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The Outsourced State: The Retraction of Public Caregiving in America

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The Outsourced State: The Retraction of Public Caregiving in America

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ABSTRACT

To date, the United States (U.S.) has no universal, long-term care insurance model. Instead, formal long-term care services are mostly provided through a privatized industry that mirrors the growing social inequalities and wealth disparities that characterize the U.S. population. Namely, a two-tiered, two-class industry has formed that consists of a minority of the population that can completely afford to pay privately for services. In contrast, the majority of those populations in need of formal long-term care services must rely on government-subsidized private enterprises and an insecure welfare state system that undergoes pertinent defunding threats, despite the growing demand for services. This dissertation is focused on the organizational structure of the long-term care industry and the role of immigrants. One central research question is: *"How does the U.S. long term care industry's organizational structure lead to an entry point for Filipino immigrant women entrepreneurs?* My study is a predominantly qualitative study and I utilized archival materials, snowball sampling, semi-structured interviews and participant observation methods.

In my study, I found that Filipino immigrant women, particularly nurses, have become entrepreneurs through owning peripheral government-subsidized businesses located in the secondary market of the long-term care industry. Many of these businesses are predicated on providing care to some of the most impoverished, mentally and physically disabled younger and older adult populations. Due to privatization and state austerity policies that have accelerated the bifurcation of the U.S. long term care industry, Filipino women immigrants have created an entrepreneurial market niche by accepting lower, fixed reimbursements and decreased profit

margins that have led to (inadvertently) assisting the U.S. government in continuing to absolve itself of having primary responsibility for providing health and social services to its own citizens. This research builds upon sociological literature, specifically theories on the political economy of the U.S. long term care industry and aging, gendered labor migration, care work, ethnic entrepreneurship and intersectionality.

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INTRODUCTION

Of the 40 million Americans age 65 and over today, 7.5 million of them have a severe psychiatric illness (John A. Hartford Foundation 2011). By 2030 the number of older Americans with serious, chronic mental illness is estimated to double to 15 million (Jeste, Alexopoulos, Bartels, Cummings, Gallo, Gottlieb, Halpain, Palmer, Patterson, Reynolds and Lebowitz 1999). This raises the question of who is providing care for this sector of the aging population. After the deinstitutionalization era (1955-1980), scholars have critiqued the state's failed promise to provide community mental health and health care centers and public housing alternatives (Emerson, Rochford and Shaw 1981; Goplerud 1979; Gronfein 1985; Kruzich 1985; Mechanic and Rochefort 1990; Phelan et al. 2000; Scull 1985; Schnittker, Massoglia and Uggen 2012). After the closure of public state mental hospitals, they found that many of these individuals with severe mental illness have spent much of their lives on the streets or in and out of family homes and psychiatric hospital wards, contained in privately-owned long-term care facilities such as nursing facilities and board and care homes or locked up in prisons across the United States (U.S.). With 51,367 licensed board and care settings (1,233,690 beds) across the nation (Mollica, Houser, and Ujvari 2012),[1] these long-term care businesses have in part, replaced the function of the mental state hospital as "the bed of last resort" (Segal and Kotler 1989:25).

[1] Board and care homes are also known as assisted living and residential care facilities. They provide room and board, meals, supervision, custodial care and health-related services, such as medication management. This number includes facilities that care for individuals with chronic illnesses such as severe mental illness, dementia and physical disabilities.

This dissertation is a social, historical, political and economic examination of how immigrant Filipino women, particularly nurses have increasingly become owners and operators of board and care facilities as well as other long-term care businesses including adult day care centers, home health and home care agencies that have catered to some of the most disenfranchised mentally and physically disabled populations in the U.S. Through extensive document analysis, snowball sampling, in-depth interviews and participant observation, I examine the rise of a secondary market in the U.S. long term care industry, consisting of predominantly government subsidized immigrant Filipino-owned and operated long-term care businesses that have provided housing, custodial care and medical services to these populations for over the past 40 years.

Currently, Filipino immigrants do not have the highest rates of ethnic entrepreneurship in comparison to other Asian immigrant groups. However, the latest national Survey of Minority Business Enterprises show that there has been a 30% growth in business ownership from 2002-2007 (U.S. Census Bureau 2011). The majority of these enterprises are found in the health care and social services sector which accounts for approximately one-third (33.4 percent) of Filipino-owned business revenue to date. Recently, some care work studies have examined the role Filipino immigrant women play in the provision of eldercare and the long-term care industry. For example, a study published in 2007 found that 97 percent of the 563 licensed residential care homes for the elderly in Honolulu, Hawaii were operated by Filipino immigrant women (Browne, Braun and Arnsberger 2007). In California, where 52 percent of U.S. Filipinos reside, Tung (2000) points out that Filipino migrant workers comprise 75 percent of all in-home eldercare providers in Los Angeles. However, to date no study has specifically examined immigrant Filipino women owned enterprises that oversee, manage and care for the long-term

health and sickness of some of the most marginalized older populations in the country—underserved, low-income individuals with severe mental illness, physical impairments and other chronic medical conditions.

Brief Overview of Filipinos in Health Care

The Philippines has become the largest exporter of nurses to richer countries such as the U.S., Great Britain and Saudi Arabia (Alinea and Senador 1973, Choy 2003, Lorenzo et al. 2007, Ong and Azores 1994, Redfoot and Houser 2005). The first significant wave of nurses from the Philippines came after WWII and after the passage of the 1965 Immigration and Nationality Act that implemented a preference system that concentrated on immigrants' technical skills and family reunifications with U.S. citizens or residents. Between 1966 and 1985, the Philippines sent nearly twenty-five thousand nurses to this country and another ten thousand between 1989 and 1991. Up until the mid-1980's, Filipino nurses made up 75% of all foreign nurses among the U.S. nurse workforce.[2] More recent data show that the Philippines send 13,000 nurses to the United States, 7,000 to Britain and over 6,000 to Saudi Arabia each year (Redfood & Houser, 2005).

Specifically, Choy's (2003) seminal works reveal that the initiation of Filipino nurse migrations were not simply due to simplified, popular assumptions like the relaxation of the 1965 U.S. immigration rules.[3] Instead, Choy complicates this mainstream narrative by emphasizing that early twentieth century U.S. colonialization of the Philippines and the

[2] U.S. General Accounting Office, Information on Foreign Nurses Working in the United States under Temporary Work Visas (Washington: GPO, 1989).

[3] The 1965 Immigration and Nationality Act also known as the Hart-Cellar Act (H.R. 2580; Pub.L. 89-236; 79 Stat. 911) replaced the previous national origins quota system that had defined U.S. immigration policy since the 1920s. The 1965 Act implemented a preference system that concentrated on immigrants' technical skills and family reunifications with U.S. citizens or residents. The U.S. would provide 170,000 visas per year.However, certain exceptions to this fixed number included those employees of the U.S. government abroad, former citizens, ministers or immediate relatives of U.S. citizens. http://library.uwb.edu/guides/usimmigration/79%20stat%20911.pdf Accessed March 13, 2014.

development of Americanized nursing and education programs actually laid the foundation for a gendered, professionalized and exportable labor force. Specifically, during the rise of modern medicine in the 20th century, white American women nurses traveled to the Philippines to train other Filipino women to become nurses and impose western medical interventions (Choy 2003). Under the guise of international heroism and universal humanitarian effort to save lives and improve health, Western medicine's "power to heal" was used to justify the creation of Americanized hospital training and education systems (Choy 2003).

Choy asserted that the implementation of the training and education system in the Philippines would later serve as a cheaper "solution" to the periodic "shortages" of nurses in the U.S. Scholars documented that Filipino nurses were often assigned by U.S hospital administrators to less desirable work shifts and were paid lower wages than their white American nurse counterparts (Capulong 1965; Alinea and Senador 1973; Choy 2003). This transnational perspective recognizes the complicated histories that shape the globalized economic restructuring processes that set the context for these immigrant Filipino women's experiences.

One major consequence of the heavy recruitment of nurses from the Philippines was the funneling of jobs, information and the creation of the health industry as an ethnic niche for Filipino immigrants in general (Parreñas 2001). Today, Filipino immigrants occupy a significant proportion of nursing positions (e.g., registered nurses, licensed vocational nurses, certified nurse's aides) in U.S. health care institutions. However, Filipinos also increasingly occupy other health related jobs such as physical therapists, occupational therapists, physicians, physician's assistants, x-ray machine operators, medical technicians and caregivers for the elderly (Parreñas 2001). In addition to hospitals, they can be found laboring in long-term care settings such as nursing homes, board and care/assisted living facilities as well as private households (Browne,

Braun and Arnsberger 2007, Choy 2003, Guevarra 2010, Lorenzo et al. 2007, Parreñas 2001, Rodriguez 2010, Tung 2000). Thus, the early colonization of the Philippines by the U.S. and the infiltration into their education and health care systems, the subsequent recruitment of immigrant Filipino nurses to fill the labor "shortages" via the relaxation of U.S. immigration policies have all significantly contributed to the development of an ethnic niche and the growing concentrations of immigrant Filipinos in health care and long-term care related fields in the United States.

Defining Long-Term Care

Unlike acute medical care, long-term care assists individuals with chronic illnesses manage their daily lives. Oftentimes, long-term care is associated with solely providing assistance to the frail elderly. However, the long-term care population is heterogeneous and includes individuals of all ages who need various forms of assistance (e.g. custodial care, medical and nursing services, mental health services, physical and occupational therapy, assistance with daily living tasks and/or housing) due to physical, mental and/or cognitive impairments. Long-term care can be provided at home or congregant settings such as a nursing facility, board and care home (also known as assisted living and residential care facility) or an adult day health care center.

Nevertheless, it is important to point out that there is a new demographic shift occurring in the United States. Currently, 39.6 million individuals comprise the older population of those who are 65 years or older. They make up 12.9% of the U.S. population, approximately one in every eight Americans. Their number is expected to double to 72.1 million by 2030 (U.S. Department of Health and Human Services 2012). It is well documented that family members provide the majority of assistance and caregiving in the U.S. However, recent studies have also

shown a growing number of families are turning to care institutions and/or hiring formalized caregivers to assist and care for their elderly and disabled family members (Boris and Klein 2012, Solis 2011, Browne, Braun and Arnsberger 2007, Tung 2000).

Due to the rapid growth of the elderly population with multiple chronic conditions, the health care labor market is expected to produce over 3.2 million new salary and wage jobs by 2018, more than any other industry (Bureau of Labor Statistics 2010-2011).[4] By 2026, the decline in the family caregiver support ratio is projected to dramatically decline from 7.2 to 4.1 and spiral downward to 2.9 between the years 2030-2050 (AARP Public Policy Institute 2013).[5] The report suggests that rising demands in long-term services and support (LTSS) and smaller family size contribute to a growing care gap occurring throughout the U.S. Other trends that contribute to the outsourcing of long-term care work services include rising employment rates for women, growing divorce rates and increased rates of childlessness (Sloan Center 2009).

Research Problem and Study Aims

Currently, more critical studies in the sociological literature have examined immigrant women, care work and servitude in the informal sector economy and the privacy of these workplaces (e.g., private homes) producing various oppressive circumstances due to the lack of protective measures and regulations around this type of work (Guevarra 2010; Hochschild 2004; Hondagneu-Sotelo 2001; Misra and Merz 2006; Mohanty 1991; Nakano Glenn 1992; Parreñas 2001; Rodriguez 2010; Romero 1992; Sassen 2008; Zinn and Dill 1994). Yet, there are far less studies that address immigrant women as entrepreneurs in the formal care work economy,

[4] Bureau of Labor Statistics, Occupational Outlook Handbook, 2010 - 2011 Edition
[5] D. Redfoot, L. Feinberg, and A. House, The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers (Washington D.C.: AARP Public Policy Institute, August 2013). www.aarp.org/research/ppi Accessed October 29, 2013

particularly in the U.S. long-term care industry. This dissertation is focused on the organization and structure of this industry and the role of immigrants.

In order to achieve this undertaking, I empirically looked at a specific group of ethnic entrepreneurs who own a spectrum of long-term care businesses including publicly and privately funded board and care facilities, adult day care centers, home care and home health care agencies. Through snowball sampling, I identified 50 and interviewed 25 Filipino-owned long-term care business owners throughout Southern California and the earliest reported business was purchased in 1974. This study was motivated by the lack of social science scholarship describing the social processes by which a group of immigrant women became owners and operators of such businesses. In other sociological literatures around the organization and structure of the U.S. long term care industry, ethnic entrepreneurship and gender, very little is known about these Filipino women business operators, the care recipients they oversee and care for as well as the kind of labor forces they employ. Overall, Filipino immigrant women's experiences around ethnic entrepreneurship in the U.S. long-term care industry remain largely under-theorized.

Utilizing empirical evidence on Filipino-owned enterprises, I examine the restructuring of this industry and the participation of immigrant entrepreneurs in this process through an analysis of its structure and organization, the entrepreneurship of immigrants and the employment of co-ethnics. More specifically, I examine the changes brought by state retrenchment to the structure and organization of the long-term care industry, the blurring of the private-public divide in long-term care industry, the capital utilized by immigrant entrepreneurs and lastly relations between co-ethnic employers and employees. My analysis focuses on the perspective of employers. At the core of my project is to understand the social, historical, political and economic practices, the dynamic interplay between agency and constraint, and how

the intersection of race/ethnicity, class and gender are reflected in the four central aims that defined my study.

First, I aimed to examine the organizational and structural conditions, underlying historical, social, political and economic processes that have created an entrepreneurial space for Filipino immigrant women in the U.S. long term care industry. In doing so, I mapped out the organization of the industry in order to better situate these women. Second, I aimed to elucidate the various forms of social, cultural and financial capital and resources these women utilized in order to develop such businesses. I sought detailed information on how they strategically utilized various modes of capital in order to attain upward social economic mobility.

Third, I aimed to understand the limits of Filipino owners' opportunity structure in relation to the type of businesses they own and operate. Situated in the secondary market and their major reliance on fixed government subsidies is particularly salient because it not only illuminates the limits of their mobility, but that they operate in an "unfree" market because of the type of funding sources they predominantly rely on in order to sustain their businesses.[6] Hence, I sought to examine how the immigrant Filipino women business owners negotiate these relations of servitude. Fourth, I aimed to elucidate the type of labor force that immigrant Filipino women operators hired in order to construct an overview of the labor structure of the workplace, describing similarities and distinctions across different types of long-term care businesses in my

[6] Mainstream narratives around U.S. entrepreneurship tout this notion of operating under the auspices of a supposedly "free" market. However, celebratory notions around privatized, neoliberal policies leading to 'liberalization' and 'free markets' is in fact misleading because it masks the reality that markets are not 'free' but rather dominated by powerful institutions whose main objectives are the pursuit of more profits including the exploitation of cheaper labor forces from less 'developed' countries (Portes and Böröcz 1989, Sassen 2008, Wallerstein 1984). Specifically, my study attempts to breakdown the social processes that led to the emergence of ethnic entrepreneurship in the secondary market. Particularly, my study aimed to illuminate how a predominantly privatized industry evades less profitable, government subsidized elderly and disabled individuals and then subsequently has come to rely on an immigrant entrepreneurial labor force to provide care to such individuals and receive lower profit margins. Hence, I sought to examine how immigrant owners negotiate these relations and conditions of care work.

study. I also sought to understand employer relations with their employees and how racialized and gendered employer perceptions of their labor force influenced employment processes.

Theoretically Situating Filipino Women Entrepreneurs

1) Political Economy of the U.S. Long Term Care Industry

For my project, it is critical to understand the political economic context within which this social phenomenon is situated in order to elucidate the opportunity structure for immigrant Filipino women to become owners and operators of long term care businesses. To date, the United States (U.S.) has no universal, long-term care insurance model. Instead, federal policy provides financial assistance through stringent asset and income means testing and has developed financial and contractual arrangements with the private sector to provide long-term health and social services to low-income adults. Historically, the U.S. government has subsidized private enterprises to provide health care, social services and housing rather than provide them directly through the public sector. For example, during the New Deal era, the Social Security Act of 1935 established a federal system of old age benefits to assist the elderly and disabled poor. Yet, the policy prevented public institutions and poor houses from attaining such funding due to its appalling living conditions. Instead of mandating and regulating better services for these populations in the public sector, these funds were allocated to privately owned nursing homes (Lerman 1982).

In 1965, Medicare and Medicaid federal programs were developed to provide medical, health care and mental health care related services to elderly and disabled individuals with low income and scarce resources. However, individual states did not allocate federal dollars to build more public hospitals, community mental health centers and develop more public housing settings. Instead, these federal reimbursements attracted for-profit enterprises to expand into the

public sector (Abramovitz 1986). Another era of government contracting and the subsidizing of services out to private enterprises began. By 1983, one of the largest corporate hospital chains, Hospital Corporation of America made $243.2 million in profits and forty-one percent of their revenues came from Medicare (Kleinfeld 1983).

Another example involves the deinstitutionalization movement that began in early 1960s. To many mental health advocates, deinstitutionalization symbolized the end of the stigma and degradation attached to mental institutions. In its place, individuals would receive appropriate community based mental health care, social services and housing. Instead, Medicare and Medicaid reimbursements were funneled into the nursing home industry (Shonick 1981; Mechanic and Rochefort 1990; Scull 1976). Nursing homes became the prevailing residential care system for individuals with chronic and severe mental health conditions. Between 1960-1970, there was a 170% increase of nursing homes for a total of 19,000 of them around the country (Gilbert 1980). Eighty percent were for-profit businesses and public funds accounted for close to seventy percent of their revenues.

In addition to chronic mentally ill individuals being discharged in Medicaid subsidized nursing homes, my study suggests that these individuals were also placed into board and care facilities as well (Emerson, Rochford and Shaw 1981; Goplerud 1979; Kruzich 1985). The U.S. government began to subsidize these businesses through the Supplemental Security Income (SSI) cash benefit program. SSI is a federal program that provides modest monthly cash benefits to those who cannot afford to meet the basic needs of subsistence such as food and housing. Currently, over 8 million individuals who are either 65 or older, blind or have a medically determined mental or physical long-term disability receive this cash benefit.[7] Administered by the Social Security Administration, SSI is one of the largest welfare programs in the nation. As I

[7] http://www.ssa.gov/pgm/ssi.htm Accessed July 7, 2013.

will emphasize in my dissertation, Filipino immigrant women, particularly nurses, started to develop small long-term care businesses, particularly board and care facilities in the peripheral sectors of the long-term care industry by providing care to a certain sector of government subsidized individuals with chronic mental health and/or physical disabilities.

2) Gendered Labor Migration and the Recruitment of Filipino Nurses

Certain sociologists have historically linked migration to the expansive structures of the capitalist world economy that gave birth to the intricate social, economic and political ties between nations and geographical regions (Castells 1989; Morawska 1990; Petras 1981; Portes and Walton 1981; Sassen 1988; Wallerstein 1974). Portes and Borocz (1989), Sassen (2008) and Wallerstein (1974) argue that political leaders and corporations of industrialized regions have infiltrated less 'developed' countries to exploit their labor and natural resources in order to retain economic domination and greater profits in a supposedly integrated world. In conjunction with world systems theory,[8] these scholars argue that it is integral to understand that labor migrations historically engaged in imperialism and the exploitation of labor. Chang (2000), Heyzer (1994), Momsen (1999), Parreñas (2003) Guevarra (2010) and Rodriguez (2010) argue that labor migration continues due to these increasingly stressful economic, political and social conditions created by neoliberalism.

Prior to the 1970s, issues around gender were largely ignored in both dominant and alternative labor migration theoretical frameworks and studies were largely androcentric

[8] Wallerstein (1974) argues that the world system is made up of three main geographical areas: core, periphery, and semi-periphery. The core comprises the geographical regions (ie. capitalist nations) where the majority of wealth is found and therefore dominates the world economy. While the majority of the world is found within the peripheral parts made up of the world's poorest populations. The remaining semi-periphery areas simultaneously exploit the periphery and are exploited by the core regions as well. He postulates that as core regions attempt to increase their power and capital accumulation in the world, they continue to penetrate these peripheral and semi-peripheral regions through governments and multinational corporations to gain access to a cheaper labor pool, attain raw materials and cheaply produced commodities. As a result, the core regions foster a growing dependence of peripheral and semi-periphery regions by further integrating them into the world capitalist system.

(Morakvasic 1984; Pedraza 1991). In other words, men's experiences were assumed to be generalizable and therefore inequalities and differences between men and women were not recognized as a matter of sociological concern (Pilcher and Whelehan 2004). Therefore, much of the literature discussed previously did not expose the gendered and ethnically segmented international division of labor found within the globalized market economy.

Since this time, feminist scholars have challenged these gender-neutral notions and androcentric knowledges and sought to legitimize the different experiences of women (Choy 2003; Fernandez-Kelly 1989; Guevarra 2010; Hondagneu-Sotelo 2001; Hossfeld 1990; Mies 1982; Misra, Woodring and Mertz 2006; Momsen 1999; Morakvasic 1984; Ong 1991; Parreñas 2001; Pedraza 1991; Safa 1995). These scholars underscored the disparities found within these theories and exposed the labor inequalities not just between men and women but within different groups of women based on cross- cutting divisions such as race, ethnicity, social class and sexuality. Also central to these arguments is the view that particular to manufacturing and production work, domestic work and care work, gender is an invaluable resource for capital and labor markets that depend on women's labor.

The initiation of Filipino immigrant care worker migrations cannot be narrowly viewed through an economic lens, but must be understood as a fundamentally transnational process that links global, neoliberal economic development with global histories of colonialism and racial domination (Choy 2003; Espiritu, 2003; Guevarra 2010). Choy's (2003) historical works contend that Filipino migration to the U.S. must be examined within the context of U.S. imperialism and the racialization of Filipinos. As mentioned earlier, Choy argues that the initiation of Filipino nurse migrations is not due to popular assumptions like changes in post 1965 U.S. immigration policies but rather the development of U.S. hospital training systems that date back to earlier

twentieth century colonial occupation (1898-1935). This training system served as a "solution" to the "shortages" of health care workers in the U.S. during that time. Choy emphasizes the contentious racialized relationships between American and Filipino nurses and the creation of racialized hierarchies with Americans superior to Filipinos. Bakan and Stasiulis (1995) posit that these legacies of imperialism in Asia, Latin America and the Caribbean intermixed with the increasingly international labor market has led to the socially and politically constructed racialized and gendered stereotypes of domestic and care workers.

Yet, Chow (1994) argues that stereotypical views around Asian American women as passive and submissive fail to see the inner strength, firmness and resourcefulness these women employ to cope with such structural constraints. Therefore, certain Filipino women may also be utilizing a prescribed gendered and racialized ethnic niche along with other resources and capital to develop care work businesses in the U.S. economy as a form of resistance and attain upward social mobility. Immigrant women who venture into ethnic entrepreneurship and capitalize on ethnic market niches can also be viewed as a way of combating and strategically coping with racial/ethnic oppression, immigrant discrimination, patriarchal domination and developing a potential pathway for socioeconomic mobility. These complex perspectives acknowledge the complicated historical and contemporary processes that produce an intersectional spectrum of oppressions and privileges.

Critically understanding the gendering dynamics that constitute and perpetuate the segregation of care work labor on a global scale is key to embarking on how these women in turn negotiate the gender constraints they face in this form of labor. The gendered labor and care work literature has expanded to critically examine and expose the immigrant and ethnic women's underpaid, undervalued waged labor. However, there are far less studies that address immigrant

women as entrepreneurs in the ethnic economy (Dallafar 1994; Westwood and Bhachu 1988). A major concern of this dissertation revolves around the view that domestic, care labor and production labor markets are dependent on women's labor and that gender is an invaluable resource for capital (Dallafar 1994; Davies-Netzley 2000; Verdaguer 2009; Westwood and Bhachu 1988). Thus, this project aims to examine the significance of gender and how immigrant women are utilizing their 'gendered capital' as well as other forms of capital to take on more profitable, entrepreneurial activities (Davies-Netzley 2000).

3) Ethnic Entrepreneurship, Capital and Co-Ethnic Employer/Employee Relations

Light and Bonacich (1988) and Waldinger (1984), describe ethnic entrepreneurship as immigrant and ethnic group members engaging in business ownership. Light (1972), Min (1984) and Waldinger (1996) claim that disadvantages such as the inability to transfer educational and occupational credentials, language barriers and employer discriminatory practices in the labor market may lead various ethnic groups toward self-employment and the perpetuation of ethnic market niches.

Immigrants who engage in entrepreneurial endeavors have pioneered a particular economic path for other immigrants that Waldinger classifies as a type of "chain migration." These "chain migration" formations can create a viable economic pathway for other immigrants to follow as a way toward upward social and economic mobility as well.

Bonacich (1973) asserts that the immigrants' marginal status as foreigners in host societies lead them into certain ethnic communities, business endeavors and occupations. These types of small business ventures allow immigrants to avoid direct competition with native majority group members. They also do not have to compete with larger business chains that play a role in perpetuating certain ethic niches. However, Bonacich (1973) also argues that ethnic

minority groups tend to act as the 'middleman,' an intermediary for absentee white capitalistic owners and perpetuate ethnic niches and exploitations.

