20 years; however minorities and women are over-represented in lower-paying and lower-status occupations [2]. Nearly 50% of medical school students are women, yet most female physicians are concentrated in family specialties [3]. Minority medical students are more likely to anticipate working in organizations and areas that provide services to underserved populations [3]. Working in specialties that focus on family services or underserved populations reduces income potentials for the physicians as compared to their peers providing private or specialized services.

2. Experiment, Results, Discussion, and Significance

Methodology

Prior research guided the development of the theoretical models investigated in this study. Individual models of earnings potential assert challenges in wage inequality can be overcome by utilizing and gaining access to resources. Jobs in health care offer wages that reward individuals based on competitive skills, education, and abilities. Structural models assert that wage determination is based upon the position occupied, and hierarchies are necessary to attract the most qualified persons to positions. Theories used to support the race model borrow from gender theoretical perspectives. Gender theorists suggest that the gender/racial composition of an occupation influence the pay and prestige of jobs. The composite model used in this research is composed of theories that suggest systemic processes influence health care industry labor pool patterns. These processes support income stratification by sorting minorities into low-paying occupations and fields. Hypotheses tested are as follows: Individual model 1(a): Net of other factors, increased age will increase income and 1(b): Net of other factors, as years of education increase income will increase. Structural model 2(a): Net of other factors, employment in a large organization (core sector) will increase income and 2(b): Net of other factors, employment in higher skilled occupations (primary market) will increase wages. Race model 3(a): Net of other factors, disadvantaged minorities will have lower income. 3(b): Disadvantaged minorities will be disproportionately represented in lower-skilled health care occupations.

This research uses data from the Current Population Survey (CPS) March 2008 Annual Social & Economic Supplement [4]. The narrow scope of this project warranted restriction of the sample to select only individuals employed in the previous year in the health care sector. Additionally the sample included only individuals between ages 18 and 65, and those not serving in the military. Only individuals with incomes above \$5,000 annually were

included in the sample and income was top-coded to avoid inflating the mean. The final sample size for this study is 19,693. The dependent variable used in this study is an interval level measurement of income in dollars for annual earnings. Variables used in the individual model include age, education, region, and residential location in terms of rural or urban. Independent variables used to analyze the structural models include worker status and hours and weeks worked in the previous year, sector, company size, occupation, and occupational prestige. Independent variables used in the race model include race and ethnicity, minority status based upon income, immigration status, sex, occupational and industry sex segregation indices, marital status, and parental status. Univariate, bivariate, and multivariate tests were used to analyze the data.

Results

Regression analysis indicates that hypothesis 1(a) of the individual model is supported: net of other factors increased education results in increased income. Non-minorities with an advanced degree make \$20,150 more than non-minorities without a high school diploma, whereas minorities with an advanced degree make \$14,440 more than minorities without a high school diploma. According to a modified chow test the difference across minority models is statistically significant. Hypothesis 1(b) of the individual model is somewhat supported, with age income increases until flattening out and eventually declining. Age is used as a proxy for experience in this project. Both non-minorities and minorities experience an increase in annual earnings with age, however there is a significant difference between non-minorities and minorities. Hypothesis 2(a) of the structural model is supported, that net of other factors employment in higher skilled occupations increases wages. This is particularly true for minority groups. Non-minorities working in medical direct occupations earn \$51,377 more annually than non-minorities employed in medical indirect assist occupations. Minorities working in medical direct occupations earn \$63,995 more annually than minorities working in medical indirect assist occupations. The difference across minority models according to a modified chow test is statistically significant. Analysis supports hypothesis 2(b), that net of other factors employment in a large organization results in increased wages.

Discussion

Significant findings include support for hypotheses of the race model: hypothesis 3(a) net of other factors, disadvantaged minorities have lower incomes than non-minorities. Minority health care workers earn on average \$3,026 less annually than non-minority health care workers. Analysis also supported hypothesis 3(b), that minorities are disproportionately represented in lower-skilled health care occupations. Nearly 51% of minorities employed in the health care sector work in lower-skilled health care occupations such as nursing assistant and home health care aid. This finding is consistent with previous research by Queneau (2006) and Gabard (2007), that minorities are over-represented in the lowest compensating health care occupations.

3. Conclusion

This research contributes to the growing body of research investigating the income disparities and representation in health care occupations. Structural factors explain the majority of the income differentials between non-minority and minority health care workers. More research is needed to address the processes of sorting minorities into the lower compensating occupations.

4. Acknowledgements

I would like to thank Dr. Twyla Hill for the guidance and assistance over the course of many projects.

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