It is also important to point out that immigrants who face certain disadvantages in the U.S. labor market do not automatically pursue self-employment due to the lack of access to the resources necessary to start up a business venture (Light 1972; Gold 1988). Not all ethnic groups and groups within a certain ethnicity have the same access to certain resources that lead to the accumulation of financial and social capital. Bourdieu (1983:249) defines social capital as "an outcome of networks and relationships which are usable, by conscious or unconscious design, in an economic sense." In other words, social capital includes the norms, networks and relationships that an individual develops within the social structure that can potentially produce and reinforce certain resources and behaviors for business ventures (Coleman 1988). Therefore, entrepreneurial activities cannot simply be narrowly viewed through an economic lens. Rather, class-based and financial capital in combination with various forms of social capital including ethnic-based resources has a significant impact on the survival and success of ethnic enterprises. Examples of such resources include the intergenerational transmittance of skills, knowledge, bourgeois attitudes, private property and personal wealth (Light and Bonacich 1988, Light and Gold 2000).

In relation to co-ethnic employer/employee relations, previous scholars have framed these relations in two major ways-- from a paternalistic standpoint (Portes and Bach 1985; Portes and Manning 1985; Portes and Zhou 1992) and a more exploitative perspective (Bonacich 1973, 1987). Portes and his colleagues argue that ethnic entrepreneurial success is rooted within the paternalist relations and reciprocal exchanges amongst co-ethnic employers and employees as well as the support, enforced trust and solidarity of the ethnic community. On the other hand,

Bonacich provides an alternative perspective and emphasized how immigrant business owners utilize such mechanisms to obtain labor cheaply and that such enterprises are in fact part of a larger brutal system of exploitation.

4) Care Work, Intersectionality and Gender

Romero (1992) argues that the gendered responsibilities of hiring and ensuring the completion of reproductive labor persist and the domestic code remains unchallenged. Despite the so-called progress toward the commodification of such labor into the marketplace; Nakano Glenn (1992) argues that labor hierarchical segregation and power inequalities between women persist. In other words, care work in both the formal and informal economy and regardless of whether you are the boss or the employee, the industry remains predominantly gendered. Therefore, my study attempts to examine how these social relations play out amongst the immigrant women entrepreneurs and other actors/stakeholders in the same industry (e.g., state and federal agents, social workers, administrators of other long term care businesses) as well as among co-ethnic employer/employee care work spaces.

I draw from the literatures on care work and intersectionality to further frame my project. Care work represents one service sector that has become a female intensive industry for Asian immigrant women and specifically has become a gendered occupational ethnic niche for Filipino immigrant women in the United States (U.S.). In the care work literature, a common understanding of this type of wage labor involves caring for children, the elderly and those who are ill and disabled (Duffy 2005:68). Today, more women are migrating independently without their husbands and families to fill these care work demands and can be found in private and institutional settings such as households, daycare centers, nursing homes and hospital settings

working as domestic workers, nannies, home healthcare workers and nurses (Ehrenreich and Hochschild 2003).

An intersectionality perspective critiques additive models which assume that oppressions simply add up and are multiplicative. This perspective also critiques the either/or approaches to privileges and oppressions. Instead this perspective provides an understanding of privileges and oppressions that interact between gender, race, ethnicity, sex, nationality, class, citizenship, historical processes and other social locations (Collins 1990, 2000; Nakano Glenn 1992). Collins (2000) argues that one form of oppression is not more dominant or salient than the next. They do not conceptualize women's identities and social relations based on applying separate methodological tools of inquiry for race, class or gender. Instead, critical feminist scholars like Crenshaw (1991), Collins (1999) and Nakano Glenn (1992) call for an intersectionality approach that provides a more holistic understanding of the simultaneous, interactive impacts of these various forms of not just oppressions, but privileges as well.

Given that these approaches recognize that women are not a homogenous group, intersectional frameworks provide spaces to analyze the power relations and stratifications between different groups of women. My dissertation project will draw from critical feminist frameworks that examine care work and how the intersections of gender, class, race, ethnicity, history, nationality and citizenship that produce both inequalities and privileges among and between women. Such a perspective will offer insight into an analysis of the hierarchical social relationships between women (Collins 1999; Espiritu 2003; Guevarra 2010; Hochschild 2004; Hondagneu-Sotelo 2001; Misra and Merz 2006; Mohanty 1991; Nakano Glenn 1992; Parreñas 2001; Rodriguez 2010; Romero 1992; Sassen 2008; Zinn and Dill 1994).

Research Methods

Various critical feminist scholars practice what Burawoy (2000, 2001) calls global ethnography. He describes this research method as a critical way of exposing "what we understand to be 'global' is itself constituted within the local; it emanates from very specific agencies, institutions and organizations whose processes can be observed first-hand" (Burawoy 2001:150). This dissertation project proposes to conduct a multi-site ethnography of Filipino-owned long-term care businesses such as a board and care facilities for the elderly and a home health agency. The choice of location for conducting this study is in Southern California because (as mentioned before) 52 percent of U.S. Filipinos reside in California and Filipino migrant workers comprise 75 percent of all in-home eldercare providers in Los Angeles (Tung 2000). However, no study has looked at these long-term care businesses that are owned and operated by Filipino immigrant women in cities located in Southern California such as Corona, Downey, Riverside, Redlands, Loma Linda, Hesperia, Perris, San Bernardino, Garden Grove, Westminster, Torrance, Los Angeles, Lomita, Valencia, Newhall, Rosemead and San Diego.

Methodology

I conducted a predominantly qualitative project and utilized some quantitative methods to broaden my analytical perspective. Through these interviews, I attempt to capture participant's experiences, labor conditions and employer dynamics with their employees. All transcripts from interviews and archival materials were coded and analyzed utilizing social science grounded theory methodology (Glaser and Strauss 1967; Strauss and Corbin 1998). Certain questions focused on background information on their socio-demographics, the number and type of care recipients they provide elderly care services to in their respective businesses, profitability, incomes, wages and actual operational costs of running various types of long-term care

enterprises. Utilizing statistical (SPSS) and mapping (ArcGIS) softwares, I created figures, tables, maps and charts from the data in search of shared patterns as well as differences found among the participants interviewed. I utilized quantitative data to provide a more comprehensive analysis of the social, political and economic structure and organization of the current U.S. long-term care labor force and industry.

Data Collection

I collected data from three main sources: in-depth interviews, participant observation and document analysis. I identified Filipino owned and operated long-term care businesses in various cities around Southern California using a snowball sampling method. Since there are no established databases that identify the racial/ethnic make up of long-term care business owners, the snowball sampling technique is most appropriate in locating such operators. This method entails locating and collecting data on a few members of the target population. Afterward, the researcher asks them if they know other members of the target population that could potentially be a participant in the study. I initiated contact by providing a flyer and an information sheet that describes my project. The flyer stated, "If you are a Filipino woman that currently owns and operates a long term care business or currently work as a long-term care worker, we want to learn more about your experiences. We are currently conducting a research project on Filipino women through the University of California, San Francisco. We want to interview you about your experiences as either a care worker and/or an owner/administrator. The interview will take place at the location of your choice." The flyer also mentioned my name, my contact information and that the interview would not exceed beyond 2 hours (See Appendix A).

Only those prospective participants who gave permission to be contacted by the researcher were recruited. Afterward, I conducted a phone call screening to determine if care

workers and business owners were interested in participating and qualify for the study. Among the prospective participants that respond positively to the project, I set up a time and place of the participant's choosing. At that time, I provided information about the nature, purpose and method of the study. The demographic sheet was also provided to the potential participant to attain some basic demographic data. Also, the informed consent form was reviewed item by item and preferably signed at that time.

The final sample included 25 Filipino women long-term care operators, 25 co-ethnic care work employees; 18 supplemental interviews of affiliated informants/stakeholders and participant-observation of 2 Filipino owned long-term care businesses. Midway through data collection, I realized that conducting supplemental interviews with other stakeholders and ancillary providers would strengthen my understanding of the organization of the U.S. long term care industry and the various meanings and conditions under which immigrant Filipinos oversee and run such businesses. Thus, I applied to amend my study to include such interviews and was granted an approval from the Committee on Human Research at the University of California, San Francisco. Through snowball sampling, I conducted 18 supplemental interviews with 4 state behavioral specialists/case workers, 2 state social workers, 2 physicians, 2 state/federal agents, 2 managers of mental health county service agencies, 2 administrator/executive directors of corporate owned long term care business, 1 sales executive of a corporate owned long term care business, 2 instructor of administrator licensing and continuing education courses; 1 immigrant (non-Filipino) owned board and care owner of Haitian Creole descent. All interviews were conducted using open ended and semi-structured questionnaires (See Appendix F). The participant was made aware that all interviews are confidential and all information obtained will not be used in a way that risks identification. Upon their consent, interviews were recorded and

took place at the participants' choice of location. Interviews were conducted in English. The interview time was approximately ranged from 1 to 2 hours in length. All audiotapes were transcribed and will be immediately erased/discarded at the end of project to ensure participants' confidentiality. Overall, this qualitative study was conducted over an 18-month period and ethical approval was granted by the Committee on Human Research at the University of California, San Francisco. The participants were not paid for taking part in the study.

My multiple social statuses by race/ethnicity/age/citizenship/gender/class and education uniquely positioned me as an insider/outsider researcher. I spoke and understood the Filipino national language (Tagalog) and shared in similar cultural customs akin to being Filipino. In addition, my mother was an immigrant Filipino women nurse/care worker as well as a long-term care business owner. These attributes potentially gave me insider status with my participants and may have put them more at ease and more willing to share their experiences. Prior to entering into my PhD program, I worked as social worker in medical and long-term care settings. Hence, my professional background may have also potentially provided me with insider status with the affiliated informants in my study. Overall, these characteristics may have further positioned me as an insider that allowed me to collect data at more ease.

Simultaneously, since I was born here in the U.S., I did not experience the migratory process, did not work as a nurse/care worker and instead was pursuing an advanced graduate degree; these attributes may have also positioned me as an outsider amongst the immigrant Filipino women in my study and may have also shaped how they interacted with me. Participants may have been less forthcoming in their responses due to these differences. I attempted to be very sensitive to the power differentials that are found between the researcher and the participant by how I drafted my interview questions and how I presented myself to my participants as

always respectful and acknowledged their role as "experts" in my field of study. However, I am still keenly aware that being sensitive to these power inequalities does not eliminate them (Buroway 1991). Overall, I am aware and acknowledge that my insider/outsider status directly influenced my interactions and the depth of the data I collected from my participants.

Second, I conducted participant observation at two Filipino owned and operated long term care businesses (assisted living/board and care facility and home health agency) in order to get a thorough understanding of their daily routine operations and organizational structure. Over the course of three months, I observed staff meetings and care work trainings that occur in their businesses. Additionally, I examined the interactional processes that took place between co-ethnic employers and employees as well as the interactions with the residents/patients they provided care for.

I also attended three conferences hosted by the Ombudsman's Office for Community and Senior Services and the Department of Mental Health in one of the major counties in Southern California. I learned about these conferences through Filipino operators who regularly attend these quarterly meetings. These meetings serve as open forums for long-term care providers, professionals (e.g. psychiatrists, geriatricians, social workers and psychologists), county administrators and community advocates. These meetings enabled me to gain a better understanding of how these professionals frame and address issues focused on caring for the long-term care population who rely on government assistance. I also attended a week-long, 40-hour administrator certification course for operators of long-term care facilities through an agency called Care and Compliance in another major county in Southern California.[9] These courses are legislatively mandated for all individuals wanting to become administrators of Long

[9] Care and Compliance is a private vendor that assists long-term care administrators and healthcare professionals in acquiring and renewing their licensing and certification. They have locations all around California and offer continuing education courses, online education and live monthly webinars.

Term Care, Residential Care Facilities for the Elderly, Adult Residential Facilities or Group Homes. I was exposed to the policies, procedures and operating requirements enforced by the State of California, Health and Human Services Agency. The Community Care Licensing Division under the Department of Social Services regulates these facilities. In particular, I learned about the requirements to operate these long-term care businesses (e.g., regulations, particular licenses required, the number of staff required to hire in relation to the number of residents/patients, required pay wages and benefits).

Finally, this study involved collecting and analyzing relevant journal articles, government documents and media articles in order to construct a chronology of policies that have shaped the U.S. long term care system. In my research, the earliest Filipino owned long-term care business was owned in 1974. This particular business was government subsidized and catered to an adult population with mental health, cognitive disabilities and physical impairments. Therefore, I attempted to search through websites and databases that focused on long-term care policies and journal and media articles that discussed how formal care was provided since the mid 1900's to attain a historical context for the current system and industry we have today. Informational and marketing materials such as brochures or websites of Filipino long-term care businesses and their competitors were also compiled and analyzed. Brochures and websites provided pertinent information such as the kind of services provided, the populations they catered to and the kind of funding sources they accepted. Overall, content analyses provided further insight into the similarities and differences of these Filipino immigrant women's experiences as owners and laborers in the long-term care work industry.

Data Analysis

All transcripts and archival materials were coded and analyzed utilizing a social science grounded theory methodology (Charmaz 2006; Glaser and Strauss 1967; Strauss and Corbin 1998). The objective of grounded theory is to formulate and construct theory from data systematically obtained and analyzed in social research. The process of generating such theory is necessarily guided and informed by the theoretical frameworks discussed previously. These theoretical frameworks assisted in framing the types and categories of questions I asked of the participants as well as guided the processes I utilized to analyze the data gathered. I analyzed the data with the intent of focusing on four aims of the study mentioned earlier as well as here: 1) the organizational and structural conditions that led to the opportunity structure for immigrant Filipino women to become more entrepreneurial in the U.S. long term care industry 2) various forms of capital utilized by immigrant Filipino entrepreneurs 3) limits of this opportunity structure and 4) employer relations with co-ethnic employees.

First, the data was analyzed through a line-by-line "microanalysis" (Strauss and Corbin 1998). Words, phrases and sentences were analyzed to generate codes that pertained to the three aims previously mentioned. As such, the data was separated into specific ideas, actions or events. To achieve the first aim, I analyzed all data sources and coded for organizational and structural conditions, underlying processes and policies pertaining to the U.S. long-term care system, the creation of formal long-term care enterprises and the divergences found between these businesses. By creating a conceptual model that provides a meso-level, heuristic overview of how long-term care is organized, I was able to elucidate how these organizational conditions shape 1) business ownership 2) market formalized care relationships 3) the conditions of care 4) the meanings of care and 5) employer relations with their employees. I was able to frame,

organize and visualize the fragmentation of the different actors and institutions involved in the long-term care industry that led to the rise of a secondary market.

To accomplish the second aim, I coded all data sources for the labor migration processes of Filipino women who became operators and owners of long-term care businesses. For example, codes described their reasons for becoming entrepreneurial, the kinds of capital and resources they utilized to own and operate businesses and the challenges they faced. I also coded for the specific populations they provide care to, how they were financially compensated and whom they hired to provide direct care services. To achieve the third aim, I coded all data sources that elucidated the challenges reported by my participants in owning and operating a long-term care business. For example, codes described their experiences with state and federal agents, operating on fixed, government budgets, their care recipients and their relations with co-ethnic employees. I also coded the supplemental interviews with affiliated long-term care informants in order to get a more in depth understanding of how other individuals involved in the U.S. long term care industry perceive these immigrant owned businesses and the recipients they care for. I paid particular attention to how social categories including gender, citizenship, race and class are constructed within these relations and the industry in general.

To achieve the last aim, I coded all data sources that elucidated the intricate employer relations and perceptions of their co-ethnic employees. For example, codes described employer perceptions of their co-ethnic employees and how this shaped opportunities, negotiations, exploitations and disparities found within these co-ethnic workspaces. Codes also described employer hiring practices, workplace conditions and labor protection standards.

Afterward, the codes (concepts) were categorized by the following: 1) concepts which represented central ideas or phenomena identified by the respondents and 2) those, which have

been generated from the data. In order to further differentiate these categories, I distinguished particular characteristics that set them apart from each other and prompted more exploration of various patterns and divergences in these categories. After this open coding phase, the axial coding process occurs through creating subcategories that relate to the already established categories. During this process, the identification of certain actions/interactions, conditions and consequences were linked to a phenomenon. Through selective coding, these categories were integrated and refined to generate a theory. This part of the coding process was initiated with the identification of core categories—those significant, central ideas/themes materializing from the data. Throughout this coding process, theoretical sampling was carried out by having data collection be guided by emerging concepts.

Comparisons between the coding process and analysis of emerging concepts continually occurred. I was able to make theoretical comparisons of the dimensions and properties of categories by comparing certain concepts (i.e., codes for events found in the data) to prior concepts found within the same category. In addition, I made comparisons based on any emergent patterns and differences across these properties that were found in other interviews and archival materials. Throughout the whole process of analyzing codes and categories, diagrams and memos were written to keep a record of my analytical process. Field notes (during interview and participant-observation) were also be analyzed to further contextualize the events that have occurred.

During data collection and the execution of three main methods (e.g., semi-structured interviews, participant observation and document analysis); challenges as well as opportunities to broaden my understanding of the role that these immigrant businesses play in the U.S. long-term care industry arose. For instance, after analyzing documents on the U.S. long term care industry,

I found that there was no information on the role of immigrant owned businesses. Hence, this lack of information both challenged and influenced me to construct an organizational analysis of the industry in order to situate these women and locate their opportunity structure. This gave me the opportunity to focus on illuminating the organizational conditions and led me to add to the literature a meso-level of analysis that included these businesses. Also, after coding immigrant Filipino employers' interviews, I thought it would be very beneficial to collect supplemental data from other informants, particularly other stakeholders from the U.S. long-term care industry to attain their role and understanding of the industry, their perceptions of these immigrant-owned businesses and their care recipients. Hence, I amended my CHR in order to include these interviews as part of my dissertation study. Though this delayed my research, it ultimately added to my work and greatly assisted me in further shaping my understanding of the structure and organization of the U.S. long-term care industry.

Dissertation Outline

My study's findings are outlined in the next four chapters followed by a conclusion chapter that provides a summary of my findings. In Chapter 2, I provide a structural overview of the U.S. long-term care industry and payment schemes. This chapter also provides a meso-level, organizational analysis for understanding how immigrant Filipino women provide long term care for some of our most vulnerable aging and disabled populations in the U.S. I focus and situate my project within the political economy of the U.S. long-term care industry and explored various factors that have led to this phenomenon including the role of economic globalization, privatization and the retrenchment of the welfare state that created an opportunity structure for immigrant Filipino women to develop businesses in the secondary market of the U.S. long term care industry.

In the third chapter, I focus on the valuable forms of capital that women utilize to develop their businesses including nursing professional knowledge, informal social networks, co-ethnic social ties and a prescribed gendered, care work niche. This chapter also focuses on labor migration policies and how the intersection of race/ ethnicity, class and gender shaped their access to capital and how Filipino women strategically utilized their constrained agency and capital to become more entrepreneurial. In chapter 4, I highlight the impacts of state retrenchment and privatization that has created an opportunity structure. Even though the state has shifted responsibility of the daily care and oversight of the severely, chronically mentally ill population, the state still routinely inspects these businesses and therefore the majority of immigrant entrepreneurs in my study do not enter the market outside the forces of government control and surveillance.

Hence, I illuminate the social interactions that these women have with state/federal agents as well as how other actors in the U.S. long-term care industry perceive these kinds of businesses. I also elucidate the simultaneity of oppression and agency in power relations that shaped their entrepreneurial activities and explored the various historical, social, cultural, political and economic, biomedical factors that have shaped this distinct form of ethnic entrepreneurship. In chapter five, I specifically analyze hiring practices, working conditions and labor protection standards within these immigrant co-ethnic workspaces and illuminate potential opportunities, negotiations as well as contestations and exploitations that may occur between these immigrant Filipino women. In Chapter 6, I conclude by outlining the theoretical and policy implications of this dissertation. Specifically, I discuss how this work builds on the following theoretical areas: the globalized political economy of long term care and aging; gendered labor migration, care work and ethnic entrepreneurship; and intersectionality.

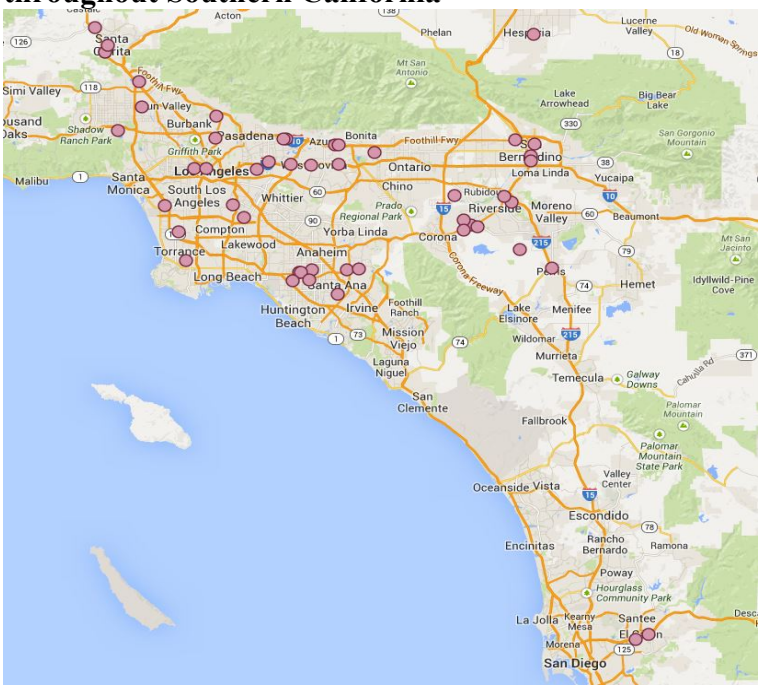
CHAPTER TWO:

THE STRUCTURE AND ORGANIZATION OF THE U.S. LONG TERM CARE INDUSTRY AND THE RISE OF ETHNIC ENTREPRENEURSHIP

In this chapter, I provide a macro and meso-level overview of the U.S. long-term care industry in order to highlight the opportunity structure for Filipino immigrant women who, enter into and own and operate various types of long-term care enterprises. In my study, I interviewed 25 Filipino women entrepreneurs that were able to identify at least one or more other co-ethnic competitors in their surrounding area. Using ArcGIS

software, I created a map to illustrate the locations of 50 businesses found in various cities across Southern California including: Corona, Riverside, Redlands, Loma Linda, Hesperia, Perris, San Bernardino, Garden Grove, Westminster, Torrance, Los Angeles, Lomita, Valencia, Newhall, Rosemead and San Diego (See Figure 1).

Figure 1: Map of 50 Immigrant Filipino Women Owned Long Term Care Businesses throughout Southern California



These Filipino-owned long-term care businesses are comprised of board and care/assisted living facilities, home health care agencies, home care agencies and senior adult day care centers. They are predominantly government funded by Medicare, Medicaid and Supplemental Security Income (SSI) payment sources. The earliest long-term care business I was able to locate was purchased in 1974, over 40 years ago.[10] In order to attain a broader understanding of the emergence of this form of ethnic entrepreneurship, I divide the chapter into three sections: (1) A brief overview of the U.S. long-term care system including a breakdown of the different kinds of businesses, the services provided and the cost of care. (2) I also provide an analysis of the restructuring of the U.S. long term care industry and the impacts of the encroachment of private enterprise within the welfare state and lastly (3) I offer a meso-level analysis that focuses on the organizational conditions that impact the kinds of businesses that Filipino immigrant women are able to establish in the U.S. long-term care industry.

SECTION I:

Overview of the U.S. Long-Term Care Industry and the Cost of Care

To date, the United States (U.S.) has no universal, long-term care insurance model. Instead, federal policy provides financial assistance through stringent asset and income means testing and has developed financial and contractual arrangements with the private sector to provide health and social services to low-income older adults. The system is funded by a "patchwork" of federal, state, and local policies affecting private providers. Formal long-term care services covered by these policies include: homecare and home health care services, adult day health care (ADHC), board and care, assisted living facilities/residential facilities for the

[10] This enterprise was an 18-bed SSI subsidized Assisted Residential Facility (ARF) that provided room and board, custodial care and medication management to younger adults (ages 18-59) with severe, chronic mental health conditions.

elderly (B&C/AL/RCFE) and skilled nursing facilities (SNF) (e.g., facilities that generally cater to older adults who are 60 years or older) and adult residential facilities (ARF) (e.g., facilities that typically care for younger adults ages between 18-59), I briefly define each of them below.

Types of Services

Homecare services provide long-term care clients assistance with their activities of daily living (ADLs) which typically include bathing, grooming, feeding, toileting, lifting, assistance with ambulation and companionship. They can also provide assistance with instrumental activities of daily living (IADLs) such as cooking, finances, shopping and transportation. Home care businesses do not provide any type of medical or nursing care. Many individuals hire a home care aide to continue to live at home. These businesses are currently not federally or state regulated and only require a business license to operate.

Conversely, *home health care services* provide long-term care clients with medical and nonmedical services in the both the home and assisted living/residential care facilities. Services include nursing care, physical therapy, occupational therapy, social work services and home care assistance with ADLs and IADLs. These businesses are federally regulated if they receive Medicare and Medicaid subsidies. They are subject to periodic inspections to ensure that the business meets federal standards.

Adult Day Health Care Services (ADHC) provide approximately 4-6 hours of daytime supervision, care and daily structure (e.g., skilled nursing, case management, dementia day programs, activities, assistance with daily living tasks, meals and transportation) for adults with physical or mental disabilities in a community based setting. Major goals of such programs include assisting adults who need supervision during the day to stay active in their communities, prevent institutional placement and provide family caregivers respite. ADHCs are federally

regulated if they receive Medicare or Medicaid reimbursements and also subject to period inspections.

Licensed home and community-based facilities for individuals in need of formal long-term care services are known as *Board and Care homes/facilities (B&C)* also known as *Assisted living facilities (AL)* and *Residential care facilities for the Elderly (RCFE).* They provide room and board, assistance and supervision with ADLs/IADLs, supervision of medications and provide coordination services with outside health care providers. Individuals that reside in a B&C, AL or RCFE do not need 24 hour nursing care and supervision. However, they need care staff monitoring for their wellbeing and safety. (Individuals under the age of 60 and need similar services reside in *Adult Residential Facilities (ARF).* These facilities require a state license to operate and are regulated by the Department of Social Services. They undergo periodic inspections to ensure that the facility meets federal standards.

Institutionalized long-term care facilities are commonly known as *Skilled Nursing Facilities (SNF).* These institutions provide room and board, 24-hour nursing care and supervision (e.g., wound care, injections, catheter care), rehabilitative therapies due to an illness or accident, assistance with ADLs/IADLs and medication management. SNFs are federally regulated if they receive Medicare or Medicaid reimbursements and are also subject to period inspections.

Different Payment Schemes:

Today, there are four ways that long-term care services are predominantly paid for: 1) Supplemental Security Income (SSI) 2) Medicaid 3) out of pocket/private pay and 4) private long-term care insurance. (It is important to note that Medicare does pay for home health care services). Supplemental Security Income (SSI) and Medicaid are means-tested joint federal-state

programs that provide long-term care medical and nonmedical services. In order to qualify for SSI or Medicaid, a recipient must fall within severe income limits and have no more than $2000 in available liquid assets and resources.[11]

SSI is a federal program that provides modest monthly cash benefits to those who cannot afford to meet the basic needs of subsistence such as food and housing. Currently, over 8 million individuals who are either 65 or older, blind or have a medically determined mental or physical long-term disability receive this cash benefit.[12] In California, the average monthly benefit is $866.40 and $1013.00 if the recipient resides in an assisted living/board and care facility. Administered by the Social Security Administration, SSI is one of the largest welfare programs in the nation. If an individual qualifies and receives SSI, they are automatically eligible for Medicaid benefits as well. Medicaid (MediCal is California's version) is a joint federal-state funded medical assistance program for low-income individuals who meet a certain poverty income level. Medicaid funds over two-thirds of all nursing home care expenditures in the United States.[13] However, this long-term care benefit is only allocated toward institutional care services. In other words, Medicaid does not provide long term care benefits for those that reside at home or in an assisted living/board and care facility. It does cover acute medical care expenses, provisional home health care and hospice services. Currently, Medicaid provides coverage to over 4.6 million low-income seniors and 3.7 million people with disabilities. This amounts to 8.3 million individuals or 17% of all Medicaid enrollees.[14]

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[11] Some exclusions do apply such as the value of individual's home, car and burial plot.

[12] http://www.ssa.gov/pgm/ssi.htm Accessed July 7, 2013.
[13] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html Accessed August 10, 2013
[14] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/By-Population.html Accessed November 2, 2013

Administered by the federal government, Medicare is a national social insurance program that mostly provides health insurance for mostly hospitalization, medical care services and prescription drugs for individuals who are either 1) 65 or older and have worked and contributed to Social Security or married to someone who did contribute to the program and 2) younger individuals with certain disabilities and diseases (e.g., kidney failure also known as end stage renal disease and Amyotrophic Lateral Sclerosis (ALS).[15] However, Medicare benefits do cover home health care services related to medical services.[16] An individual is eligible for Medicare coverage if they are under the regular care of a doctor and he/she certifies that you need recurrent skilled nursing care, speech-language pathology services, occupational therapy and/or physical therapy provided in the home. (Medicare does not cover custodial long-term care services such as 24-hour day care at home, meal delivery, homemaker services or personal care). For those who do not qualify for these three programs, long-term care is a largely private, out-of-pocket expense. Annual median costs can range from $41,756 to $83,950 per year depending on the type of care services needed (Genworth Financial 2013) (Refer to Figure 2).

[15] www.medicare.gov Accessed on July 6, 2015
[16] Medicare does also provide coverage for skilled nursing care services in a facility but only for a very limited time (e.g., maximum 100 days).

Figure 2: National median annual rate for long-term care services such as home care, home health services, adult day care, assisted living facility and nursing home (Genworth Financial 2013).

		RATE RANGE			MEDIAN	FIVE-YEAR
		MINIMUM	MEDIAN	MAXIMUM	ANNUAL RATE[1]	ANNUAL GROWTH[2]
HOME	Homemaker Services (Licensed) **Hourly Rates**	$10	**$18**	$36	**$41,756**	1%
HOME	Home Health Aide Services (Licensed) **Hourly Rates**	$10	**$19**	$37	**$44,479**	1%
COMMUNITY	Adult Day Health Care **Daily Rates**	$15	**$65**	$210	**$16,900**	2%
FACILITY	Assisted Living Facility (One Bedroom - Single Occupancy) **Monthly Rates**	$718	**$3,450**	$9,500	**$41,400**	4%
FACILITY	Nursing Home (Semi-Private Room) **Daily Rates**	$85	**$207**	$948	**$75,405**	4%
FACILITY	Nursing Home (Private Room) **Daily Rates**	$100	**$230**	$948	**$83,950**	4%

Some individuals purchase long-term care insurance to avert devastating financial consequences of potential long-term care costs. Similar to private medical insurance, private long-term care insurance is a financial contract whereby the policyholder pays regular premium fees in exchange for covered benefits. Depending on type of policy purchased, it can cover the cost of assisted living, nursing homes, home care, adult day care and hospice care. In 2010, the average annual premium cost for someone 65-69 is $2,781 and increases by age. By the time an individual is 75 or over, the average premium cost is $4,123 per year (AARP Public Policy Institute 2012). Despite the growing aging population, the private long-term care insurance market has not expanded at the same rate and only covers a small percentage (12%) of all long-term care costs (AARP Public Policy Institute 2012). The majority of individuals do not purchase this type of

insurance due to expensive premiums; no guaranteed benefit adjustments to account for inflation; stringent payment requirements and the fluctuating amount and length of coverage.

Two-Tiered, Two Class Long-Term Care Industry

This brief overview elucidates an increasingly bifurcated formal long-term care industry that mirrors the growing social inequalities and wealth disparities that characterize the U.S. population. Similar to the critique of the U.S. health care system (Becker 2007), separate private and public long term care sectors perpetuate a segregated approach to long term care that further widens the gap between the rich and the poor. This bifurcation is established by stringent eligibility requirements for government-subsidized programs. Only individuals who meet official poverty income levels can qualify for government subsidies such as SSI and Medi-Cal benefits. There are strict eligibility prerequisites for Medicare benefits as well including age requirement, type of disability and disease diagnosis. The rest of the individuals in need of certain types of formal long-term care assistance must privately pay for services (e.g., board and care/assisted living, skilled nursing facility care for more than 100 days, adult day health care (ADHD) home care and home health care services). Power struggles between the role of the welfare state and the privatization, neoliberal agenda continue to shape the U.S. government (Brown 2003, Friedman 1999, Steger 2009).

The *welfare state* refers to the role the government plays in ensuring the well-being of its citizens through the creation of a social system that provides access to basic resources such as education, housing, employment and health care (Quadagno 2004a). *Neoliberalism* entails the neoclassical economic strategies that minimize state financial support and state regulations in favor of private enterprise and an unregulated free global market (Brown 2003, Clark 2004). The lack of a universal provision of long-term care and the privatization of formal long-term care

services in the U.S. signify the economic restructuring toward a scaled-down welfare state that advances a globalized, increasingly privatized, neoliberal agenda.

This is particularly salient in the board and care/assisted living long-term care sector of the industry. For example, corporate-owned businesses Sunrise Senior Living, Emeritus and Atria Senior Living developed assisted living facilities in response to market demands of a growing upper-income elderly population that did not require 24 hour nursing care but needed custodial care and personal assistance. In fact, Sunrise Senior Living is a conglomerate of 300 assisted living facilities that can be found in 3 countries including the U.S., U.K. and Canada.[17] The majority of corporate owned businesses do not accept any form of government-subsidized assistance as a form of payment. In California, the median annual base rate is $44,520 (Genworth Financial 2013). This rate can fluctuate based on the kind of accommodations and the custodial care services needed (e.g., someone in need of advanced dementia care may pay a higher rate).

Home Instead Senior Care is one of the largest home care franchise industries with over 900 locations.[18] They are located throughout the U.S. and other countries such as Canada, France, Japan, South Korea, Germany, Italy, Switzerland and the United Kingdom (U.K). Since they provide non-medical, custodial assistance in the home, they only accept private pay financing or private long-term care insurance. Home care agency rates average $18 per hour (Genworth Financial 2013).

Many of these chain assisted living facilities and home care franchise industries tend to cater and accept more profitable private-pay individuals to attain a higher payer mix that optimizes their reimbursement. Capitalist market systems tout that privatization, limited government and regulation leads to better efficiency and better quality of care (Roberts and Olson

[17] http://www.sunriseseniorliving.com/corporate-info/careers-with-sunrise.aspx Accessed November 1, 2013
[18] http://www.homeinstead.com/international/franchise-opportunity/Pages/Available-Business-Opportunities.aspx Accessed November 1, 2013

2013). However, Emeritus, one of the largest for-profit assisted corporations with 483 facilities around the country was recently featured on PBS/Frontline due to cases of alleged abuse and neglect, issues of understaffing and keeping individuals at their facility despite the resident needing a higher level of medical care.[19]

In March of 2013, a jury in California found Emeritus was culpable for the death of an 81-year old woman who had severe bedsores. The family received $4.1 million in compensatory damages. These kinds of assisted living facilities can charge thousands of dollars per month and have no limitations on fee increases. In an interview with one of the Emeritus salespersons in one of their Southern California locations, the average cost of care per month can range from $3500-$7,800. This example emphasizes that higher costs do not necessarily equate to a better quality of care.

In addition, most individuals and their families that require these kinds of care services are unable to cover these exorbitant rates. Most individuals have not saved enough to account for these costs, much less have the resources to purchase long-term care insurance. On February 3, 2011, Ben Bernanke, Chairman of the Federal Reserve spoke in front of top financial policy reporters in Washington, D.C. and declared that the "the two most important driving forces for the federal budget are the aging of the U.S. population and rapidly rising health-care costs." This issue has become a top concern of the Federal Reserve and the U.S. government. Bernanke went on to claim that the costs of caring for the growing aging population will be an unsustainable drain for the U.S. budget and will inhibit the U.S. economic recovery. Since January 2011, everyday 10,000 baby boomers turn 65 years old. Bernanke warned that projected increased federal spending projections for Medicare, Medicaid and Social Security will assist in leading us to an unsustainable trajectory unless the Congress enacts significant changes. "The ability to

[19] http://www.pbs.org/wgbh/pages/frontline/life-and-death-in-assisted-living/ (Assessed October 25, 2013)

control health-care costs, while still providing high-quality care to those who need it, will be critical for bringing the federal budget onto a sustainable path."[20]

In the U.S., a two-tiered, two-class long-term care industry has formed that consist of the minority of elderly populations that can afford to pay privately for long-term care services. In contrast, the majority of the elderly and disabled populations must rely on an insecure welfare state system that undergoes pertinent defunding threats to its subsidies, despite the growing demand for services. In addition, those in the middle class do not qualify for the two main entitlement, means-tested social programs that provide long-term care assistance. Many have to spend down their assets in order to qualify for Medicaid because they cannot afford the costs of long-term care services otherwise (Kitchener et al. 2005).

Families and patients have to bear the huge costs, not just financially but emotionally and physically as well. However, this is never part of the industry's cost-benefit analyses (Gordon 1998). As a result, the elderly poor or formerly middle class elderly in the U.S. that suffer from a chronic mental health or physical disability and require formal care assistance with ADLs/IADLs have become all the more vulnerable.

SECTION II:

THE RESTRUCTURING OF THE U.S. LONG-TERM CARE INDUSTRY

The *Encroachment of Private Enterprise within the Welfare State: A Brief History*

The current U.S. long-term care system is sharply characterized by its bifurcation, segregation and commodification of elderly and disabled populations. A huge market industry has formed whereby corporate owned chains and franchises predominantly cater to the wealthy private sector. However, it is also important to point out that private enterprises have also gained

[20] http://www.federalreserve.gov/newsevents/speech/bernanke20110203a.htm Accessed November 6, 2013

substantial profits from the welfare state. Instead of developing a robust welfare state in which the government takes on direct responsibility for its citizens' social welfare, the U.S. government has opted for a more subsidiary approach. Hence, the blurring of the private-public divide has occurred and is characterized by how corporations have encroached and profited from the public sector through government contracts and subsidies. The privatization of the provision of different forms of health and social services has in fact created the "corporate welfare state" (Scull 1984).

Historically, the U.S. government has subsidized private enterprises to provide health care, social services and housing rather than provide them directly through the public sector. For example, during the New Deal era, the Social Security Act of 1935 established a federal system of old age benefits to assist the elderly and disabled poor. Yet, the policy prevented public institutions and poor houses from attaining such funding due to its appalling living conditions. Instead of mandating and regulating better services for these populations in the public sector, these funds were allocated to privately owned nursing homes (Lerman 1982).

In 1965, Medicare and Medicaid federal programs were developed to provide medical, health care and mental health care related services to elderly and disabled individuals with low income and scarce resources. However, individual states did not allocate federal dollars to build more public hospitals, community mental health centers and develop more public housing settings. Instead, these federal reimbursements attracted for-profit enterprises to expand into the public sector (Abramovitz 1986). Another era of government contracting and the subsidizing of services out to private enterprises began. By 1983, one of the largest corporate hospital chains, Hospital Corporation of America made $243.2 million in profits and forty-one percent of their revenues came from Medicaid (Kleinfeld 1983).

Another example involves the deinstitutionalization movement that began in early 1960s.

To many mental health advocates, deinstitutionalization symbolized the end of the stigma and degradation attached to mental institutions. In its place, individuals would receive appropriate community based mental health care, social services and housing. Instead, Medicare and Medicaid reimbursements were funneled into the nursing home industry (Mechanic and Rochefort 1990., Scull 1984, Shonick 1981). Nursing homes became the prevailing residential care system for individuals with chronic and severe mental health conditions. Estroff (1982) found that fewer individuals returned to live with biological family members or relatives. Increasingly, mentally ill patients were discharged directly to these locations. Between 1960-1970, there was a 170% increase of nursing homes for a total of 19,000 of them around the country (Gilbert 1983). Eighty percent were for-profit businesses and public funds accounted for close to seventy percent of their revenues.

But my findings indicate that business enterprise stratifications also exist *within* the private long-term care industry. In my research, I found that a growing number of Filipino immigrant women started to develop small long-term care businesses, particularly residential care/ board and care facilities beginning in the early 1970s. They began to establish themselves in the peripheral sector, particularly the secondary market of the long-term care industry by providing care to a certain sector of government subsidized individuals with chronic mental health and/or physical disabilities.

The Emergence of Filipino Entrepreneurship in the Secondary Market of the Long Term Care Industry

Medicare and Medicaid subsidies brought in huge profit margins for corporate owned hospitals and the nursing home industry at the expense of nonprofit and public hospitals and facilities. By the early 1980s, over 475 corporate chains owned, managed or leased over 7,000 hospitals and nursing homes. These corporations also oversaw more than 800 public and

community hospitals in the U.S. (Kennedy 1981, Kleinfeld 1983). This onset period of expansion also led to the closure of many state public hospitals, mental health institutions and facilities. Between 1979 and 1982, seventy public hospitals closed or were procured by for-profit chains (Tolchin 1985). In relation to state mental hospitals, three-quarters of the national reduction followed with the implementation of welfare programs such as Medicare, Medicaid and SSI that in turn subsidized private enterprise (Gronfein 1985). By 1975, the number of patients in state mental hospitals declined by sixty-two percent and by 1990 there were only 110,000 individuals in mental health hospitals (Mechanic and Rochefort 1990).

Unlike public facilities that are obligated to the principle of providing care to all those in need, private enterprises are not required to do so. For example, private hospitals are not required to care for the poor or take Medicaid insurance unless the individual's medical needs are urgent. However once they receive emergency care and are stabilized, they are often transferred to the nearest public hospital or outpatient setting (Tolchin 1985). Keep in mind that Medicaid only reimburses long-term nursing home care. Individuals who do not need 24 hour nursing care supervision, but still need custodial care and ADL assistance and have weak familial, social support systems were often left with few options. As mentioned earlier, corporate owned assisted living/residential care facilities followed a fee-for-service model that predominantly provided long-term custodial care and ADL/IADL assistance to those who could pay privately and/or had long-term care insurance. They choose *not* to accept Medicaid or SSI due to their low reimbursement rates. Similar to private insurance companies and various health care providers, these privately owned corporations operate in accordance with principles of profit motive and risk avoidance (Hollar 2009; Feder 2004; Woodlander, Himmelstein, et al. 2003). They do not necessarily compete by lowering prices or improving quality. Instead, they evade less profitable

elderly and disabled individuals and shift back these costs to individuals, their families and/or the state. As a result, some of the most vulnerable populations have less access to these services.

In 1982, a National Long-Term Care Survey showed that 40% or 3.2 million elderly individuals with one or more ADL deficit were not obtaining the care assistance they needed. Additionally, declines in funding for federal housing starting in the 1980s onward, left many elderly individuals on waiting lists for more than two years (Rich, Rich and Mullins 1995). Moreover, public mental health community centers remain underfunded and only 40% of individuals with serious mental illnesses receive minimal treatment (Kessler et al. 2005). Hence, many vulnerable individuals were unable to afford and/or find mental health services and were at risk of becoming chronically homeless (Scull 1985). This group made up a growing vulnerable, "economically undesirable" population who I define as the elderly poor, or formerly middle class elderly that require assistance with ADLS/IADLS, have chronic mental and/or physical disabilities and weak social supports. Many of them rely on Medicaid to cover medical expenses and qualify for SSI benefits as well.

In addition to chronically mentally ill individuals being placed in Medicaid subsidized nursing homes that started in the 1960s, these individuals were also being discharged to board and care facilities as well (Emerson, Rochford and Shaw 1981; Goplerud 1979; Kruzich 1985). The U.S. government began to subsidize these businesses through the SSI cash benefit program. As mentioned earlier, the earliest Filipino immigrant operated long-term care business I found was a board and care facility purchased in 1974. This enterprise was an 18-bed (ARF) board and care facility that provided room and board and custodial care to adults (ages 18-59) with chronic mental health conditions.

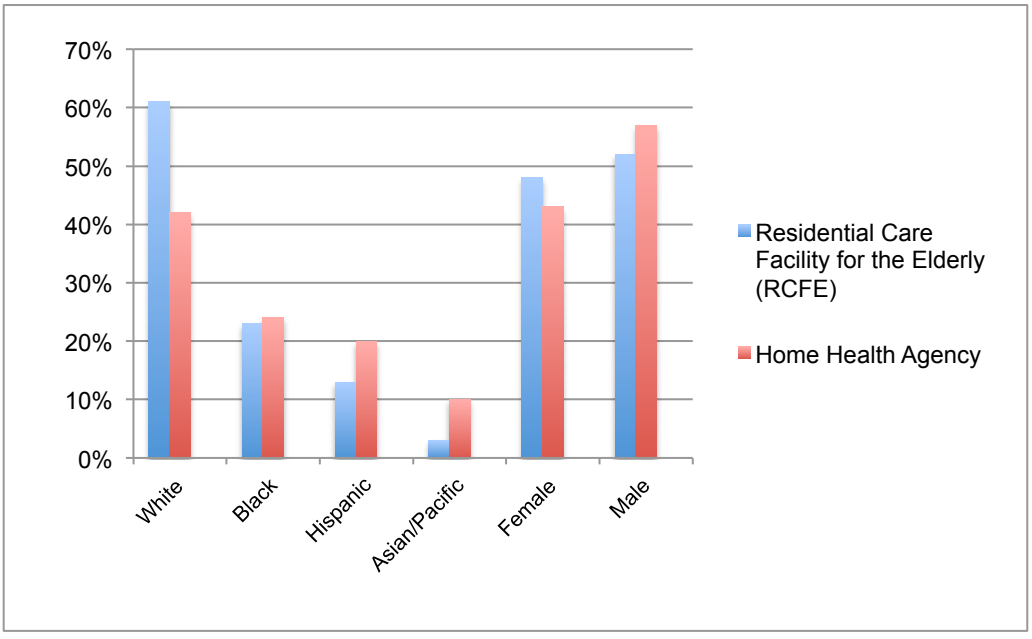
Since there are no established databases that identify the racial/ethnic makeup of long-term care business owners, I utilized the snowball sampling technique to locate immigrant Filipino women operators. In my preliminary findings, I initially located a few immigrant Filipino owned board and care facilities. Through snowball sampling, I was able to identify and gain access to Filipinos who owned similar businesses as well as other types of long term care businesses including adult day care centers, home health care agencies and home care agencies. Below, is a breakdown of my study sample that included 25 Filipino immigrant women and the type of business they own and operate (Figure 3).

Figure 3: Filipino Immigrant Women Owned and Operated Long-Term Care Businesses in Southern California

Type of Business	**Number of Filipino Immigrant Women Long-Term Care Business Owners**
Welfare State/ Government –Subsidized	
SSI subsidized Residential Care Facility for the Elderly (RCFE)	10
SSI subsidized Adult Residential Facility (ARF) SSI funded	4
Medi-Cal subsidized Adult Day Health Care Center (ADHC)	2
Medi-Cal/Medicare subsidized Home Health Care Agency	3
Private Pay	
Residential Care Facility for the Elderly (RCFE)	4
Home Care Agency	2

As shown, the majority of businesses in my sample were government subsidized and a minority of businesses was privately funded. Specifically, these businesses included SSI-subsidized and nonsubsidized, private-pay residential care facilities for the elderly (RCFE), SSI subsidized Adult Residential Facilities (ARF) for younger adults, Medi-Cal subsidized adult day care centers (ADHC), Medi-Cal/Medicare subsidized home health agencies and nonsubsidized, private-pay home care agencies. Participant observation was conducted at two government-subsidized Filipino owned businesses. The sites were a residential care facility for the elderly (RCFE) that had an occupancy of 75 residents and a home health agency that cared for 223 patients. Both sites provided demographic information on the recipients they cared for between February 2012-January 2013. The racial-ethnic and gender breakdown of residents are illustrated in the chart below (Figure 4).

Figure 4: Racial Ethnic and Gender Break Down of Care Recipients



In both businesses there was an over-representation of racial/ethnic minorities in comparison to the demographic characteristics of the overall U.S. elderly population. According to the U.S. Census Bureau (2010), 20 percent of persons 65 or older are minorities. Blacks represented 8.4 percent of the older population, while persons of Hispanic origin represented 6.9 percent. Asian or Pacific Islanders represented approximately 3.5 percent, and less than 1 percent were Native Alaskan and American Indian. Yet, by 2020, minority populations are projected to increase to 24% of the elderly (13.1 million). In addition, between 2010 and 2030, the 65 and older minority population is expected to increase by 160 percent compared with 59% for older white population (Administration on Aging, U.S. Department of Health and Human Services 2011).

The government-subsidized residential care facility and home health agency in the sample are reflective of these growing demographic trends. In terms of gender, males were slightly over-represented at both sites in comparison to U.S. national statistics. According to the U.S. Census Bureau 2010, there were 17.5 million older men in comparison to 23.0 million older women. The female to male sex ratio is 132 women for every 100 men and this further increases with age since women generally have a longer life expectancy than men (Administration on Aging, U.S. Department of Health and Human Services 2011).

Respondents who were owners of government subsidized RCFEs and ARFs also mentioned that the overwhelming majority of the individuals they provide board and care services to individuals with a primary diagnosis of a severe, chronic mental health diagnosis such as schizophrenia, bipolar disorder and depression and need assistance with daily living tasks. According to the respondents, a large number of them also have medical co-morbidities such as Chronic Obstructive Pulmonary Disease (COPD), diabetes, hyperlipidemia, Congestive Heart

Failure (CHF), obesity, hypertension and arthritis. The home health agency owners reported that the majority of their patients that they care for have diabetes, hypertension, COPD, asthma, degenerative joint disease or are in need of wound care. These findings potentially point to a group of racial/ethnic minorities with serious mental health, medical and physical impairments that make up a disenfranchised, poor sector of a growing elderly and disabled population. Just as significant, these findings also point to a set of multiple processes that have transpired after the deinstitutionalization of this population—including the historical and current displacement of this population into skilled nursing facilities (Gronfein 1985, Mechanic and Rochefort 1990., Scull 1985), jails (Schnittker, Massoglia and Uggen 2012), the streets (Mechanic and Rochefort 1990., Phelan et al. 2000) and as my findings demonstrate—into immigrant owned board and care/assisted living residential care facilities.

I also found that a minority of Filipino women business owners in my sample catered to the more affluent private sector as well (See Figure 3). They own and operate residential care facilities and home care agencies that cater to mostly white affluent men and women with a primary diagnosis of Alzheimer's or dementia with similar comorbidities. (I will be addressing these findings further in Chapter 4). Equivalent to the large assisted living chains and home care franchises, they only accept private pay or private long-term care insurance and do not take any form of government subsidization. However, they charge lower rates than corporate owned businesses and provide affluent families and individuals with a less-expensive alternative.

In addition, the participants also reported that other Filipinos were their biggest competitors, followed by other ethnic groups such as Romanians, Iranians, Armenians and Russians.[21] I found that those that acquired their businesses in the 1970s and 1980s were

[21] My participants also mentioned Jews as one of their biggest competitors but erroneously perceived them as an ethnic group.

purchased from white owners. Those that began their businesses in the 1990s and thereafter either purchased their business from another immigrant owner or developed it themselves. (I will discuss these findings further in my next chapter). Thus, far, my findings have illuminated the restructuring of the U.S. long-term care industry and the emergence of immigrant of Filipino enterprises. In the next section, I offer a meso-level, organizational analysis in order to elucidate how people access care.

SECTION III

ORGANIZATION OF CARE

Meso-Level Analysis of the U.S. Long Term Care Industry

Since the U.S. does not have a universal provision of long-term care, understanding how long-term care is paid for and figuring out who provides it can be a complicated process, particularly once a family member can no longer provide informal care to an aging or disabled relative. I use a chart to provide a meso-level, heuristic overview of how long-term care is organized. These organizational conditions shape 1) business ownership 2) market formalized care relationships 3) the conditions of care and 4) the meanings of care and 5) employer/employee relations. For this section, I specifically will refer to the first 2 points: business ownership and market formalized care relationships. (The latter three points will be discussed in Chapters 4 and 5).

The chart attempts to elucidate the organization of care through utilizing three dominant modes or "ideal types" that I have constructed in order to illustrate how individuals access long-term care services. Weber's (1947) subjective social constructs of "ideal types" are a tool for interpreting the abstract and making it more concrete. Weber does not claim that their validity is

based on complete reproduction in reality. Rather, their validity is based on whether certain elements are found to be common. They are hypothetical concepts simply used as "measures" in order to compare and understand common elements of a particular social phenomenon.[22] In addition, by separating them into these three modes, the opportunity structure and entry points for the Filipino immigrant women entrepreneurs in my study are further elucidated (See Figure 5).

The organization of care model is characterized by three dominant modes or "ideal types" (i.e., wealth reliant, family reliant, and state reliant), that I have constructed in order to also illustrate how individuals access long-term care services. Below, you will find a description of each ideal type, the kinds of services available to them and their price points.

Wealth Reliant. Individuals who rely on personal assets and savings, private health care and long term care insurance, retirement accounts and private pensions to pay for *formal* long-term care services. A sector of the long-term care industry specifically caters to this population. Services provided in the home include home care assistance ($15-30 per hour) and home health care services ($22-30 per hour). Services provided in the community include adult day care services ($77-160 per day). Assisted living facilities (ALF), residential care facilities for the elderly (RCFE) and adult residential facilities (ARF) are places for individuals who do not need 24 hour nursing supervision. However, they cannot live in their home alone and do not have someone in the home to provide assistance daily living tasks. These facilities cost between $933-$8445 per month.

Skilled nursing facilities (SNF) provide 24 hour medical related nursing care and the daily rate can fluctuate between $230-$615. These facility costs fluctuate because they provide a

[22] Stanford Encyclopedia of Philosophy-Max Weber (5.2. Ideal Type) http://plato.stanford.edu/entries/weber/#IdeTyp Accessed October 30, 2013

la carte services that are priced and itemized. Large corporations and franchises predominantly own these businesses that cater specifically to those that can pay out of pocket or have private insurance. They do not accept any form of government subsidized funding to offset the costs.

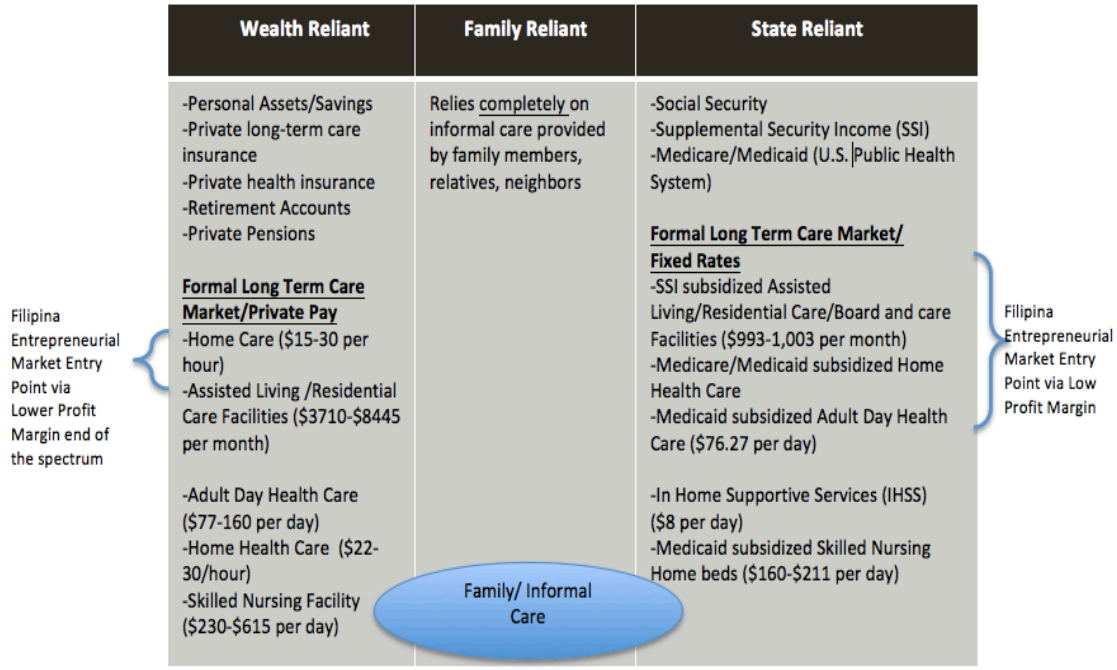
Family Reliant. Individuals who can totally depend on *informal* assistance via family members, relatives, friends and neighbors to provide long-term care assistance in the home. Family members provide the majority of assistance and caregiving in the U.S. However, current demographic trends such as smaller family size, rising employment rates for women, increased rates of childlessness and growing divorce rates contribute to the rising demands for formal long-term care services (AARP 2013; Sloan Center 2009). Even if family members do eventually outsource care, they may still be involved through overseeing and/or financially assisting with these services.

State Reliant. Individuals who rely on government social insurance and social welfare programs including Medicare, Medicaid and Social Security programs in order to attain *formal* long-term care assistance. Specific to California, In Home Supportive Services (IHSS) is a state and county funded program whereby you can hire a family member, friend or neighbor to assist you with daily living tasks so that you can remain in your home. The state pays this individual a minimum wage of $9.00 per hour. In order to qualify for the IHSS program, you have to be disabled, blind or 65 years or older, deemed by a county social worker as unable to live safely at home without care assistance and qualify for SSI or Medi-Cal (California's Medicaid program).

Medi-Cal and Medicare also subsidize home health care services and reimbursements are correlated with an individual's health care needs. Medi-Cal also subsidizes adult day care centers and reimburses a flat rate of $76.27 per day. Medi-Cal subsidized skilled nursing facility beds have flat rates ranging from $160-$211 per day. Assisted residential care facilities for the

younger and older adults (ARF/RCFE) are available to individuals who qualify for SSI, need room and board and assistance with daily living tasks. The current SSI reimbursement rate is a fixed rate of $993-1003 per month).

Figure 5: Organization of Care Model



Note: Costs based on rates in California (Genworth Financial 2013; California Department of Health Care Services)

What Does This Overview of the Long-Term Care Industry Mean?

Privatization of Care and the Biopolitics of Aging

Many assume that individuals attain formal long-term care through a blend or combination of services found in the public and private sectors. However, this chapter has emphasized an increasingly bifurcated, two-tiered *formal* care industry for how the U.S. provides formal long-term care services. (The category "Family Reliant" in my Organization of Care model pertains to informal care). These market-formalized relationships are underscored by the commodification of the elderly and disabled populations. These populations are socially and

spatially segregated to the point where they receive long-term care via different hospitals, different nursing homes and different assisted living/residential care facilities. This segregation of care is part of a far larger set of historical, social, political and economic processes at play. In particular, these processes include the U.S. government's subsidiary approach to caring for the social welfare of its citizens. Also, the ever-increasing privatization of care services force even more citizens to become dependent on the auspices of private enterprise. Thus, much more critical attention must be placed on the underlying social processes and power relations that maintain and reify a two-tiered model that marginalizes the majority of the U.S. elderly and disabled populations.

Government contractual arrangements with the private sector to provide health and social services has led to private corporations infiltrating both the private and public sectors. They have immensely profited from the currently fragmented system. As a result, they have also become very influential stakeholders. These private long-term care insurance companies, large for-profit home health organizations, nursing home and assisted living chains have a vested interest in politically mobilizing against government market regulations or any kind of national form of long-term care that would provide health care, social services and housing directly through the public sector. (Estes 2004:23) argues that the defunding and privatization of government programs signals "major transfers of power and control from the state to private corporate capital and a veiled effort to "discipline" and institutionalize a kind of market based citizenship." These policies that maintain a weakened welfare state is undergirded by the undue levels of influence of various interest groups over the executive and legislative branches of the U.S. government. Quadagno (2004b) points out that political decisions regarding economic and social policies are not made on the basis of objective information. Instead, political enemies, threats, fiscal crises

and problems are socially constructed and are constituted by normative values, symbols, images, and beliefs about the characteristics of various groups in society (Edelman 1988).

This segregation reflects a normalized ideology and a biopolitical division tightly bounded to power relations and deeply-rooted cultural views about self-sufficiency without any regard for both historical and contemporary social inequities that pervade our country today. Strongly structured through hierarchical relations of difference, the segregation of the private and public sectors are constitutive of binary symbolic categories and the social production of an "us" versus "them" distinction that is reproduced in this current long-term care system (Appelbaum 2001). For example, perceptions can be reinforced around "wealth-reliant" elderly bodies deemed "deserving" due to a lifetime of a strong productive work ethic whereas "state-reliant" elderly deemed "undeserving" due to a lifetime of a poor unproductive work ethic that reinforces certain stereotypes and preserve these social divisions.

Neilson (2006) argues that we are witnessing the withdrawal of welfare-state provisions over long-term care and a new biopolitical regime for the governance of aging bodies has emerged. Therefore, matters and concerns around aging are becoming less regarded as a collective social responsibility and have predominantly become more about individual risk (Phillipson 2009). We are witnessing a shift of emphasis from the view that health is a collective right to it being constituted as an individual duty to maintain one's health as one ages. Individuals can no longer rely on the state for social protection and must now conceptualize themselves as rational agents who bear the onus of protecting themselves from making certain risky choices, even with the inevitabilities of poor health that often come with aging.

Thus, a 'new public health' has emerged wherein a health risk discourse has become internalized in the consciousness of individuals and are thus expected to uphold and maintain

their bodies and health (Petersen and Lupton 1997). The World Health Organization (2001) has actually adopted this discourse through an international campaign entitled "Active Aging" that encourages the empowerment of older people through health promotion schemes. Governments worldwide have embraced concepts such as "healthy aging," and "successful aging" to promote an individualist mindset toward experiences around aging that in turn reduce demands and dependency upon public systems (Neilson 2006). These changing biopolitical arrangements have produced subjects that now must navigate within the remains of the welfare state and an expanding privatized long-term care industry and system.

As a result, the U.S. has a weakened welfare state that is characterized by a government that has absolved itself of having primary responsibility to provide health and social services directly through the public sector. Meanwhile, government contracted enterprises profit from the growing influx of poor and formerly middle class elderly that privatization schemes itself created. At the same time, the poor and new poor elderly become susceptible to market inequities including lack of access to care, shortages due to uneven distribution of services, denial of services or provided less services because of lower social insurance reimbursement rates, the enforcement of voucher programs and cost sharing schemes. Again, private businesses are not obligated to provide services to all who need care. Despite receiving government subsidies, they can choose to accept or deny based on anticipated profitability of the individual. Thus, the blurring of the private/public divide and the ever-increasing privatization of care services has created a situation whereby individuals who are in need of formal long-term care services are at the mercy and whims of private enterprise.

Conclusion

In my study based in Southern California, my findings indicate that Filipino immigrant women became entrepreneurs by becoming private owners and operators of peripheral government subsidized businesses located in the secondary market of the long- term care industry. Many of these businesses are predicated on providing care to some of the most impoverished, mentally and physically disabled elderly populations. In my research findings, many of these Filipino owned businesses include government subsidized board and care facilities, home health agencies and senior adult day care centers. Their path to entrepreneurship was based on providing care to individuals receiving government aid and who were in need of custodial care, medical care and room and board services. I also found that a minority of Filipino immigrant owners has also developed businesses in the privately funded long-term care market that do not rely on government subsidiaries. Nevertheless, the sustainability of their operations was still based on providing lower cost care services in comparison to already established corporate owned long-term care businesses. In both cases, their ability to compete in the long-term care industry is based on fiscally devaluing their own services based on accepting lower, fixed reimbursements and decreased profit margins.

Filipino immigrant entrepreneurs have developed a niche around some of most vulnerable, underserved and disenfranchised populations that large corporations have deemed less profitable and may even be viewed as unworthy of investment. Specifically, their opportunity structure and entry point into the market is based on providing cheaper care services, accepting lower, fixed reimbursements and overall decreased profit margins that large profit corporations would not accept. They are not competing with large conglomerates that require capital investments and can be found on the New York and American Stock Exchanges. Rather, their opportunity is based on

providing care services to those that others do not want to care for either because they are viewed as less profitable or undeserving.

The restructuring of the welfare state characterized by the continued trend toward privatization has created a deluge of racial/ethnic minority, impoverished, under-served, economic undesirables that have low social supports, insecure housing options and a lack of long-term care health and mental health assistance in the community. In reference to nonsubsidized Filipino women owned businesses in the private sector, they compete by accepting government subsidies and providing care services at cheaper rates. Below, I compare the different price points of a government subsidized Filipino women owned business, a nonsubsidized Filipino women owned business and a corporate owned business.

I found that over 70% (n=10) of the Filipino care operators of board and care/assisted living/residential care facilities in my study received a fixed rate of $1013 per month ($33 per day) in federal SSI government funds to provide a poor elderly resident with room and board, assistance with ADLs/IADLs by care workers, housekeeping services, meals, activities and transportation. Many of their residents have a chronic mental health condition such as schizophrenia, bipolar disorder or depression. Nonsubsidized Filipino owned businesses charged between $2000-$3200 per month to provide similar long-term care services. However, they cater to individuals with Alzheimer's or dementia. Whereas, large proprietary corporate owned assisted living facilities charged an average base rate of $3,000 per month to live in the facility alone. An individual has to pay additional costs for care services and can pay up to $7000 or more per month depending on their care needs and accommodations. These corporations particularly catered to individuals with Alzheimer's or dementia as well. Thus, these findings emphasize the business enterprise stratifications that exist within the privatized long-term care industry. More

significantly, these findings further indicate that the entry point for Filipino immigrant women entrepreneurs is based on providing care labor at far cheaper rates and providing care to some of the least cared for in society.

Despite the growing demand for services, threats of defunding persist around an already inadequate long-term care safety net. Yet, the push for private responsibility reproduces and masks certain social conditions and uneven inequalities that interlink the global North and South regions of the world. In other words, the hierarchical, two-tiered long-term care industry mirrors the recurrent patterns of disparities, which have only exacerbated over time in an ever-expanding globalized, privatized economy.

Filipino immigrant women provide care labor in more than 160 countries making them "the domestic workers par excellence of globalization" today (Parreñas 2001:3). The perpetual mass recruitment of nurses from the Philippines that date back to the mid 1960s has led to an ethnic market niche for Filipino migrants in the health care industry. In situating the Filipino immigrant entrepreneurs within this terrain, these social conditions have interconnected health care systems of advanced capitalist societies such as the U.S. long-term care business industry to a world economic labor force that not only depends on the work of Filipino immigrant women domestic workers, care workers; but I contend – Filipino immigrant entrepreneurs as well.

Therefore, the purpose of this chapter was to describe the complex structure and organization of the U.S. long-term care system and its industry. I examined the context for the emergence of the industry, including a rising population of elderly people and the changing age structure of wealthier regions of the world; the impacts of privatization that continues to further dismantle a poorly conceived "patchwork" welfare state and in its place, the growth of a "corporate welfare state;" the closing of public health facilities; the depopulation of mental state

hospitals; the intensifying shortages of public housing and community-based services that have all culminated to an unprecedented terrain of a globalized market demand for long-term care work services. In the next chapter, I will examine why Filipino immigrant women decide to become owners and operators of these less profitable, government subsidized businesses and the various forms of capital they utilized to become more entrepreneurial.

CHAPTER THREE

FILIPINO IMMIGRANT WOMEN ENTPREPRENEURS AND DIFFERENT FORMS OF CAPITAL

Filipino immigrant women are highly represented in the service sectors of global labor markets and can be found in U.S. nursing homes, assisted living facilities, hospital settings and private households working as formal caregivers, nurses and other health care workers (Browne, Braun and Arnsberger 2007, Choy 2003, Guevarra 2010, Lorenzo et al. 2007, Parreñas 2001, Rodriguez 2010, Tung 2000). However, very little is known about Filipino immigrant women who have pursued entrepreneurial activities in the United States (U.S.), many of whom have toiled in these care-related settings and institutions.

Most contemporary immigration and ethnic enterprise research around U.S. Asian communities has mostly concentrated on Koreans, Chinese and Vietnamese immigrant groups (Cao 1996, Gold 1988, Lee 2002, Light and Bonacich 1988, Min 1984, Nguyen and Eckstein 2011, Yoon 1997, Zhou 1992). Common explanations for why immigrants engage in ethnic enterprises focus on disadvantages in the mainstream labor market. Such drawbacks include an immigrant's inability to transfer educational and occupational credentials, language barriers and employer discriminatory practices toward immigrants (Light 1972, Min 1984). Entrepreneurial activities also require access to various forms of capital since not all who face certain disadvantages in the U.S. labor market can automatically pursue self-employment (Gold 1988).

The purpose of this chapter is to examine why and how immigrant Filipino women became entrepreneurial and uncover the resources and capital they utilized to move into business ownership. I specifically elucidate how the intersection of race/ethnicity, class and gender shaped their access to capital and how particular historical circumstances and labor immigration policies

also shape how resources are accrued over time, I also examine how these business owners strategically utilized their constrained agency to become more entrepreneurial. These social conditions have heavily conditioned the types of businesses immigrant Filipino women own and operate. They own small to medium sized business enterprises include board and care homes, adult day care centers, home health and home care agencies that provide a range of services from custodial room and board care to outpatient home health care. In the results that follow, (1) I first provide an overview of my findings, (2) then I provide an analysis of the various forms of capital that immigrant Filipino women utilized in order to become owners and operators of long-term care enterprises and lastly, (3) I discuss *why* they decided to become business owners and the various symbolic and material awards that immigrant Filipino women attained by becoming more entrepreneurial.

SECTION I: FINDINGS

The findings from my project indicate that the majority of migrant Filipino women entrepreneurs come from middle-class backgrounds and were nurses (n=15) or had a health related occupational or educational background (e.g., pharmacist, social worker, dentist, medical and pharmacist technician) (n=6) prior to becoming a business owner (see Figure 6). A smaller number of participants worked outside of the health care sector prior to becoming an entrepreneur. These individuals reported having different types of educational backgrounds such as business/commerce and teaching degrees. Others were involved in administrative/office type work or selling real estate prior to becoming a business owner (n=4). Many stated that they were influenced to open up a business from extended family members, friends and/or co-workers who had a health care-related background and owned a long-term care business. All participants were heterosexually married and had children. The majority of participants stated that they went

into the business with their respective husbands. However, since more of the women had a health care-related occupational background in relation to their spouses, they became the officially designated licensed administrator and operator. Those without a health care background stated that they were largely influenced and mentored by other immigrant Filipino women owners. Others stated that this was a "caring business" so it was easier for them (versus their husband) to transition into this position.[23]

Figure 6: Occupation Prior to Owning a Long-Term Care Business

Nursing (Registered Nurses, Licensed Vocational Nurses)	**15**
Health Related Occupation Other Than Nursing (Pharmacist, Dentist, Social Worker, Medical and Pharmacist Technicians)	**6**
Non- Health Care Related Occupation (Teacher, Real Estate Agent, Administrative/Office Work)	**4**

SECTION II: DIFFERENT FORMS OF CAPITAL

One central question of my dissertation project is "How have Filipino immigrant women strategically renegotiated their social positions to become more entrepreneurial and own their own business?" Light (1972) argues that becoming a business owner and engaging in co-ethnic entrepreneurial activities is not a feasible option for all ethnic groups. While some groups have developed particular niches for other prospective co-ethnic business entrepreneurs to follow, not all ethnic groups follow a similar socioeconomic pathway and/or exhibit equivalent rates of self-employment. Light argues that the access and accumulation of various forms of social capital account for this disparity. Bourdieu (1983:249) defines social capital as "an outcome of networks

[23] This view points to the activities and roles that women engage in both the private household sphere and outside employment as persistently shaped by the gender division of labor and a dominant ideology that defines care work as women's primary responsibility (Davies-Netzley 2000; Duffy 2005; Tiano 1994).

and relationships which are usable, by conscious or unconscious design, in an economic sense." In other words, social capital includes the norms, networks and relationships that an individual develops within the social structure that can potentially produce and reinforce certain resources and behaviors for business ventures (Coleman 1988).

Entrepreneurial activities cannot simply be narrowly viewed through an economic lens. Rather, class-based and financial capital in combination with various forms of social capital including ethnic-based resources has a significant impact on the survival and success of ethnic enterprises. Examples of such resources include the intergenerational transmittance of skills, knowledge, bourgeois attitudes, private property and personal wealth (Light and Bonacich 1988, Light and Gold 2000). Such scholars assert that not all ethnic groups as well as groups within a certain ethnicity have the same access to such resources that lead to the accumulation of financial and social capital. At the same time, historical and structural forces of the larger socioeconomic context also play a critical role in exposing how they entered into this type of employment structure (Waldinger 1994).

My data indicates that the rationales for why and how certain immigrant Filipino women became more entrepreneurial can be directly connected to the distinctive historical colonial ties between the U.S. and the Philippines. Specifically, during the rise of modern medicine in the 20th century, white American women nurses traveled to the Philippines to train other Filipino women to become nurses and impose western medical interventions (Choy 2003). Under the guise of international heroism and universal humanitarian effort to save lives and improve health, Western medicine's "power to heal" was used to justify the creation of Americanized hospital training and education systems.[24]

[24] Catherine Ceniza Choy's (2003) Empire of Care and Warwick Anderson's (2006) Colonial Pathologies provide critical overviews of the impacts of western medical colonialization on the Philippines.

The U.S. then intentionally recruited these professionals as a cheaper labor force to fill the frequent shortage of medical personnel in their nursing homes, hospitals and health organizations (Choy 2003, Espiritu 2003). The majority of nurse respondents in my study reported that they first worked in hospitals located in urban poor cities and more desolate areas across the U.S. These transnational processes as well as shifts in how U.S. long-term care industry is organized (as discussed in the previous chapter) have significantly structured the opportunities and constraints unequally and hierarchically amongst the Filipino immigrant women in my study. Situated in this way, this chapter exposes the constrained agentic strategies and segmented forms of resources and capital immigrant Filipino women have accumulated in order to become small long-term care business owners and oversee and manage the health and sickness of some of the most disenfranchised populations in the U.S.

Nursing Capital

According to my data, the majority of the Filipino immigrant women participants had access to various resources, information and capital prior to migrating to the U.S. One significant form of capital these women viewed as assisting them become more entrepreneurial was their *professionalized* nursing credentials.[25] Starting in at least the early 1970s, I found that a growing number of immigrant Filipino nurses began to own and operate small long-term care businesses. The research participants in my study migrated to the U.S. between the years 1959-1995. The earliest immigrant Filipino women business owner in my study came to the U.S. in 1959 to do her nursing post-graduate work in Rhode Island. Another participant was a nurse instructor at a hospital in the Philippines and came to Pennsylvania through a visitors exchange program in 1967. A high concentration of my participants migrated between the early 1970's and mid 1990s

[25] A body of knowledge around the professionalization of occupations that demarcates the qualified and unqualified as well as creates stratified occupations that maintain a hierarchical social system that perpetuates a stratified system of classes (see Freidson, 1988; Mcdonald 1995; Mechanic, 1991)

through the occupational preference categories or family reunification policies laid out by the 1965 U.S. Immigration and Nationality Act.[26]

Despite the agentic constraints of migrating to the U.S. as a cheaper health care labor force and underpaid and working less desirable work shifts, I found that the majority of nurse participants viewed their technical skills and years of working in the U.S. health care system as a valuable resource and strategically used them to start up their long-term care businesses. Crespina, a 62-year old owner of an 82-bed board and care facility for the elderly states,

"My nursing experience really help me a lot. You can just jump in quickly if there's a problem with the resident. You can talk to the doctor very easily. I know the medications they're on and can trouble shoot right away if I think that the dosage is too much or I feel something is wrong. I can call them right away, plus they rely on me too because I'm the one with the resident so I know what's going on."

Understanding various medical terminologies also greatly assisted women entrepreneurs in communicating with other professionals that were involved in the health care of their residents/patients. Those nurse participants that owned non-medical home care agencies, adult day care centers and board and care facilities stated that having a nursing background gave them a "competitive edge." These participants shared with me that they have observed a growing number of their co-ethnic competitors do not have a health care occupational background. Therefore, despite not being required to be a licensed nurse in order to own and operate these specific kinds of businesses, they constantly distinguished themselves from other owners by

[26] The 1965 Immigration and Nationality Act also known as the Hart-Cellar Act (H.R. 2580; Pub.L. 89-236; 79 Stat. 911) replaced the previous national origins quota system that had defined U.S. immigration policy since the 1920s. The 1965 Act implemented a preference system that concentrated on immigrants' skills and family reunifications with U.S. citizens or residents. The U.S. would provide 170,000 visas per year. However, certain exceptions to this fixed number included those employees of the U.S. government abroad, former citizens, ministers or immediate relatives of U.S. citizens. http://library.uwb.edu/guides/usimmigration/79%20stat%20911.pdf Accessed March 13, 2014.

promoting their technical skills and medical knowledge. Marisol, a 35-year old home care agency owner states,

"For me, being a nurse gives me the confidence to talk to the families and let them know what's going on with the patient. I let the families know right away when they are looking for a home care agency for their family member that I am a nurse and will be there to assist our caregivers. If there's a problem they know they can call me."

Although individual human capital accumulation in the form of education, professional skills and work backgrounds are an important determinant of self-employment, it is important to situate the attainment of such capital within a broader framework. Certain social scientists have moved the emphasis away from individualistic employment determining factors and have broadened the ethnic entrepreneurship discourse to take into account important structural conditions and contextual factors such as migration policies, class-based and financial capital in combination with various forms of social capital, intergenerational transmittance of skills, knowledge, bourgeois attitudes, private property and personal wealth (Bonacich 1973, Lee 2002, Light and Gold 2000, Portes 1996, Zhou 1992).

In addition, Choy's (2003) seminal works around the history of immigrant Filipino nurses in the U.S. asserts that the origins of Filipino nurse migrations are not simply due to the relaxation of U.S. immigration rules in 1965. Instead, early twentieth century U.S. colonialization of the Philippines and the development of Americanized nursing and education programs laid the foundation for this gendered, professionalized and exportable labor force that make up the majority of my entrepreneurial research participants. This transnational perspective recognizes the complicated histories that shape the globalized neoliberal restructuring processes that set the context for these immigrant Filipino women's experiences.

In addition to sharing the advantages of having the nursing credentials to migrate to the U.S., many women in my sample shared various constraints they faced during the first few years

of working in a U.S. care institution. A 74-year old informant, Alicia, who came to the U.S. in 1959 to do her post-graduate work in nursing, currently owns a home health agency. While working at the Veteran's Hospital in Los Angeles in 1972, she recalls the following statement she overheard a colleague mention when she was working in the nurse's station and then proceeded to ask a different colleague what was meant by that statement:

Alicia to Interviewer: It was early, middle 70's, 1972…when I moved here. And there was this one, I was not receptive of their vocabulary.

Co-Worker 1: Oh, they are the displaced people.

Alicia to Interviewer: I clarified that later because I worked nights,

Alicia to Co-Worker 2: What does this mean they said that we are displaced people?

Co-Worker 2: It is because you are neither white or black.

Alicia to Interviewer: But of course, the Filipinos here, most of our position here was higher, we were not nurse's aides, we were not LVNs. We got the position of charge nurse, head nurses and supervisors!

In this excerpt, Alicia wanted to make the point that she was upset that they were labeled in this way and wanted to emphasize that Filipino nurses also took on managerial and supervisor positions in the hospital setting during that time. However, Susan, a 72-year old Filipino woman who also owns a home health agency claims that she was simply not given a choice over work shifts. She migrated to the U.S. in 1971 and first worked as a nurse in Cook County Hospital in Chicago, Illinois for seven years prior to moving to California. She states,

"During those times the Americans won't get the evening shift or the night shift. Its always the Filipinos with the graveyard. The Americans always wants to be on the day shift….They are given the choice probably, but we just weren't."

Another participant, Lita, is a 44-year old Filipino woman who owns a 96-bed government subsidized board and care facility claims that she only received a fixed salary despite working overtime in a nursing home. She migrated to the U.S. in 1995 and her first nursing job was located in the south side of Chicago, Illinois. She states,

"They [nursing home owners] petitioned us so we have a working visa but at the same time, our fear of being dropped off, no longer being petitioned was there, you know what I mean…and so we have to do whatever management wants us to do. They give us fixed pay even with the overtime we were working. There are some cases, some Filipinos, they just gave up and went home. Before coming to California, before then, at that time, it is hard. I have too much hardship when starting. We were first to be called, even during our off days, to work. We have to stay home in case we are forced to work overtime. We know its illegal but at the same time, we couldn't say anything because we were being petitioned at that time."

Even though this participant migrated more recently to the U.S., this example points out the exploitative working conditions and constraints that can still occur in the labor arrangements constituted through guest worker programs and petition-based labor contracts. These accounts are consistent with previous findings whereby Filipino migrant nurses were assigned less desirable work shifts than their white American nurse counterparts and U.S. hospital administrators purposely paid Filipino exchange nurses the wage of nurse's aides (Alinea and Senador 1973, Capulong 1965). Such racialized hierarchies emphasize the unequal power dynamics found in the workplace. Choy (2003) and Guevarra (2010) argue that Filipino women nurses would serve as a cheaper, more flexible gendered and racialized labor force for the U.S. health care industry.

Over time, the Philippines became the largest exporter of nurses to richer countries such as the U.S., Great Britain and Saudi Arabia (Alinea and Senador 1973, Choy 2003, Lorenzo et al. 2007, Ong and Azores 1994, Redfoot and Houser 2005). Ehrenreich and Hochschild (2003) has referred to this gendered and racialized globalized phenomenon as the "global chains of care," Parreñas (2001) has referred to the care labor transfer system as the "international system of

caretaking" while Hondagneu-Sotelo (2001) calls this international flow of gendered labor as a "new world domestic order." Parreñas (2001) asserts that the continual recruitment of nurses from the Philippines has also led to an ethnic niche for Filipino immigrants in the health care industry.

Today Filipino migrants not only occupy a significant proportion of nursing positions (e.g., registered nurses, licensed vocational nurses, certified nurses aides) in U.S. health care institutions, but they can be found occupying other health related jobs such as physical therapists, occupational therapists, physicians, physician's assistants, x-ray machine operators, medical technicians and caregivers for the elderly (Parreñas 2001). Guevarra (2010) and Rodriguez (2010) also call attention to the Philippine government and state officials and their active role in reformulating social relations with its own citizens to position the Philippines as one of the largest global distributors of domestic and care labor. Guevarra (2010) emphasizes the strategies that the Philippine state and its state-supported actors such as co-ethnic employment and recruitment agencies employed in perpetuating a socially constructed racial and gender logic. These rationalities were influenced by feminine and masculine traditional norms as well as Filipino cultural and social values that they use to manufacture and sell *Filipinas*. Guevarra argues that the institutionalization of such labor practices has also contributed to this ethnic niche formation.

Thus, the early colonization of the Philippines and infiltration into their education systems by the U.S., the subsequent development of an ethnic niche in the health care industry and the active position of the Philippine state in producing a cheaper, gendered, racialized and exportable workforce have significantly contributed to the growing concentrations of migrant Filipinos in health care related fields in the U.S. and other wealthier countries. Based on my own

findings, I contribute to this knowledge base by arguing that Filipino immigrants have attempted to renegotiate these constrained agencies and strategically capitalize on these racialized and gendered tropes concerning nursing and care labor. Despite the ability to attain wage labor positions in U.S. mainstream society, I found that many of my participants utilized their nursing capital and an expanding ethnic niche around the U.S. health care industry to accumulate and transmit information and social capital into more profitable, entrepreneurial opportunities.

For example, Minda is a 71-year old Filipino woman who migrated to the U.S. in 1964 to work as a nurse in hospital in Pennsylvania. In 1974, Minda became the owner and licensed administrator of an 18-bed government subsidized adult residential facility for younger adults ranging from 18-59. When asked the question, "How did you learn about opening a long-term care business?," she stated,

"One of our family friends from back home was a dentist here and we know owns a board and care in Anaheim. So, we…we went to visit them. We walked around the facility and they encouraged us to also open our own….that we can do it also. They made it sound like it wasn't so difficult. So we talked to them about how they started and what they did and, you know….we go from there."

Another nurse participant Lourdes, 64, migrated to the U.S. in 1973 and owned and operated her first business in 1986. The first facility she owned was a government subsidized 12-bed board and care facility stated,

"I learned about this business from my husband's sisters [also nurses]. One of them already owned like five board and cares at that time. My other sister in law had just bought one and was already starting to run her business too. They seemed to be doing very good. They have a very nice house, cars…so I just became so curious…so at family parties we would talk and I would ask them about how they started, how they got clients…everything…how everything runs, the ins and outs and I try to just learn and I think to myself, I'm a nurse too, I can also do this….why not?"

This next participant did not have a nursing background. Nita, 53, owner of a 6-bed private pay board and care home, migrated to the U.S. through a family reunification visa in 1985 and first worked as a cashier at a gas station. Prior to coming to the U.S., she worked as a front office staff member for a hotel in the Philippines. After 5 years working as a gas station cashier in the U.S., Nita attained a job as a receptionist in a corporate owned nursing home. While working in the nursing home setting, she was approached by a white female nurse who owned a home care agency.

"She approached me because I was in the desk and then she was…you know signing in and saying "how are you," you know. So I said I'm Nita and I work…blah blah blah, okay, and she said, "hey, you want to work part time?" and I asked, "like what, doing what?" She then said, "taking care of the elderly in their home." So you know, I try it to make some extra money on the side. I take care of a private patient, one-on-one. He has dementia. It was okay, I can handle it. So, you know, that is how I was introduced first, yeah, this was in 1990. Her name was Cindy, she was very nice. But you know what, the one that really motivated me was my husband's friend. His sister in law, Filipino too. They've been living in Loma Linda also and she has a board and care home. She's the one that really show me how to do this kind of business. You know, how to get the license, how to start. I got my license in 2005 and we were able to open one the next year."

Nurses and Social Networks

These examples point to the significance of these Filipino immigrants' social networks found within and around an increasing ethnic niche in the health care industry. These social networks have played a key role in economic activities and outcomes. In other words, the transmission of ideas, merchant attitudes and information through an individual's ties with multiple networks (e.g., family, friends, co-workers, acquaintances) can have a direct impact on their social positions in society, including in the labor market (Granovetter 2005). Refuting an atomized view of economic action, Granovetter (1988) points out that these individual actions are influenced and embedded within social networks of relationships. The intertwining of these

economic and noneconomic motives and actions is what Granovetter (1985) terms the "social embeddedness" of the economy.

As mentioned earlier, many of these immigrant nurses were segmented to laboring in many urban poor and desolate hospitals throughout the U.S. However, despite such constraints, the concentration of such labor forces in these institutions also led to the women in this study to agentically develop co-ethnic social networks and attain resources and capital in the form of ideas around entrepreneurship and meeting potential future business partners. Many of my research participants emphasized that by working in care institutions (e.g., hospitals, nursing homes, home health agencies); they were able to develop a network of co-ethnic nursing and other health-related professionals cumulatively over time. Some of the participants were first introduced to the possibility of developing their own businesses in these workspaces from informal conversations shared with their co-workers and acquaintances. Others were introduced through family and extended kin members. Specific to the participants who owned home health agencies that provide skilled nursing and rehabilitative services, they stated that these networks assisted them in targeting various physicians and discharge planners to advertise their businesses and attain patient referrals. In fact, one of my nurse participants Marybeth, who currently owns and operates four home health agencies in three different Southern California cities and stated, "Having good networks is so important. If you only know one or two doctors..forget it, your business will not last!"

Care Market Niche

Instead of catering to co-ethnic patrons and selling cultural foods and products that typically characterize ethnic niche enterprises (Aldrich and Waldinger 1990), the majority of Filipino businesses were established outside of the ethnic community and instead predominantly

catered to a disenfranchised, low-income sector of the U.S. aging and chronically ill population. As shown in the previous chapter, their businesses concentrated on providing room and board, custodial care and outpatient medicalized care to certain groups of elderly, disabled and/or individuals with chronic mental health conditions.

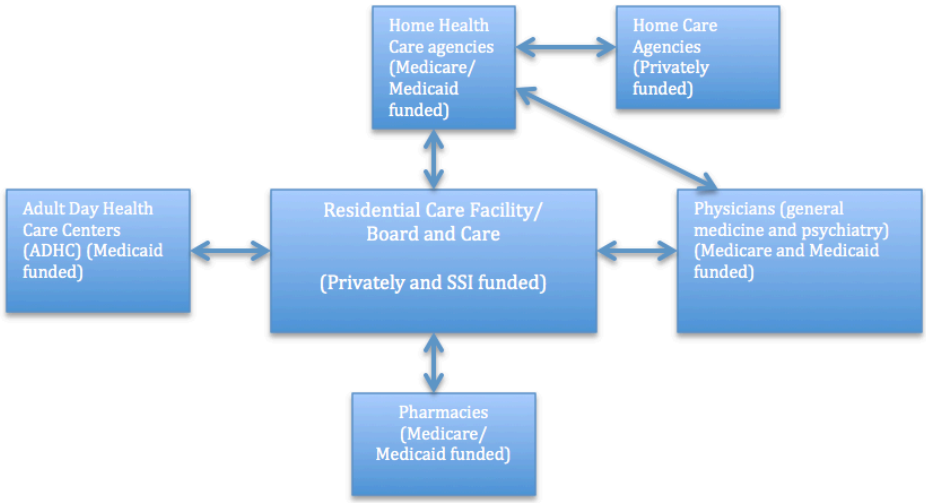
I found that Filipino women entrepreneurs would collaborate and network with each other for the benefit and sustainability of their respective long-term care businesses. Specifically, during my participant observation of a Filipino owned home health agency I uncovered that the Filipino nurse owner would offer to provide discount-rated caregiver training and continuing education courses to staff members of a co-ethnic owned board and care facility. The board and care staff members were continually required to be recertified in specific areas such as medication management and First Aid by an outside licensed care vendor. In exchange, the owner of the home health agency hoped to develop a business relationship and attain future patient referrals from the co-ethnic owner of the board and care facility.

As mentioned in the previous chapter, entrepreneurs in my sample claimed that co-ethnic enterprises are among their biggest competitors. I found that many Filipino women that owned home health agencies and adult day care centers would compete amongst each other to attain the business opportunity to work in partnership with co-ethnic owned board and care/assisted living facilities in order to secure them as a consistent patient/resident referral source. I also found that co-ethnic as well as other ethnic minority physicians and pharmacists would also be vying to develop business relations with them in order to attain and secure patient referrals as well (e.g., Filipinos, Indians, Armenians, Chinese). Thus, they mutually benefited from these business relations that cultivated reciprocal obligations and reliance between these co-ethnic and intra-ethnic social network of business owners and health care providers. Furthermore, my participants

also revealed that they would compete and collaborate with other ethnic/racial that owned similar businesses including Armenians, Russians, Iranians and Romanians.[27] Below is a diagram that illustrates the organizational structure within this care market niche developed by predominantly government subsidized Filipino and intra-ethnic long-term care enterprises. (See Figure 7)

Figure 7

Diagram of the Organizational Structure of Filipino and Intra-Ethnic Enterprises in the Secondary Market of the Long-Term Care Industry



Bailey and Waldinger (1991) highlight that social networks also serve a critical role in organizing information flows between co-ethnic workers and employers and reducing the risks associated with hiring and training. Coleman (1988) asserts that networks create a social structure for facilitating activities around job opportunities, recruitment and training. My findings coincide with these assertions whereby social networks assisted Filipino women owners of home health agencies recruit other co-ethnic nurses and health care professionals (e.g., physical therapist, occupational therapist, social worker, physician) to contract and work for them.

[27] My participants also mentioned Jews as one of their biggest competitors but erroneously perceived them as an ethnic group.

Filipino owners of non-medical businesses (e.g., board and cares, home care agencies) stated that they usually hired caregiver employees through co-ethnic informal ties as well. They turned to family members, friends, extended kin and their current co-ethnic staff members to find other employees. In my sample, it was not unusual for women to report that they found relatives (e.g. sisters, husband and wife, cousins) working together as caregivers and nurses in these co-ethnic enterprises. These types of "word of mouth" social ties for patient referrals and employee recruitment schemes characterize these social networks amongst Filipino entrepreneurs.

Hence, my findings suggest that a specific kind of care market ethnic niche in the formal economy has been established. Within this niche, Filipino women have been able to capitalize on both the high concentration of co-ethnic professionals and low-waged formal caregivers laboring in the U.S. health care and long-term care industry. (Co-ethnic employer and employee relations are discussed in Chapter 5). Overall, information sharing, business collaborations, professional credentials and the available supply of a co-ethnic care labor force are resources that have assisted in the initiation, survival and success of their business ventures. Access to these various forms of social networks and "weak" social ties has increased their entrepreneurial chances and opportunities (Granovetter 1973). Granovetter (1973) characterizes having weak ties as partaking in diffuse social networks with less interpersonal dissonance (e.g., acquaintances, loose contacts). Having access to and developing these kinds of networks could generate new connections and lead to more opportunities for mobility.

Start-up Capital

Filipino migrants also claimed that they learned how to acquire the start-up capital from the mentorship and guidance of those in their social networks. It is important to note that the amount of start-up capital varied and depended on the type of care business (e.g., board and care

facility versus home care agency). Also, some of the women in my study purchased long-term care businesses that were already licensed to operate and had been functioning as a business for years. Others revealed that they purchased single-family homes that they converted into board and care homes or leased an office space and created it into a home health agency. These informants had to wait six months to over a year prior to become a fully licensed business because they had to pass all building code inspections, adhered to all business operating regulations and have their billing processes in order. Therefore, they would have to have the necessary capital to sustain them through this waiting period.

Women in my sample acquired start-up capital through a combination of ethnic and class-based resources including their savings, home mortgage refinancing, loans from different sources and borrowed credit from the previous owners. For example, many of the nurses reported that they would work overtime and take weekend shifts in order to contribute to the down payment to purchase a commercial property. One participant reported that she went into business with three other nurses and each contributed $25,000 to cover start-up costs. Nursing and non-nursing participants also reported that they would take out a second mortgage, a line of credit and borrow against their homes in order to come up with the start-up capital. Others also reported acquiring small loans from a third party such as a bank to aid in the purchasing of their business.

Some of the participants who purchased their businesses from the late 1980s-early 2000s stated that it was easier to attain personal loans and lines of credit from banks and credit card companies. However, they mentioned that at the time, the interest rates were relatively high and much was financially at stake. For example, Regina, 43, worked as a pharmacy technician and shared how she was able to purchase a home that she initially converted to a 6-bed government

subsidized board and care business. (Discussed later in chapter four, she converted her business into a private-pay 6-bed entity). She and her family would live in one of the rooms while the other rooms were used to provide custodial care services to elderly residents. She purchased this home in 2001 and states,

"We have…we didn't have that much money. I think what we need before I think I have like $10,000 for the closing costs and everything is utang (credit). You know, from the bank already. Whatever, everything is there. I have first and second mortgage. I have to close my eyes! Our interest is exploding up to the sky you know, but we don't have no choice, we want to start already. I think my second mortgage was 30.75 percent!! So you know it goes up! And I'm pregnant too. So you know, I applied for credit cards. It came right away. Second and third came right away. One thing though, my husband has a job at Kaiser, that help us so we can have insurance through him. So you know, we started, you know, we were able buy the house...barely."

This example points to the savings and loan bubble that took place during the early 2000s. This particular time period also played a role in participants' ability to attain financial capital that was needed to pursue self-employment endeavors. However, this example also highlights the financial risk that these Filipino entrepreneurs were willing to take in order to start a business. In this case, taking such risk paid off. (However, the limitation of this study is that I did not capture those individuals whose businesses failed after securing high interest loans).

Many participants also reported that they received loans from family/kin members. Often times, their family members were already running a similar business and were able to provide both mentorship and financial loan assistance. Turning to home care agencies, these particular owners stated that they had far less overhead. They initially started their businesses from home with a cell phone and a computer with Internet connection. Once they received their license to operate and attained the necessary business insurances, they would post formal caregiver ads on Craigslist and retail and grocery stores that cater to Filipinos. One home care owner stated that

before she rented a small office space, she would conduct job interviews in public spaces like local restaurants and shopping malls.

Similar to Lee's (2002) findings, I found that the majority of board and care/assisted living owners as well as adult day care centers were able to purchase their businesses through borrowed credit from the prior owners. They would acquire businesses from fellow ethnics, family relatives or non co-ethnics and provide a down payment of a certain percent of the value of the business and pay the rest in monthly installments. For example, one of my participants purchased a 12-bed board and care facility in 1986 for approximately $300,000 (including value of business and all assets including real estate). She stated that she provided the previous owner (white male) with a $60,000 down payment and would pay monthly installments thereafter (approximately $2,500 per month for the next 20 years). She accumulated this down payment from a combination of sources. She described that she used ten years of savings she and that her husband had accumulated working as a nurse and an orderly in the hospital, cashed out her 401K-retirement pension and attained a $10,000 personal loan from a bank.

The Pew Research Center recently conducted a nationwide survey that highlights current immigrant Filipino household incomes (2013).[28] They surveyed six of the major Asian American groups in the U.S. including Chinese, Filipinos, Indians, Vietnamese, Koreans and Japanese in order to contain a nationally representative sample of each Asian American group in the U.S. Regardless of immigration status, they interviewed a total of 3,511 Asian American adults (18 or older) living in the U.S. They found that nearly three-quarters (74%) of Asian American adults were foreign born and were the "highest-income, best-educated and fastest-growing racial group in the United States" (Pew Research Center 2013:v).

[28] Pew Research Center. 2013. The Rise of Asian Americans. Washington D.C. http://www.pewsocialtrends.org/files/2013/04/Asian-Americans-new-full-report-04-2013.pdf Retrieved February 1, 2014.

Specific to the Filipino population, their median household income is the second highest among Asian Americans at $75,000 (overall U.S. median household income is $68,529), 47% of them have a college degree or higher and they are the second largest Asian American group in the U.S).[29] The average size household of Filipino American was 3.4 (Pew Research Center 2013). (See Figures 8, 9, and 10). This number was higher than the national average at 2.6. (U.S. Census Bureau 2013). According to the Pew Report (2013), Asian Americans are more likely than the general public to live in multi-generational family households. They found that approximately 28% live with at least two adult generations in the same household. "This number is twice the share of whites and slightly more than the share of blacks and Hispanics who live in such households" (Pew Research Center 2013:3).[30] In terms of homeownership, the Pew study found that 62% Filipino Americans (more than 6 out of 10) own a home, compared with 58% of all Asian Americans and 65% of the general U.S. population. In relation to poverty status, the study also found that 6% of adult Filipino Americans live in poverty, lower than both all Asian Americans (12%) and the U.S. population (13%) overall.

The majority (two-thirds) reported living in the western part of the U.S. where my study took place. According to the 2010 Census Bureau, the largest concentration of Filipinos resides in California (1,474,707). These findings emphasize that a certain proportion of Filipinos in U.S. have access to certain economic resources to potentially start up a business that often requires much start-up capital. [31]

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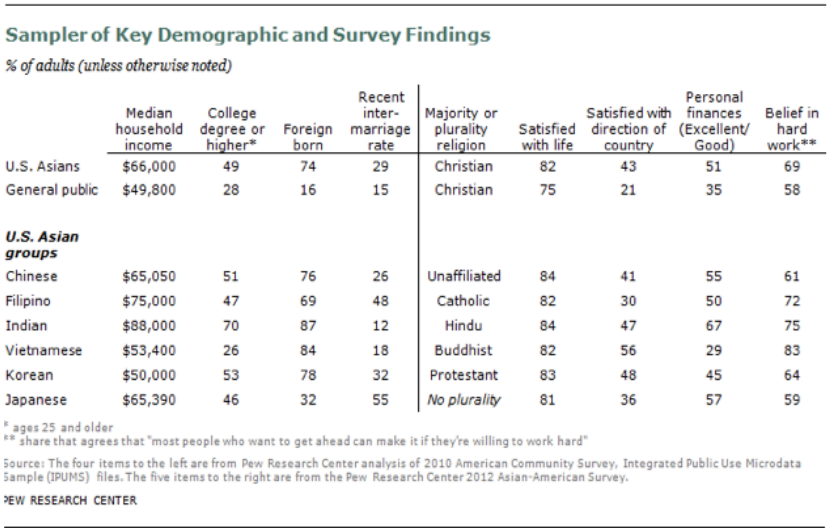
[29] U.S. Census Bureau. 2010. Asian Alone or in Combination with one or more other Races and with one or more Asian Categories for Selected Groups. Washington, D.C.: U.S. Department of Commerce. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_PCT7&prodType=table#tab_map Retrieved February 24, 2013.

[30] These adults besides the head(s) of the household (e.g., aging parents, adult relatives) may be also fiscally contributing to the household and/or assisting with informal child-care services. Also, the adult children (e.g., head(s) of the household) may be providing informal care services to their aging parents that live with them.

[31] A recent study, *A Community of Contrasts: Asian Americans and Native Hawaiian and Pacific Islanders* reaffirms these findings around Filipinos in California (Asian American Center for Advancing Justice 2013). However, they

Figure 8: Key Demographic and Survey Findings (Pew Research Center 2013)



Sampler of Key Demographic and Survey Findings

% of adults (unless otherwise noted)

	Median household income	College degree or higher*	Foreign born	Recent inter-marriage rate	Majority or plurality religion	Satisfied with life	Satisfied with direction of country	Personal finances (Excellent/ Good)	Belief in hard work**
U.S. Asians	$66,000	49	74	29	Christian	82	43	51	69
General public	$49,800	28	16	15	Christian	75	21	35	58
U.S. Asian groups									
Chinese	$65,050	51	76	26	Unaffiliated	84	41	55	61
Filipino	$75,000	47	69	48	Catholic	82	30	50	72
Indian	$88,000	70	87	12	Hindu	84	47	67	75
Vietnamese	$53,400	26	84	18	Buddhist	82	56	29	83
Korean	$50,000	53	78	32	Protestant	83	48	45	64
Japanese	$65,390	46	32	55	*No plurality*	81	36	57	59

* ages 25 and older
** share that agrees that "most people who want to get ahead can make it if they're willing to work hard"

Source: The four items to the left are from Pew Research Center analysis of 2010 American Community Survey, Integrated Public Use Microdata Sample (IPUMS) files. The five items to the right are from the Pew Research Center 2012 Asian-American Survey.

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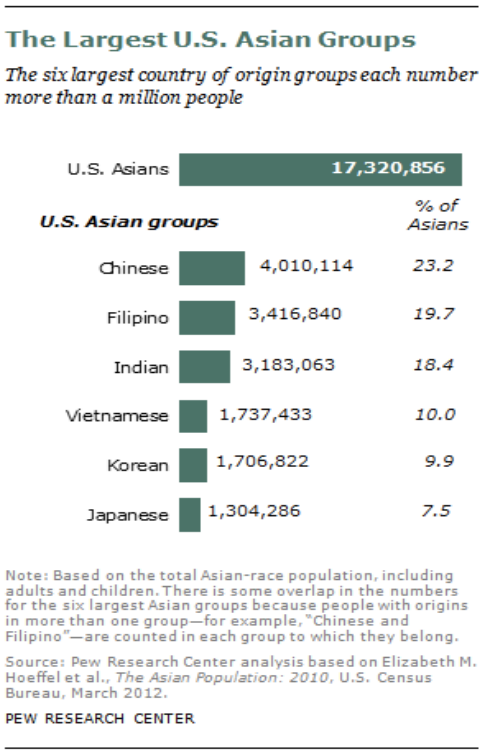
Figure 9: Largest U.S. Asian Groups (Pew Research Center 2013)



also found that despite having higher household incomes in comparison to other Asian groups, they have the lowest admission rates in the University of California system. See http://napca.org/wp-content/uploads/2012/11/AAJC-Community-of-Contrast.pdf and http://globalnation.inquirer.net/63691/filipinos-are-biggest-asian-group-in-california-new-study, Retrieved March 13, 2014.

Figure 10: Average Household Size of Filipino Americans (Pew Research Center 2013)

Characteristics of U.S. Filipino Adults, 2010

% (unless otherwise noted)

	U.S. Total	U.S. Asians	U.S. Filipinos
Foreign born	15.8	74.1	69.1
Of these, arrived in past 10 years	26.3	28.8	24.5
Citizen	91.4	69.6	77.4
Median age *(in years)*	45	41	43
Married	51.4	59.0	56.3
Fertility (women ages 18-44)			
Had a birth in the past 12 months	7.1	6.8	6.5
Of these, % unmarried	37.1	14.6	26.5
Educational attainment (ages 25+)			
Less than high school	14.4	13.9	7.7
High school or more	85.6	86.1	92.3
Bachelor's degree or more	28.2	49.0	47.0
Median annual personal earnings			
Full-time, year-round workers	$40,000	$48,000	$43,000
Household annual income			
Median	$49,800	$66,000	$75,000
Average household size *(persons)*	2.6	3.1	3.4
Homeownership rate	65.4	58.1	61.8
In poverty	12.8	11.9	6.2
Language			
Speaks English "very well"	90.4	63.5	77.7
Speaks English less than "very well"	9.6	36.5	22.3
Region of residence			
Northeast	18.3	20.1	9.7
Midwest	21.6	11.3	8.6
South	37.0	21.5	15.8
West	23.0	47.1	65.9

Note: Unmarried women include those who are divorced, separated, widowed or never married. "High school or more" includes those who attained at least a high school diploma or an equivalent, such as a General Education Development (GED) certificate. "Speaks English 'very well'" includes those who speak only English at home. U.S. Asians and U.S. Filipinos include mixed-race and mixed-group populations, regardless of Hispanic origin.

Source: Pew Research Center analysis of 2010 American Community Survey, Integrated Public Use Microdata Sample (IPUMS) files

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Currently, Filipino immigrants do not have the highest rates of ethnic entrepreneurship in comparison to other Asian immigrant groups. However, the latest national Survey of Minority Business Enterprises shows that there has been a 30% growth in business ownership from 2002-2007 (U.S. Census Bureau 2011).[32] The majority of these enterprises are found in the health care

[32] U.S. Census Bureau. 2011. "Facts for Features: Asian/Pacific Heritage Month: May 2011." Washington, D.C.: U.S. Department of Commerce. http://www.census.gov/newsroom/releases/pdf/cb11ff-06_asian.pdf Retrieved January 27, 2014.

and social services sector which accounts for approximately one-third (33.4 percent) of Filipino-owned business revenue to date.

Recently, some care work studies have examined the role Filipino immigrant women play in the provision of eldercare and the long-term care industry. For example, a study published in 2007 found that 97 percent of the 563 licensed residential care homes for the elderly in Honolulu, Hawaii were operated by Filipino immigrant women (Browne, Braun and Arnsberger 2007). In California, where 52 percent of U.S. Filipinos reside, Tung (2000) points out that Filipino migrant workers comprise 75 percent of all in-home eldercare providers in Los Angeles.

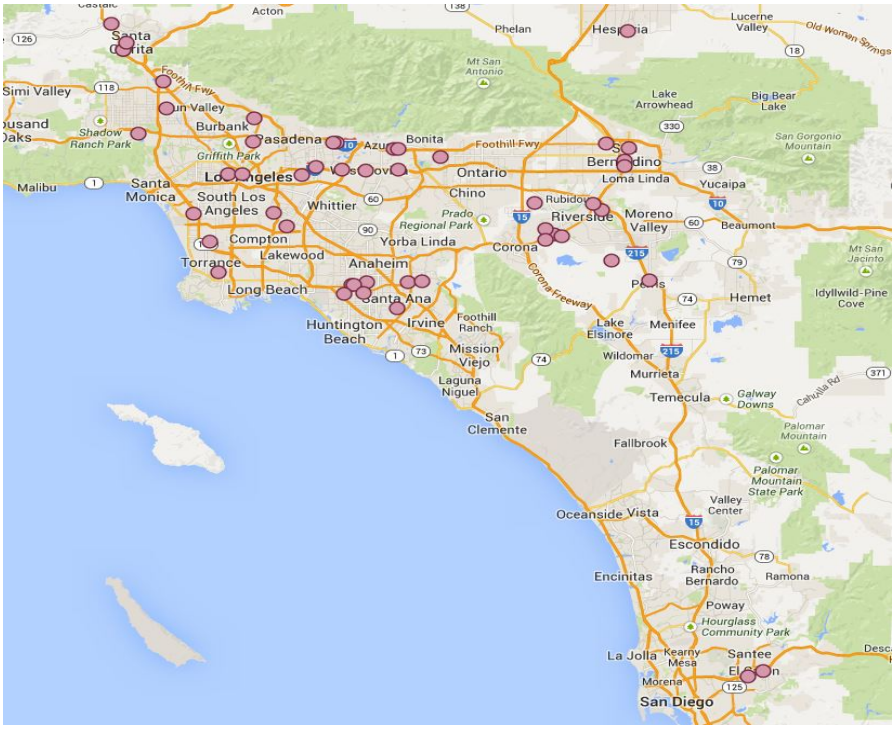
Unfortunately, there are no formal national or statewide statistics that break down data by race/ethnicity or gender of U.S. long-term care business owners. However, through supplemental interviews, I spoke with an owner of a business enterprise (white male) that provided initial and continuing education and training courses for individuals who want to become licensed administrators of RCFEs, ARFs and Nursing Homes. His business provided these types of courses in three different counties in Southern California (San Diego, Riverside and Orange counties). In the 12 years that he has owned this business and taught administrator courses, he estimated that 60-70% of his participants are Filipino immigrants and the majority are women. According to a county behavioral specialist and case worker (white female) who currently works for one of the major county mental health department in Southern California stated,

"In the 15 years that I've been with county, I have probably dealt with between 25-30 board and cares and mostly all were run by Filipinos, maybe two or three of them were run by African Americans."[33]

[33] According to the data, the participants did not view African Americans as major competitors overall. The participants' businesses were located throughout Southern California including Riverside; San Bernardino; San Diego; Orange and Los Angeles counties and the majority of them stated that other co-ethnic businesses were their biggest competitors, followed by other religious and ethnic minority groups including Jews, Romanians, Iranians, Armenians and Russians. The participants did not clarify the ethnic make-up of those they identified as Jewish.

As mentioned in Chapter 2, in my interviews with 25 Filipino women entrepreneurs, they were able to identify at least one or more other co-ethnic competitors in their surrounding area. These findings further support my claim that an emerging form of ethnic entrepreneurship among immigrant Filipino women is occurring as displayed in the map that was first shown in the previous chapter (See Figure 1).

Figure 1: Map of 50 Immigrant Filipino Women Owned Long-Term Care Businesses throughout Southern California



"Gendered Capital"

The ability of Filipino immigrant women to utilize their resources to enter into more entrepreneurial endeavors speaks to their command and access to various forms of social and economic capital. Yet, another form of capital that is often overlooked pertains to their gendered resources. More recently, feminist scholars have challenged various gender-neutral notions and

androcentric knowledges around labor immigration and sought to legitimize the different experiences of women (Choy 2003, Fernandez-Kelly 1989, Guevarra 2010, Hondagneu-Sotelo 2001, Hossfeld 1993, Mies 1998, Misra, Woodring and Merz 2006, Momsen 1999, Ong 1991, Parreñas 2001, Pedraza 1991, Safa 1995). These scholars challenged the differences found within labor migration theories and exposed the labor disparities not just between men and women, but also between women. Currently, more women are migrating and entering the global market independently and are often the first in their family to migrate due to occupational preference categories around care work (Choy 2003; Ehrenreich and Hochschild 2003, Parreñas 2001).

Similar to the sociological literature around labor migrations, scholars have also critiqued the gender-blind biases that permeated earlier theoretical frameworks around ethnic entrepreneurship (Dallafar 1994, Davies-Netzley 2000, Verdaguer 2009, Westwood and Bhachu 1988). In addition, care literature has expanded to critically examine and expose the immigrant women's underpaid, undervalued waged labor (Collins 1999, Espiritu 2003, Guevarra 2010, Hochschild 2004, Hondagneu-Sotelo 2001, Misra, Woodring and Merz 2006, Mohanty 1991, Nakano Glenn 1992, Parreñas 2001, Rodriguez 2010, Romero 1992, Sassen 2008, Zinn and Dill 1994). However, there are far fewer studies that address immigrant women as entrepreneurs in the ethnic economy (Dallafar 1994, Davies-Netzley 2000, Verdaguer 2009, Westwood and Bhachu 1988).

As was discussed previously, not all ethnic groups and groups within a certain ethnicity have the same access to certain resources that lead to the accumulation of financial and social capital. Dallafar (1994); Davies-Netzley (2000); Verdaguer (2009) and Westwood and Bhachu (1988) assert that gender is also an invaluable resource for capital or what Davies-Netzley (2000)

refers to as "gendered capital." They argue that labor markets depend on women's labor, particularly in production work, domestic work and care work. Similar to their own findings on immigrant women entrepreneurs, these gendered ethnic enterprises have become a source of empowerment and social mobility for the immigrant Filipino women entrepreneurs in the current study as well. They have advantageously used their gendered resources to develop profitable small care businesses, which underscores the sense of personal agency, resistance and upward mobility in ethnic enterprises. Immigrant women who venture into entrepreneurship and capitalize on care market ethnic niches can be viewed as a way of combating and strategically coping with racial/ethnic oppression, immigrant discrimination, patriarchal domination and economic exploitation.

For example, Hossfeld (1993) examined how gendered social constructions and racialized and gendered stereotypes are utilized to recruit, manipulate particular women workers and the justification for the undervaluation and cheapened labor force. Hossfeld pointed to the "immigrant logic" and "racial logic" that Silicon Valley electronic plant employers ascribe in their hiring preferences of 'Third World' immigrants such as "quiet," "patient," "relatively small in size" that translates to being "easier for them to sit quietly for long periods of time" and thus viewed as "better suited" for assembly line-style repetition of a small set of tasks (Hossfeld 1993:74-82). To expand on Hossfeld's views, Chow (1994) showed how Asian American women at work coped daily and developed survival and resistant strategies to negotiate the complex relationships around the multiple oppressions and exploitations in the workplace. Chow (1994) asserts that stereotypical views around Asian American women as passive and submissive fail to see the inner strength, firmness and resourcefulness these women employ to cope with structural constraints.

In much of the ethnic entrepreneurship literature, structural constraints include disadvantages such as an inability to transfer educational and occupational credentials, language barriers and employer discriminatory practices toward immigrants that have funneled various ethnic groups toward self-employment (Light 1972 and Min 1984). Parreñas (2001) argues that Filipinos are less entrepreneurial than other Asian immigrants such as Korean merchants because Filipinos are able to utilize their English-language skills and seek wage employment instead. Parreñas goes on to assert that a Filipino ethnic enclave is not established because its creation would confer no significant economic benefit because of their ability to find jobs in the mainstream marketplace. For instance, unlike Korean, Chinese and Vietnamese immigrant owners (Lee 2002, Nguyen and Eckstein 2011, Zhou 1992), Filipino immigrant women in the current study were able to transfer their educational and occupational credentials and faced fewer language barrier issues. They were able to attain jobs in the wage labor markets in workplaces like hospitals and nursing homes. And unlike Chinese and Cuban ethnic enclaves (Portes and Bach 1985, Zhou 1992), similar robust ethnic concentrated communities amongst Filipino immigrants living in the U.S. do not exist in the ethnic entrepreneurship literature.

However, my findings indicate that it is *because* of women's unique social locations and the historical moment in which they were embedded. Specifically, this led to the constrained agency and the social practice of transferring their nursing education and occupational credentials into the U.S., their English language proficiency and the gendered and racialized prescriptions and stereotypical views around Filipinos as care laborers and health care workers that they have become more entrepreneurial in the long-term care industry sector. These findings point to the impacts of the distinctive historical relationship between the U.S. and the Philippines

as well as more contemporary forces (that were discussed earlier in the Nursing Capital section) that have influenced the formation of a gendered, racialized care market niche.

In addition, these ethnic businesses may continue to grow due to a new demographic shift occurring in the U.S. Currently, 39.6 million individuals comprise the older population of those who are 65 years or older. They make up 12.9% of the U.S. population, approximately one in every eight Americans. Their number is expected to double to 72.1 million by 2030 (U.S. Department of Health and Human Services 2012).[34] It has been well documented that family members provide the majority of assistance and caregiving in the U.S. However, recent studies have also shown a growing number of families are turning to care institutions and/or hiring care workers to assist and care for their elderly and disabled family members (Boris and Klein 2012, Browne, Braun and Arnsberger 2007, Solis 2011, Tung 2000).

In fact, by 2020, the U.S. healthcare and social assistance industries are expected to increase by 33 percent, or 5.7 million new jobs due to the growth of the U.S. aging populations (Bureau of Labor Statistics 2010-2011).[35] According to the Bureau of Labor Statistics, between 2010-2020, twenty-eight percent of all new jobs will be found in nursing and residential care facilities, public and private hospitals and family and individual services. This may be due to the dramatic projected decline of the informal family caregiver support ratio from 7.2 to 4.1 and spiral downward to 2.9 between the years 2030-2050 (AARP Public Policy Institute 2013).[36] The report suggests that rising demands in long-term services and support (LTSS) and smaller

[34] U.S. Department of Health and Human Services. 2012. *National Clearinghouse for Long Term Care Information,* U.S. Department of Health and Human Services: Planning for Long Term Care. http://www.nasuad.org/documentation/hcbs2011/Presentations/M2RegencyC.pdf Last accessed March 13, 2014.
[35] Bureau of Labor Statistics, Occupational Outlook Handbook, 2010 - 2011 Edition http://www.bls.gov/ooh/About/Projections-Overview.htm#laborforce Last accessed October 20, 2013.
[36] D. Redfoot, L. Feinberg, and A. House, The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers (Washington D.C.: AARP Public Policy Institute, August 2013). www.aarp.org/research/ppi Retrieved October 29, 2013

family size contribute to a growing care gap occurring through out the U.S. Other trends that contribute to the outsourcing of long-term care include rising employment rates for women, growing divorce rates and increased rates of childlessness (Sloan Center 2009).

SECTION III:

MATERIAL AND SYMBOLIC REWARDS

As the demand for their services continue to increase, immigrant Filipino women who are long-term care owners have amassed various material and symbolic rewards as long-term care business owners. When posed the question, "Why did you decide to open a business?" The majority of participants' responses included becoming one's own boss, increasing their financial income and no longer relying on fixed wages and having a sense of control over their own workplace and time. For example, one of my participants, Marybeth, 69, came to the U.S. in 1968 and first worked as a nurse in New York. While in New York, she received her master's degree in nursing from a prominent university in New York in 1975 and subsequently worked in various administrator-level positions in Texas, Kansas and California. Her roles included working as a clinical nursing director and instructor in both the hospital and university settings. Marybeth claims to have been the first Filipino to hold the position of clinical director and oversaw seven departments at a major hospital institution in Los Angeles from 1990-1995. She currently owns four home health care agencies, and stated that she was still inclined to become a business owner for the following reasons:

"Hospital work is tiring, even if you are a supervisor…you have pressures from the higher ups in a big hospital regarding budgeting and staffing, so even if staff needs something, if its not in the budget, you can't do anything about it, you can't change anything, you just have to follow what the higher ups say. Also, you depend on your salary every two weeks so you can't really go against them. Being an owner has similar pressure, but you control the budget you see… its satisfying when you're in control, you can determine what's important, what to focus on. Also,

hmmm… more freedom, more ability to do what you want. Also, less physical activity (laughter)…my gosh, like in the hospital if you're an ICU nurse, you have to run around!"

Marybeth also disclosed that she made around $70,000 per year as a clinical director in Los Angeles in the 1990's. However, as a business owner, she was able to budget and pay herself an income of approximately $125,000 per year. She reported that that she reinvested her business profits in opening other sites in order to continue to expand her business enterprise. She also revealed that her children have also become part of the family business. Marybeth's two daughters and one daughter-in-law are also nurses and assist in managing the four home health care sites they currently own. Marybeth also stated that, "You can help your kids more, they don't have to take loans out to go to school and you can even hire your children to work for you or even open their own business too."

Other participants also highlighted that there are limitations to being an employee including constantly having to wait for physician orders prior to conducting the majority of their job responsibilities, reliance on fixed incomes and rigid work hour shifts. Alicia (74 years old and owner of a home health care agency) states, "In the hospital, I remember, there's a time clock. You have to be there all eight hours. You clock in, you clock out. I will always look at the clock. With a business, you can get out anytime."

In addition, during my participant observation of a 75-bed government subsidized board and care facility for the chronic mentally ill elderly, I took note of the power dynamics between nursing owners and physicians and pharmacists. As mentioned earlier, I found that physicians and pharmacists were also competing to develop business relations with board and care facilities in order to attain a constant referral base. As opposed to a rigid, hierarchical professional dynamic found in the hospital setting, I observed that the owner of this facility treated and

viewed the current contracted physicians (e.g., general practitioner and psychiatrist) and pharmacist as mutual partners in business and vice versa. My observation points to the change in traditional doctor-nurse power dynamics once they became business partners and mutually benefitted from working together as opposed to the doctor simply providing orders to the nurse in a hospital setting.

Overall, the majority of informants mentioned that they had a sense of pride from becoming the "boss," and a sense of control and freedom that they did not have when they worked in their previous occupations and workplaces. The majority also reported that they became more financially secure, were able to qualify for certain tax write offs and increase their savings which allowed them to assist their families in the U.S. as well as send more remittances back to the Philippines. For example, Lourdes, 64, owner of a government subsidized 12-bed board and care facility stated states,

"It does help [to have a business]. It's easier to give money to the family in the Philippines. Also, it's just more flexible. It's easier for you to move around. I mean, before when you are nurse, you think about, "Can I afford that?, but now…if you like it…Okay! See what I mean…you don't always have to count your money first."

Another informant, Emie, 62, has been an owner of a 15 bed government subsidized board and care facility in San Diego since 1993 and she stated:

"Now that I'm in my 60s…now that I'm old now, this is a stable business, the money is stable because…well there's always need for placement. Plus my husband lost his job and it's hard to find a job nowadays so this provides us with security."

Participants also indicated that they were able to send their children to U.S. colleges without having to take out major loans as well as assist their children with down payments for cars and first home purchases. According to Susan, 72 (quoted earlier), "Hospital work wouldn't

allow us to do this as much for our kids and family." Marisol, 35, (nurse who currently owns a home care agency) agreed:

"We were able to save something and have some freedoms. You know if you are a simple employee, you're limited. So we came to a point, where you can eat whatever you want, buy whatever you want like the IPhone, the Wii, those different kinds of gadgets, a big TV, a nice place to live...that's good enough."

Another informant, Nita, 53 who did not have a health care occupational background and owns a 6-bed privately funded board and care home, shared similar sentiments,

"I couldn't have this kind of life if I still worked as an admin…[administrator's assistant]. Me and my husband can save for our kid's schooling and give them what we didn't have. We don't spoil them too much…but, you know…we weren't able to finish college in the Philippines but now my kids can have this kind of opportunities."

Although this emerging form of ethnic entrepreneurship in care work is in some ways circumscribed by the historical colonial ties between the U.S. and the Philippines, immigrant Filipino women have agentically renegotiated structural constraints to obtain social and economic upward mobility.[37] The majority of participants expressed a sense of pride and confidence in being able to achieve such material and symbolic successes. By becoming the owners and operators of care-related businesses, they attained more financial security, time and workplace flexibility, found themselves in a stronger fiscal position to assist their families in both the U.S. and the Philippines and felt more empowered as small business owners when comparing their current work to previously more disempowering and constraining work.

[37] C. Wright Mills (1956) provides a critical analysis and argues that despite the inequalities permeated through capitalism and injustices that migrant workers may undergo, they are often subdued by new accumulation of wages, new social status and new commodities. They are manipulated by the tiny, narrow, instant gratifications and the small rewards allocated to them by the powerful elite (corporate, political and military power) who control the overwhelming majority of the nation's wealth.

Conclusion

This chapter focused on immigrant Filipino women with predominantly middle-class backgrounds and the different forms of social capital, particular historical circumstances and labor immigration policies that both facilitated and sustained their enterprises in the U.S. long term care industry. My findings indicated that Filipino immigrant women were predominantly nurses who worked in the U.S. health care system, prior to becoming private owners and operators of long-term care businesses in order to gain upward mobility. This central finding challenges the notion that Filipino immigrants do not engage in entrepreneurial pursuits because of their access to waged labor jobs in the mainstream labor market. Instead, they strategically used their access to waged labor nursing jobs, their English language proficiency and the gendered and racialized prescriptions and stereotypical views around Filipinos as care laborers and health care workers to become more entrepreneurial in the long-term care industry sector.

Light (1972) emphasized that the success and sustainability of immigrant business ventures were significantly dependent on group resources. The data suggests that these migrant Filipino women have strategically extracted and agentically benefited from their group's social class, particularly resources from their middle class and professional backgrounds in order to pursue entrepreneurial pursuits. The concept "middle class minority culture of mobility" points to the various resources utilized by the minority class in generating mobility such as professional associations, ethnic organizations and schools, ethnic ties and labor paternalism (Neckerman, Carter and Lee 1999). The social class of the Filipino women in my study served as a significant resource in relation to their professionalized nursing backgrounds and the co-ethnic social networks that ensued due to a high concentration of Filipino professional workers in the U.S. health care industry. Also, the historical and structural forces such as the Americanized nursing

training and education programs during U.S.-Philippine colonial rule and the 1965 U.S. Immigration Act have also considerably impacted the development of this form of ethnic enterprise around care work. Particularly, they played a significant role in selecting certain classes of Filipino women to migrate at certain times in history since 1965 immigration policies favored those with professional skills, high levels of education and vocational training (Chow 1994). Thus, I argue that the combination of these various forms of resources and capital has significantly contributed to the agency and emergence of immigrant Filipino women entrepreneurs in the U.S. long-term care industry.

Nevertheless, my findings from Chapter 2 indicate that many Filipino immigrant women became entrepreneurs by becoming private owners and operators of peripheral government subsidized businesses located in the secondary market that highlights their constraints as business owners. Their path to entrepreneurship was based on providing care to some of the most impoverished, mentally and physically disabled populations in the U.S. Though some of the Filipino owned care businesses are located in the privately funded long-term care market, the permanence of their operations was still based on providing lower cost, cheaper care services. Overall, my findings reveal that their businesses are founded on accepting lower, fixed reimbursements and decreased profit margins in order to compete in the long-term care industry.

In further situating my findings within the ethnic entrepreneurship literature, the question then arises—have Filipino immigrant women who are long-term care owners become the petty bourgeois who are both victims and oppressors in the capitalist system? Bonacich (1973) argues that the sojourning orientation of immigrants and their marginal status as foreigners in the host society lead them into certain ethnic communities, business endeavors and occupations. In addition, these types of small business ventures allow immigrants to avoid direct competition

with native majority group members. Though they do not have to compete with larger business chains, they act as an intermediary for absentee white capitalistic owners and perpetuate ethic niches and exploitations.

The very formation of a two-tiered, two-class long term care industry and the concentration of ethnic enterprises in the secondary market of this industry underscore the maintenance and reproduction of various structural inequalities (as discussed in Chapter 2). Namely, Filipino long-term care businesses have in many ways replaced and stepped in to meet the needs that have resulted from a retracting, austere state and now directly provide housing, custodial and medical care to some of its most vulnerable citizens. Hence, the U.S. government continues to take on a more subsidiary approach instead of being held directly accountable for its citizens' social welfare. In chapter 2, I analyzed the implementation of various social and public policies in order to determine the entry points and opportunity structures for these Filipino immigrant women to enter into the long-term care industry sector. In situating the emergence of some of the earliest businesses located in Southern California, one significant historical connection that was uncovered was the development of such ethnic enterprises occurring soon after the mass deinstitutionalization of U.S. mental health state hospitals.[38] According to the data, since at least the 1970s, Filipino board and care facilities have catered to this chronic mentally ill, indigent population.

Segal and Kotler (1989:25) assert that board and care facilities have taken over the function of the mental state hospital as "the bed of last resort." I extend this argument by claiming that for over the past forty years, Filipino ethnic businesses have played a relevant role in serving as one

[38] Though the deinstitutionalization movement began in 1955, the mass movement of individuals with chronic mental health conditions out of state mental hospitals occurred ten years later. The enactment of Medicare and Medicaid funding policies in 1965 served as a major impetus for the displacement of these individuals into private nursing homes and board and care facilities (Mechanic and Rochefort 1990, Scull 1984, Shonick 1981, Segal and Kotler 1999).

the overseers of such beds. Hence, a new kind of ethnic enterprise has emerged in the long-term care industry and these Filipino-owned businesses have in fact become "state replacements." This chapter attempted to emphasize the spaces of contradiction and paradox whereby Filipino immigrant women are practicing constrained agency given their embeddedness in larger historical and contemporary processes. These social processes produce an intersectional spectrum of opportunities and constraints that have led to the proliferation of a gendered and racialized form of entrepreneurship around care work. As women develop businesses around taking care of disenfranchised populations in order to achieve upward social and economic mobility, their care businesses may be (inadvertently) serving as an apparatus to the state. In other words, long-term care businesses in the secondary market is part of a larger organizational structure that epitomizes the restructuring of the welfare state and the globalized, privatization policies that have not only created the rising number of poor, under-served, chronically ill and aging populations in the U.S.; but a migrant, female cheapened labor force that not only cares for them, but now manages and oversees this care as well. In the next chapter, I revisit my findings from Chapter 2 and more critically analyze their path to entrepreneurship. I specifically examine the consequences related to the state having absolved itself of the primary responsibility to provide long term care services to some of the most marginalized U.S. populations and the further examine the role Filipino entrepreneurs play as "state replacements."

CHAPTER FOUR

STATE REPLACEMENTS:

IMMIGRANT FILIPINO WOMEN OWNED CARE BUSINESSES

The Limits and Challenges of Replacing the State in the U.S. Long Term Care Industry

A distinct kind of ethnic entrepreneurship has emerged in relation to how formal long-term care has been structured and organized in the United States over the past forty years. Since 1974, immigrant Filipino women have owned and operated long-term care businesses including board and care/assisted living facilities, adult day health care centers, home care and home healthcare agencies. One form of this unique type of ethnic entrepreneurship involves their role as *state replacements* after the deinstitutionalization era (1960-1970) and the enactment of Medicare, Medicaid and Social Security government funded policies (1965). Individual states did not allocate these federal dollars to build more public hospitals, community mental health centers and public housing settings. Instead, dollars were used to attract for-profit enterprises to encroach into the public sector (Abramovitz 1986, Mechanic and Rochefort 1990, Scull 1985, Shonick 1981).

Thus, the phenomenon of ethnic enterprises playing a role in the long-term care industry given state retrenchment is rooted in and characterized by 1) the lack of a universal provision of long-term care due to the privatization of formal long-term care services in the U.S. and a scaled-down welfare state and 2) the stratification *within* the privatized long term care industry. Even though private enterprises were government subsidized to provide long-term care services, many of the corporate-owned assisted living and home care franchise industries preferred to cater to the wealthier sectors of society (e.g., top 1%) and accepted more profitable private-pay

individuals.[39] 3) Immigrant entrepreneurs, particularly immigrant Filipino women have stepped in to meet the long-term care needs of the less profitable, government-subsidized individuals that not only resulted from a retracted welfare state, but also from corporations preferring to provide long-term care services to a higher payer mix that optimized their reimbursements. According to my findings, recruited immigrant Filipino women nurses who served as a cheaper labor force in the 1960s were some of the earliest long-term care business owners in Southern California.

I define *state replacements* as government subsidized, small ethnic enterprises that have stepped in to meet the needs that have resulted from welfare state retrenchment and now directly provide and oversee the long-term care, medical care, day care and housing of some of the most vulnerable U.S. populations: the elderly poor with low social supports and have a form of a severe, chronic mental illness and/or chronic physical disability. The sustainability of these state replacement businesses were based on directly overseeing the care of some of the least cared for in society, providing cheaper care services, accepting fixed, lower government subsidized reimbursements and attaining overall decreased profit margins. Additionally, these businesses have (inadvertently) assisted the U.S. government in continuing to absolve itself of having primary responsibility for providing health and social services to its own citizens.

In the previous chapters, I provided a macro-structural analysis on how intersecting social forces have systemically influenced the globalized political economy of care and the peripheral forms of a gendered, racialized and class based form of ethnic entrepreneurship. I also offered a meso-level of analysis on the organizational conditions that arranged and shaped the marketized care relationships in the long-term care industry. In this chapter I integrated a social psychological/symbolic interactionist framework to analyze the micro-level interpersonal

[39] Some of biggest long-term care businesses (e.g., Sunrise Senior Living, Emeritus, Atria Senior Living, Home Instead Senior Care) are owned and operated by transnational corporations. They are located throughout the U.S. and other countries such as Canada, France, Japan, South Korea, Germany, Italy, Switzerland and the UK.

processes between Filipino entrepreneurs and other stakeholders in the long-term care industry. Specifically, I examined the experiences of the immigrant Filipino women in my study and the limits of their social, political and economic mobility as gendered ethnic entrepreneurs and their role as *state replacements.*

I break down this chapter into the following four sections: (1) I first provide an overview of my findings and provide an overview of how immigrant businesses become licensed to operate as state replacements (2) then in the second section I discuss the connections between how macro social forces and the organization of care influenced the subtle, elusive web of subjective meanings and perceptions ascribed to immigrant Filipino women and their businesses. Specifically, I examine the social interactions and kinds of meanings ascribed to these ethnic owned businesses by state/federal agents and other long-term care providers. I also analyze various meanings attached to care recipients residing in Filipino-owned facilities. (3) In the third section I analyze how these pervasive views have shaped and maintained the kinds of conditions under which immigrant Filipino women entrepreneurs operate and provide services. Lastly, (4) I also examine how medicalization and biomedicalization processes have influenced the U.S. long-term care markets.[40] Overall, this chapter emphasizes how the meanings and conditions of care (determined by macro and meso structures) created certain micro-level interactions and conditions that have deepened the stratifications and inequalities found within the privatized U.S. long-term care industry made up of segregated primary and secondary markets.

[40] Sociologists framed the concept of *medicalization* in order to theorize the process that occurs when medical terms are used to describe human conditions and behaviors (Conrad 1975, Conrad 2007, Freidson 1970, Szasz 1974, Zola 1972). *Biomedicalization* captured the intensification, reconstitution and reorganization of these medicalization processes in today's society and its institutional infrastructures due to the integration of computer and information technologies and innovations (Clarke et al. 2003).

SECTION I: FINDINGS

In my study, I found that immigrant Filipino women owned businesses predominantly provided long-term care services to two populations labeled with different chronic diagnoses and resided in separate facilities. Of the 25 respondents in my sample, I found that over 76% (n=19) of the immigrant Filipino women entrepreneurs were owners and operators of government-subsidized long-term care businesses (e.g., residential board and care facilities for the elderly, younger adult residential facilities, adult day health care centers and home health agencies) who oversaw the long-term care of an impoverished, state-reliant population with a primary diagnosis of a severe, chronic *mental illness*. Care recipients also had physical disabilities and weak social supports (See Figure 3).

Fourteen of the immigrant Filipino entrepreneurs owned board and care residential care facilities for either older adults (60 or older) or younger adults (18-59 years of age) and were subsidized by the federal Supplemental Security Income (SSI) cash benefit program. Two other participants owned Medi-Cal funded adult day health care (ADHC) centers that catered to this population as well.[41] The remaining three informants owned Medicare/Medi-Cal government subsidized home health agencies.[42] These co-ethnic owned ADHC centers and home health care agencies were contracted with board and care/assisted facilities (both government and non-government subsidized) to provide their respective services.[43]

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[41] Adult day health care services (ADHC)- provides approximately 4-6 hours of daytime supervision, care and daily structure (e.g., skilled nursing, case management, dementia day programs, activities, assistance with daily living tasks, meals and transportation) for adults with physical or mental disabilities in a community based setting. Major goals of such programs include assisting adults who need supervision during the day to stay active in their communities, prevent institutional placement and provide family caregivers respite. ADHCs are federally regulated if they receive Medicare or Medicaid reimbursements and also subject to period inspections.

[42] Home health agencies provide long-term care clients with medical and nonmedical services in the home and assisted living/residential care facilities Services include nursing care, physical therapy, occupational therapy, social work services and home care assistance.

[43] Home health care owners also reported that many of their patients were also individuals who recently were discharged from the hospital and required home health care services in the home.

A smaller subset of the immigrant Filipino women owned businesses in my study catered to the affluent, private pay clientele. The majority of their care recipients had a primary diagnosis of some form of *dementia*. They provided care to the wealth-reliant sector that could afford services without assistance from government subsidies (n=6) (See Figure 3). However, I found that these immigrant Filipino women businesses served as a less expensive alternative to the corporate owned businesses that predominantly serviced this population as well.[44]

Figure 3: Filipino Immigrant Women Owned and Operated Long-Term Care Businesses in Southern California

Type of Business	Number of Filipino Immigrant Women Long-Term Care Business Owners
Welfare State/Government – Subsidized	
Residential Care Facility for the Elderly (RCFE)	10
Adult Residential Facility (ARF)	4
Adult Day Health Care Center (ADHC)	2
Home Health Care Agency	3
Private Pay	
Residential Care Facility for the Elderly (RCFE)	4
Home Care Agency	2

For this chapter, I predominantly analyzed data collected through in-depth interviews with the 19 owners of government-subsidized businesses that provided care services to individuals with serious mental health, medical and physical impairments that make up a

[44] In Chapter 2 I reported that non-government subsidized Filipino owned businesses charged between $2000-$3500 per month to provide similar long-term care services. Whereas, large proprietary corporate owned assisted living facilities charged an average base rate of $3,000 per month to live in the facility alone. An individual has to pay additional costs for care services and can pay up to $7000 or more per month depending on their care needs and accommodations.

disenfranchised, indigent sector of a growing elderly and disabled population. These respondents were asked, "What are some of your biggest challenges in running your business?" The data indicated that some of the most significant challenges that the majority of government-subsidized immigrant Filipino women entrepreneurs experienced were 1) employee relations and finding "good," "reliable" and "selfless" caregivers and 2) dealing with the stress and anxiety concerning the scrutiny and pressures from state and federal agents around attaining and maintaining their license to operate. Another significant challenge was 3) operating and sustaining their businesses on limited, fixed, state/federal government reimbursement rates.[45] In this chapter, I specifically focus on the latter two challenges of immigrant Filipino women business owners because it framed and provided further contextual analyses for the antagonistic employer-employee dynamics and their dependence on a low-wage, predominantly co-ethnic, gendered labor force. The degree of agency and constraint found in these inter-ethnic class tensions and labor hierarchical segregations that persist between racial/ethnic women will be discussed in the subsequent chapter.

Becoming State Replacements

All long-term care businesses (e.g., government subsidized and private-pay) must attain a state or federal issued license in order to operate. In order to become an owner and administrator, the state and/or federal government required them to have a certain number of college credentials, go through various administrator and continuing education courses, pass a

[45] Another challenge reported by government-subsidized respondents, but to a lesser degree was the difficulties surrounding the eviction of a "problem" resident and that their business was a "dumping ground" for residents no other long-term care facilities would accept. In comparison to non-government subsidized Filipina businesses, finding "good," "reliable" and "selfless" staff and dealing with state and federal regulators were also major challenges reported. However, operating on limited, fixed reimbursements were not a concern since they did not accept government subsidies. Instead, attracting private-pay clientele due to competition amongst other co-ethnics, intra-ethnics and corporations was another significant challenge reported.

criminal background check, show a certain amount of monetary funds in bank accounts, undergo health screening tests and pass building inspections set by state and/or federal agents. In terms of educational background and licensing requirements specific to becoming an administrator of a board and care/assisted living facility, the potential operator must be 21 years old, have a high school or GED education, undergo a 40-hour administrator course and pass a 40 question standardized exam for a facility of 16 or less residents. They must attend continuing education courses every 24 months to keep their administrator's license current.[46] The licensing procedures are similar for home care agencies and adult day care centers. However, for home health care agencies, there are more *professionalized* requirements since they provide *medicalized* care services and thus have stricter requirements.[47]

Afterward, the federal and state agents are mandated to carry out unannounced inspections of these businesses in order to ensure they are in compliance with policies, procedures and operating requirements enforced by the State of California, Health and Human Services Agency/Community Care Licensing Division (CCLD) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). On average, many of the respondents reported that they received an unannounced comprehensive inspection visit by a CCLD state licensing agent at least once every one to two years. Respondents also shared that, at times, the

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[46] The potential administrator must also pass a background check and pay a $100 processing fee. For a facility of 16 residents or less, the administrator must have a high school or GED certificate. For facilities with 16-49 bed capacities, the administrator would need to have at least 15 college or continuing education units and experience. If the facility has 50 beds or more, the administrator is required to have 2 years of college education and 3 years of experience in providing residential care for the elderly. All is subject to the approval of the state's Community Care Licensing division. It is important to note the minimal requirements needed to care for a long-term care population, particularly for facilities that have 16 residents or less. Also, an owner of a long-term care business can outsource and hire a licensed administrator to handle the daily operations. In other words, the administrator and owner do not have to be one and the same. http://www.ccld.ca.gov/pg471.htm Retrieved July 18, 2014

[47] A physician is required to act as the clinical supervisor and oversee the work of nurses (e.g., RN, LVN, CNA), physical therapists and occupational therapists. http://www.cdph.ca.gov/pubsforms/forms/Documents/HHA-AppRequestLtrChecklist.pdf
Retrieved July 18, 2014

licensing agent would visit the facility for a consecutive number of days (e.g., 3 days to a week), depending on the type of violation for which they were being investigated.

By law, CCLD is only required to conduct such an inspection visit every five years.[48] The respondents reported that they received more frequent visits by social workers, public guardians and representatives from the ombudsman/resident advocacy office to visit residents and/or to investigate complaints or concerns made by the resident themselves, an outside vendor related to the care of the recipient or a family member. Federally licensed long-term care businesses such as home health care agencies were subject to an announced inspection at least once every three years by a JCAHO agent.[49] On average, those respondents subject to JCAHO inspections reported that they received a visit every three years. However, as one of the licensing analysts stated in a recent meeting I attended, "They should always be open or ready to see us and not be surprised. Because we can come out 24/7."

[48] Prior to 2003, the CCLD was required to conduct annual announced visits to long-term care businesses such as RCFE's, ARFs and ADHCs. However, due to state budgetary constraints, legislation passed to reduce program costs by requiring annual visits to only those long-term care facilities with a history of compliancy issues and probation. State licensing agents were only required to annually visit 20% of facilities that did not exhibit persistent compliancy concerns. By law, a facility had to be visited at least once every five years. However, in 2014 a bill (AB 1454) was recently passed by the Senate Human Services Committee to reinstate annual unannounced visits to all facilities. This law will go into effect by July 1, 2017. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1454 Retrieved on May 2, 2014.

[49] http://www.jointcommission.org/state_recognition/state_recognition_details.aspx?ps=100&s=CA Retrieved on May 2, 2014

SECTION II: MEANINGS OF CARE

"Armenians are #1 in Medicare Fraud and Filipinos are #2"(Alicia, 74, an owner of a home health agency was referring to a statement made by a federal agent during an unannounced visit to her business.***)***

Challenges with State and Federal Agents

On October 22, 2013, I attended a public meeting that was sponsored by one of the major Southern California county Department of Mental Health and Social Services where they hosted two state licensing agents. The purpose of the meeting was for those involved in overseeing and caring of long-term care populations in formal institutions an opportunity to discuss their concerns and pose questions. Assisted living/board and care owners and administrators, managers/supervisors of mental health related clinics, social workers, behavioral therapists and psychiatrists who worked with long-term care populations in these state licensed formal institutions were in attendance. However, I observed that many of the immigrant owners rarely asked questions or shared concerns to the hosts regarding state licensing practices. Instead, a moderator (state employed behavioral specialist/case worker) asked the majority of the questions and led the conversation.

State licensing agents provided an overview of their roles, discussed the growing need for more board and care facilities that provided care and supervision to the low-income, chronic mentally ill population and stated the top 3 cited complaints/violations in regards to board and care/assisted living facilities. These three included severe neglect of residents, financial disputes regarding refunds when a resident leaves a facility or passes away and unlicensed facilities that take in residents who are in need of a higher level of care. Nevertheless, the majority of operators (majority were immigrant women administrators and owners) did not question these types of

complaints or shared any further opinions on such matters. My findings below may assist in elucidating why this may have occurred.

The majority of the participants in my study emphasized their compulsory compliance as well as rather contentious interactions they had with their state-licensing analysts and federal surveyors. For example, one of the nurse participants, Lita, 44, who owned a government subsidized board and care facility for the elderly stated,

"Oh licensing….they are terrible! Its just so stressful. Plus this is SSI. Nobody takes SSI anymore! She [licensing analyst] even says, "can I talk to your staff in private?" I never see that and so I asked. But she wanted to talk to them privately without me. I think they wanted to see if they have papers. I said that was fine, go ahead! I asked my staff afterwards and talk to them. Licensing really asks them when they did start, their ID and stuff like that. She even went to the umm, the grocery cabinet and to see if it's full. She borrowed the stool and looked at the top of all the shelves! All I could say, do what you have to do! They are checking the expiration date, and…and they also see if there's enough food or are we just putting the food toward…li.like…the front, so, like nothing behind. She wants to see if we are just trying to make it look full but, but it's not really…you know what I'm saying. Then I remember, she said, "Because we learned from you guys." What does that mean?! You can't generalize…I sometimes want to kind of…like say something to them! But I just let it go…"

Another participant, Crespina, 62, who also owned a government subsidized board and care facility for the elderly stated,

"Licensing can close you down so we just follow the regulations…we follow and try to just get along. We just do the best we can and give them whatever they ask when they come…like the charts, also the medication records, paper works, everything…um..umm...they even go through all our personal files too… social security numbers, drivers license…they are like that."

Alicia, 74, an owner of a home health agency recounted a contentious statement made by a Medicare surveyor during an unannounced federally mandated inspection,

"I remember one of the surveyors was…was reeaally really bad. He was saying that the Filipinos, they are second to the Armenians. He said something like…oh that the Armenians are #1 in Medicare fraud and Filipinos are #2!...I mean..we know it happens, we see it in the news you know, there is a Filipino on the news like I think almost 2-3 years ago..not sure, but she went to jail but I think she's already out now. Hmmm..well what can you say, it happened. But not all of us are doing like that…its embarrassing for the Filipinos when you hear it…"

Long-term care scholars have often argued for more policy regulations related to the increase of inspections and oversight for these types of businesses in order to ensure patient/resident health and safety (Flores, Bostrom and Newcomer 2009). Also, they have written extensively on the need for more staff members as well as better training and education in order for them to adequately care for the U.S. long-term care population (Harrington and Carrillo 1999, Harrington et al. 2012). Back in 1981, both Harrington and Estes criticized the subsequent poor care of the displaced chronically mentally ill population received due to the deinstitutionalization era and the government subsidization of the private sector (Estes and Harrington 1981). Other social scientists have addressed the consequences of social control (Foucault 1965), the political economy (Estes and Harrington 1981, Scull 1985) and medicalization (Aneshensel, Phelan and Bierman 2013, Brown 1979, Mechanic and Rochefort 1990., Scull 1984) of individuals labeled as "mentally ill." All are important contributions to the literature. However, I argue that the dominant focus so often remains at the resident/patient/client care perspective. Through this chapter, I contribute to the U.S. long-term care literature by examining the immigrant and racial minority labor force and how the industry has been structured and organized in such a way that has created such micro-level interactions and conditions.

Interpersonal processes between the immigrant Filipino women owners and other stakeholders in the U.S. long term care industry can be examined through a symbolic interactionist (SI) framework to understand how individuals act in accordance to the meanings stemmed from social interactions and altered through interpretations (Blumer 1962; 1969). SI is one of the major theoretical perspectives in contemporary sociology that emphasizes the precedence of society and ongoing social processes in shaping the individual mind and the self

(Mead 1913). Heavily influenced by philosopher, sociologist and psychologist Mead, sociologist Blumer wanted to deeply understand "the peculiar and distinctive character of interaction as it takes place between human beings; how human beings interpret and define each other's actions and responses based on the meaning attached to the action" (Blumer 1962:180).

In other words, individuals do not simply respond individually or automatically to social situations but interpret, negotiate and define each other's actions through the use of shared symbols such as words, gestures and language. Thus, the symbolic interactionist perspective focuses on the ways in which individuals and groups generate, maintain and transform subjective meanings and perceptions in our everyday social lives. Hence, how the state/federal agents interacted with Filipina owners emphasized the kinds of meanings they assigned to these ethnic owned businesses and specifically how they viewed the immigrant women who operated them.

I can extrapolate from the above-mentioned excerpts that federal and state agents viewed the respondents as not only potentially providing low quality care, but care provided fraudulently as well as "illegally" through the suspected hiring of undocumented immigrant employees. Lita and Crespina's statements found in the beginning of this section elucidated how state-licensing officials unlawfully searched through legal documents and the conduction of private interviews with employees in order to confirm citizenship statuses.[50] Lita and Alicia's statements also provided a more in depth example of the types of scrutiny that occurred and a confrontation that

[50] Police officers, immigration officers and other officials have the right to question an individual about their U.S. citizenship status, however the person in question does not have to disclose their status, how they entered into the U.S. or where they were born. Only an immigration agent may ask to provide documentation confirming your U.S. citizenship. However, these employers reported that the state-licensing officials did not directly ask their employees if they could view their legal documentation. Instead, they simply asked the employer to provide them with these materials. Unfamiliar with the law, employers reported that they complied in order to not be perceived as harboring undocumented employees. https://www.aclu.org/drug-law-reform-immigrants-rights-racial-justice/know-your-rights-what-do-if-you#4
Retrieved June 1, 2014

became overtly racialized via the statements, "we learned from you guys" and "Armenians are #1 in Medicare fraud and Filipinos are #2."

However, it is important to point out that Medicare reimbursements are based on an "honor system" type of billing model.[51] For example, the doctor sees the patient and then prescribes various recommendations and orders. The home health agency follows these orders and their employed medical biller inputs these orders into a particular software system that bills Medicare for services rendered. The government then reimburses the parties involved in providing the care without first verifying whether or not the patient actually needed these medical services. It would be impossible for a government official to check each and every order prescribed by a doctor on a daily basis prior to reimbursement. Hence, repayments are predominantly based on an "honor system." As mentioned earlier, federal agents from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) would carry out inspections at least once every three years. They would conduct unannounced visits to Medicare-subsidized health care organizations in order to ensure they are in compliance with policies, procedures and operating requirements. Research and reports have pointed out that Medicare fraud will continue to persist as long as the fee-for-service reimbursement environment remains one of the main organizing principles for provider reimbursement (Anderson and Robinson 1992, Freudenheim 1993, Friedrichs 2004, Lindorff 1992, Sparrow 1996, United States Department of Justice 1999, Vandenburgh 2005).

Also, the largest example of Medicare fraud in the U.S. occurred in 1996 and involved a huge transnational corporation made up of approximately 300 hospitals and surgery centers in the U.S. and the UK. Hospital Corporations of America (HCA) was found guilty of various

[51] http://medicarefraudcenter.org/medicare-fraud-information/11-medicare-a-system-ripe-for-fraud.html Retrieved June 2, 2014

fraudulent activities such as providing monetary benefits and kickbacks to physicians for eliciting and referring new patients to HCA, performing false billing practices by fabricating procedures and inflating diagnoses in order to attain larger Medicare reimbursements.[52] Unlike the immigrant Filipino women mentioned in Alicia's statement, in the case of HCA, the corporation avoided criminal charges by paying close to $2 billion in settlement fees. Rick Scott, the CEO of the corporation was forced to step down from his position but was never personally charged with any wrongdoing. Instead, he went onto become the governor of Florida and has been in this position since 2011.

This example emphasizes the enormous inequity in power and influence of large corporations who find themselves above the law while specific ethnic businesses are marked as *criminals*. The meanings placed on specific ethnic groups emphasize the contradictory tensions surrounding immigrant labor in the United States. These racialized sentiments can be connected to a larger, elusive web of dominant sociocultural meanings around immigrant labor in general and immigrant ethnic entrepreneurship specifically.

Anti-immigrant rhetoric has long been rooted in an individualist, ahistorical argument that blames immigrants (both undocumented and documented) for certain social "ills" of this country. They are accused of taking away American, native jobs, depressing wages, abusing the health care, educational, and welfare systems and not paying taxes. However, there is an inherent paradox within this type of conventional ideology that simultaneously supports both nativism and a free market, neoliberal agenda. However, it is important to emphasize that the majority of immigrant Filipino women owned businesses in my study are situated within the secondary market and their major reliance on fixed government subsidies is particularly salient. This phenomenon not only illuminates the limits of their mobility, but that they operate in an "unfree"

[52] http://www.justice.gov/opa/pr/2003/June/03_civ_386.htm Retrieved July 11, 2014

market and do not operate under the auspices of a supposed "free" capitalist market. Also, the celebratory notions around neoliberal policies leading to 'liberalization' and 'free markets' is in fact misleading because it masks the reality that markets are not 'free' but rather dominated by powerful institutions whose main objectives are the pursuit of more profits including the exploitation of cheaper labor forces from less 'developed' countries (Portes and Böröcz 1989, Sassen 2008, Wallerstein 1984).

The contentious social interactions with state and federal officials are often remiss of the critical understanding that labor migration patterns are historically engaged in U.S. imperialism and the recruitment and exploitation of cheaper immigrant labor forces. Specific to the immigrant Filipina nurses in my study, the U.S. intentionally recruited these nursing professionals to fill the frequent *shortage* of medical personnel in their nursing homes, hospitals and health organizations (Choy 2003, Espiritu 2003). They served as a cheaper, more flexible, gendered and racialized labor force for the U.S. health care industry (Choy 2003, Guevarra 2010). My findings were consistent with these assertions whereby many of the respondents reported that when they first came to the U.S., they worked undesirable work shifts, received lower wages and filled hospitals and nursing home positions located in urban/poor cities and desolate areas that their native counterparts were adverse to taking. Structurally constrained within these contradictory social conditions that are intertwined with gendered, racialized and class-based tensions, the Filipina immigrants in my study agentically accumulated social, cultural and financial capital to become more entrepreneurial. However, there is a major distinction in perception between conventional, native entrepreneurship and relegated, immigrant ethnic entrepreneurship.

Different Meanings Around "Entrepreneurship"

The notion of "entrepreneur," "entrepreneurial spirit" and the development of "small businesses" are part and parcel to America's prevailing sociocultural narrative around individualistic, "self-made" success in the "land of opportunity." In general, an entrepreneur is defined as a "person who starts a business and is willing to risk loss in order to make money; one who organizes, manages, and assumes the risks of a business or enterprise."[53] Universities across the country characterized mainstream entrepreneurship as start-ups based on new technologies and patented ideas funded by venture capitalists.[54] This type of entrepreneur carries very positive meanings as innovators and is touted as the visionary leader of the future. In fact, a 2013 Kauffman report featured in Bloomsberg Businessweek showed that back in 1985 there were only 250 college courses that taught entrepreneurship. In 2008, they found that approximately 5,000 courses were offered in two and four year college institutions. By 2013, the report found that there were over 400,000 college students who took entrepreneurship courses and 9,000 faculty members who taught them each academic year.[55]

However, immigrant ethnic entrepreneurship is not captured by mainstream news feeds and instead are defined and viewed very differently from U.S. conventional entrepreneurship. Aldrich and Waldinger (1990) argued that ethnic enterprises are part of another market 'niche' that included developing a business in poor urban areas and inner city communities that large mainstream businesses avoid. Therefore, opportunities emerge for immigrant groups to open up businesses such as grocery stores, drug stores, nail salons and restaurants that larger mainstream

[53] http://www.merriam-webster.com/dictionary/entrepreneur Retrieved on June 3, 2014
[54] Various universities throughout the country such as Harvard, MIT, Stanford, UCLA and USC provide entrepreneurship courses and degrees. Their websites predominantly focus on entrepreneurial ventures based on new innovations in science, engineering and technologies.
[55] http://www.businessweek.com/articles/2013-08-08/entrepreneurship-education-is-hot-dot-but-too-many-get-it-wrong Retrieved June 6, 2014

businesses choose not to invest in. Sociologists argued that the development of immigrant ethnic entrepreneurship was a way to create and protect economic spaces for ethnic groups that have been marginalized and sought further opportunities for upward mobility for themselves and their extended families (Aldrich and Waldinger 1990, Bonacich 1973, Portes and Zhou 1992). Light (1972) and Min (1984) claimed that disadvantages in the labor market led various ethnic groups toward self-employment due to an inability to transfer educational and occupational credentials, language barriers and employer discriminatory practices toward immigrants. Thus, ethnic economies in the form of ethnic niches and ethnic enclaves were developed in reaction to hostile mainstream workplace environments with much fewer options for socioeconomic growth.

However, my findings from Chapter 3 provided another perspective on the initiation of immigrant ethnic entrepreneurship. Specifically, due to the distinctive historical relationship between the U.S. and the Philippines in relation to the development of an Americanized hospital system in the Philippines during the time of occupation (1898-1946);[56] immigrant Filipino women had a high English language proficiency, were able to transfer their nursing education and occupational credentials and agentically utilized gendered and racialized prescriptions and stereotypical views around Filipinos as care laborers and health care workers to become more entrepreneurial in the long-term care industry sector.

In the field of U.S. immigration history though, these types of imperialistic historical accounts and the social structural root causes and motives behind the development of immigrant ethnic entrepreneurship are still barely acknowledged and recognized. Instead, my findings in this chapter uncovered that immigrant entrepreneurship in the U.S. long-term care industry

[56] Specifically, during the rise of modern medicine in the 20th century, white American women nurses traveled to the Philippines to train other Filipino women to become nurses and impose western medical interventions (Choy 2003). Under the guise of international heroism and universal humanitarian effort to save lives and improve health, Western medicine's "power to heal" was used to justify the creation of Americanized hospital training and education systems.

conjured up sentiments of both suspicion and disparagement. These contentious micro-level encounters and the meanings attached to them have become ahistoricized and depoliticalized and displaced the blame of the inequities of a stratified and fragmented U.S. long-term care system onto immigrant ethnic care businesses.

Moreover, I found that respondents did not publicly voice their frustrations as exhibited in the meeting I attended, much less sought any type of legal retribution in relation to the racist interactions with certain state/federal agents. Instead, the majority of the 19 informants had very similar responses to Crespina and Lita's statements where they stated, "…we follow and try to just get along" and "I just let it go." For example, Marina, 60, who owned one adult day care center and two board and care facilities stated, "You know, you're not gonna win if you try to fight against them, you have to just keep to the regulations…and you're okay. If you don't, they…they're in your facility everyday, watching over you!...I don't want that!"

Unlike corporate owned long-term care businesses, these small immigrant enterprises have nowhere near the same types of capital, power or legal representation to protect them, pay out and settle potential lawsuits. As Crespina pointed out earlier, "Licensing can close you down…" and the majority of these immigrant Filipino women invested the bulk, if not all their savings, took out significant amounts of loans from family, friends, lines of credit and refinanced their own homes in order to open their respective businesses. Therefore they were very invested in ensuring that they sustain their small and medium sized enterprises.

Waldinger (1994) and Zhou (1992) described ethnic enterprises as labor-intensive, low-profit unstable businesses that natives avoided due to these very reasons. Nevertheless, this business symbolically represented the potential for providing upward social and economic mobility for their families not only in the U.S., but in the Philippines as well (as discussed in

Chapter 3). Contentious interactions with state and federal agents were a top challenge amongst the 19 respondents who owned and operated government subsidized long-term care enterprises. My findings uncovered that the very fear (real or imagined) of losing their businesses, regardless if the actions by the state and federal licensing officials were unjust or not, maintained their compliance.

Foucaultian (1977) theory on *disciplinary power* emphasizes a structure and system of surveillance that is interiorized to the extent that each person becomes their own overseer. Foucault recognized this type of policing strategy through disciplinary training in various populations found within institutions including prisons, schools and hospitals. The populace, in this case—immigrant Filipina owners were panoptically surveilled through the anxiety and fear of unannounced visits by state and federal licensing officials, social workers and representatives from the state ombudsman's office. Hence, the state has produced "the obedient subject, the individual subjected to habits, rules, orders; an authority that is exercised continually around him and upon him and which he must allow to function automatically in him" (Foucault 1977:227). Through forms of racist and discriminatory intimidation and the fear of losing their businesses, immigrant Filipino owners internalized the panoptic tower and policed themselves. Treated as a "perpetual foreigner," through my in-depth interviews, I found that many respondents acquiesced and complied in the face of discriminatory acts. They reported that they were very concerned about maintaining their license to operate their respective businesses. According to all my respondents, losing their license would mean the loss of years of accumulated savings, defaulting on loans and the overall loss of their livelihood. Within this form of discipline, lies the diffuse power in manipulating a gendered, racialized and compliant ethnic entrepreneurial workforce to

internalize the norms and values that have fostered the continued advancement of a privatized system in the long-term care industry and a retracted welfare state.

Immigrant Care = "Slumlord Care"

Despite extending the privatization agenda and contouring themselves to be "good" citizen subjects, my findings also uncovered that some stakeholders shared similar sentiments to that of state and federal agents. I conducted 18 supplemental interviews with other stakeholders and ancillary providers in order to understand their perceptions of these immigrant-owned businesses in the U.S. long-term care industry (e.g., 4 state behavioral specialists/case workers, 2 state social workers, 2 physicians, 2 state/federal agents, 2 managers of mental health county service agencies, 2 administrator/executive directors of corporate owned long term care business, 1 sales executive of a corporate owned long term care business, 2 instructor of administrator licensing and continuing education courses; 1 immigrant (non-Filipino) owned board and care owner of Haitian Creole descent). They all reported that many of the government subsidized board and care homes in their respective counties are owned and operated by immigrant Filipinos.

When asked, "What do you think of Filipino owned long-term care businesses in the industry?," many mentioned that Filipinos are "very caring," "very patient," "do the dirty work that others don't really want to do" and also alluded to cultural and naturalized traits around taking care of their aging parents as indicative of why Filipinos run these types of businesses. However, I also found that many of the respondents shared perceptions of immigrant Filipino businesses that related to caring less about the residents/patients and more so about making profits and meeting maximum bed capacities. For example, a county social worker, Elizabeth (middle aged Caucasion women) stated, "For many of them, I think this is just, its just a business

for them, they don't really care about the well-being of the clients. They just see it as a business.

" A behavioral specialist/case worker, Richard (middle aged Latino male) mentioned,

Richard: "Many are not trained in taking care of the mentally ill, yeah…some may have a medical field background, but its not just about the medical stuff. Many don't understand the social component, like the, the social and behavioral supports needed and addressing the particular issues of this population…sometimes it's just, it becomes about maximizing beds and not really about spending on making their facilities nicer. I just visited one facility that used to be a board and care that took SSI residents but it was bought out and now it's really fixed up and nice."

Interviewer: Is it corporate owned?

Richard: Yeah, I think so.

Interviewer: Can you still place your clients there?

Richard: A few were able to stay, like grandfathered in...but the rest…I had to find another board and care because they don't accept SSI. It's all private.

Perhaps, the most striking statement was made by a previous owner of private-pay board and care facilities and now worked as an executive director for a corporate owned assisted living facility. This corporation predominantly catered to individuals with various forms of dementia. Prior to becoming an executive director of a large corporate-owned entity, Michelle, (middle aged Caucasian women) previously owned residential homes that she converted to 6-bed board and care facilities for the elderly. She also mentioned that she has known Filipino immigrants to be in the long-term care business industry since the 1980s. When posed the same question, she stated,

"A lot of Filipino families were inundated and still are in the board and care business. Very few of these gals were like me... I had an edge because of my educational background. No language barriers. Did things the right way. I didn't hire any family and do any of those things.…I wasn't like that slumlord, everything was very high end. Beautiful homes, amenities, location..country club style. I don't take SSI residents… don't do any Medi-Cal beds, no subsidized anything."

Michelle's statement points to the unequal relations that persist between women due to the dominant perceptions shaped by cross cutting race/ethnicity, social class, nationality and citizenship cleavages found in U.S. society. Intersectionality as a perspective accentuates the interconnected social and power relations and stratifications between women and the simultaneous, interactive impacts of these various forms of both oppressions and privileges (Collins 1999, Nakano Glenn 1992). Immigrant Filipino women entrepreneurs underwent what Collins described as the "matrix of domination." Collins (2000) described this social phenomenon as mutually intersecting systems where one could simultaneously experience disadvantage and privilege through these combined statuses. Hence, immigrant Filipina women in my study attained upward social and economic mobility through the owning and operating of their own businesses through their different forms of privilege. Yet, they simultaneously experienced the disadvantages of being an immigrant women entrepreneur in a host society that dominantly views them as inferior and their respective businesses as substandard.

In reference to her statement, Michelle alluded to the hierarchies found within the privatized long-term care businesses and insinuated that immigrant Filipino-owned businesses were second-rate in comparison to how she characterized her businesses as "beautiful homes, amenities, location, country club-style." Also, she specifically referred to immigrant Filipino women as inferior in comparison to herself in relation to education, English language proficiency and the hiring of co-ethnic family members. Yet, as mentioned earlier in Chapter 3, my study found that the majority of immigrant Filipino women participants had a college degree and spoke English fluently due to the Americanized school system imposed onto Philippine civil society in the late 19th century. In addition, they are working with much more constrained government subsidized budgets in comparison to corporate owned long-term care businesses and may have to

resort to hiring family members and extended kin who may be more inclined to accept lower wages.[57] Despite such constraints and variations in capital, immigrant Filipino women were viewed by various stakeholders and ancillary providers as doing things the *wrong* way and the meanings attached to immigrant care were substandard and poor and subsequently regarded as providing, what I term— "slumlord care."

Low-Income, Chronic Mentally Ill Population = "SSI"

In my study, I found that this notion of "slumlord care" frequently extended beyond the adverse sentiments related to immigrant Filipino women owners. My findings suggested that certain negative meanings have not only been attached to government subsidized long-term care businesses, but to the kinds of care recipients they provided care services to. The term slumlord is defined as "a person who owns a building with apartments that are in bad condition and rents them to poor people" or "a landlord who receives unusually large profits from substandard properties."[58]

In a supplemental interview with a board and care administrator, Janet (first-generation, U.S. born Filipino women, in her early 30s) of another corporately owned assisted living facility owned by physician investors stated,[59]

"About six-seven years ago, our facility used to be one of those crappy SSI buildings for younger adults, like one of those ARF's, you know, the younger mentally ill…anyway, I just know it had such a bad reputation amongst the board and cares around here! The new owners decided to change it to a facility and got an Alzheimer's and hospice waiver and made it so much nicer. It was such a dump before!"

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[57] In the literature, scholars found that ethnic concentrations within enclaves and niches supplied ethnic entrepreneurs with a pool of co-ethnic low wage or unpaid family labor (Light and Bonacich 1988; Waldinger, Aldrich and Ward 1990; Wilson and Portes 1980). Wilson and Portes (1980) also found that family members might experience the "reciprocal obligation" of working for a family business with little or no pay.

[58] http://www.merriam-webster.com/dictionary/slumlord Retrieved July 7, 2014

[59] In my research, I found that there were first generation, U.S. born Filipino administrators and/or owners. This potential finding points to the perpetuation of this particular care ethnic market niche and economic pathway for first generation children of Filipino immigrants.

Michelle and Janet's statements elucidated that their establishment did not admit any individuals who relied on government subsidies. This was true for most corporate owned assisted living facilities.[60] In other words, they did not admit individuals who were not only considered to be low income and deemed less profitable; but those who had a severe, chronic mental illness. In the industry, I uncovered that "SSI" was a code word used to describe this population and simply referred to them as such. Throughout my interviews, not only did the ancillary providers and corporate owned business administrators/executive directors refer to them in this way, but the immigrant Filipino women business owners as well. For example, in Lita's earlier statement where she stated, "Plus this is SSI. Nobody takes SSI anymore!." However, Lita had a somewhat different perspective from Michelle's viewpoint in that Lita was attempting to make the point that her facility was one of the few businesses that still admitted and oversaw the care of impoverished residents with a chronic mental illness. As Cora, 64, a non-subsidized owner of a board and care facility stated,

"I think the reason why some Filipinos accept SSI because of a lot of competition out there…so a lot of facilities I know they are accepting SSI instead of nothing...nobody. I mean, who else wants them? Who wants to get only $1000? Its mostly...its only like us Filipinos who are taking them anyway."

Such excerpts from both the corporate owned and immigrant owned businesses emphasized varying perspectives and meanings attached to how the chronic mentally ill population has been commodified to the point where they are degraded to just a single label—SSI. Social scientists have long critiqued such negative labeling processes and its consequences (Becker 1963, Lemert 1967). Labeling theory stems from Becker's account of the relativistic term—deviance. Becker argued, "Deviance is not a quality of the act the person commits, but

[60] My data indicated that most corporate owned assisted living facilities provided services to individuals who could privately pay for long-term care and did not accept any form of government subsidies as part of payment.

rather a consequence of the application by others of rules and sanctions to an "offender." The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label" (1963:9). My findings uncovered that once a person was labeled as "SSI" in the U.S. long-term care industry, the reactions of the majority of the participants to this individual was significantly based on this "master status."[61]

Yet, the label inherently disregarded this population's continued marginalization in society, the racialized and class-based dynamics around this disenfranchised population and the types of negative perceptions and conditions that they have endured historically and in more contemporary times.[62] The SSI label also masked the often forgotten, overlooked set of multiple processes that have transpired after the deinstitutionalization of this population as well—including the historical and current displacement of them into skilled nursing facilities (Gronfein 1985, Mechanic and Rochefort 1990., Scull 1985), jails (Schnittker, Massoglia and Uggen 2012), the streets (Mechanic and Rochefort 1990., Phelan et al. 2000) and as my findings uncovered, immigrant owned board and care homes. These particular immigrant Filipino women owned long-term care businesses were situated within the increasingly corporate owned/privatized U.S. mental health system (See Figure 11).

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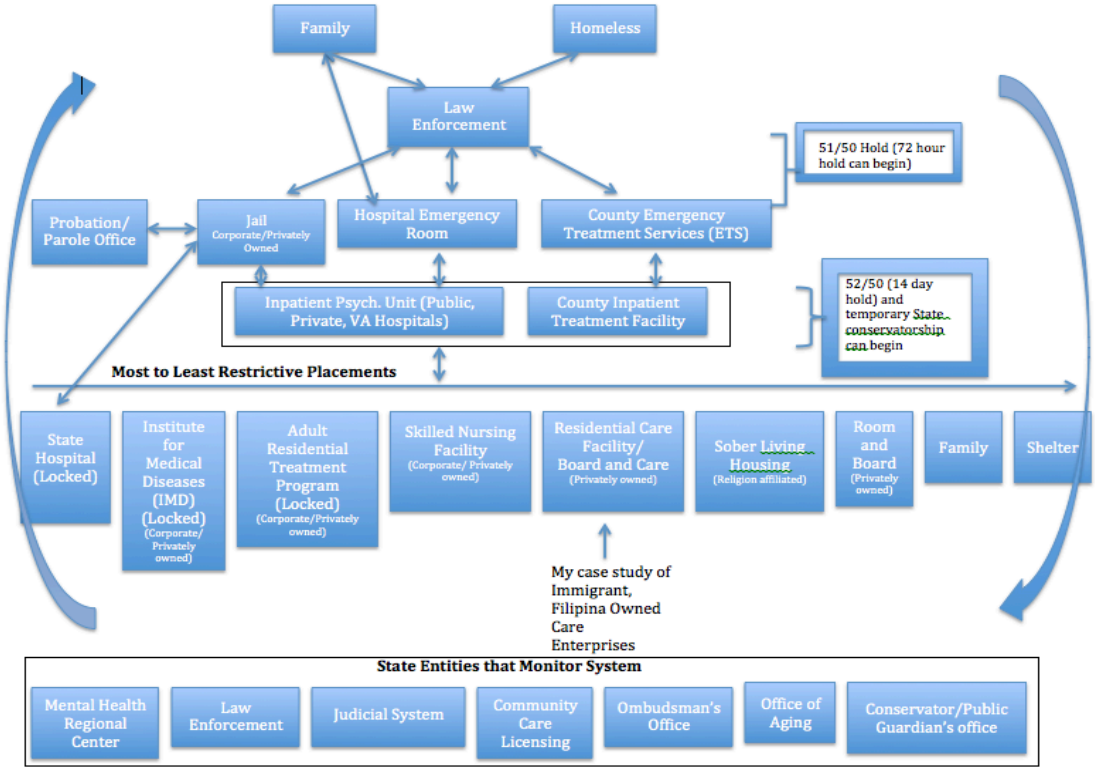
[61] A person's master status is the primary social identity that overrides all others and directly impacts their social (inter)actions, how they are perceived and judged by others (Becker 1963).

[62] My data indicated that in both long-term care businesses where I conducted participant observation, there was an over-representation of racial/ethnic minorities in comparison to the demographic characteristics of the overall U.S. elderly populations. In reference to the board and care facility in Orange County, California where I conducted participant observation, 61% White, 23% Black, 13% Hispanic and 3% Asian which equated to 33% of the elderly residents were racial/ethnic minorities. A home health agency in Los Angeles County, California reported providing medical care to 223 patients and 54% of them were racial/ethnic minorities (42% white, 24% Black, 20% Hispanic, 10% Asian and 4% other).

Figure 11: The Social Organization of a Southern California County Mental Health System



I created an organizational/navigational chart to illustrate the current mental health system and I specifically located immigrant Filipino women long-term care enterprises in relation to the other entities that cared for, housed, confined and treated one of the country's most disenfranchised populations. (I do not extensively describe this chart in my dissertation but plan to do so in a future publication). In the next section, I discuss another significant challenge reported by employers in relation to operating and sustaining their businesses on limited, fixed, state/federal government reimbursement rates.

SECTION III: CONDITIONS OF CARE

Thirty-Three Dollars a Day: Operating on Below Poverty Level Budgets

Given the meanings attached to this "SSI" population in the U.S. long-term care industry, one major implication is that government subsidies have remained meager and have impacted how

immigrant businesses operate. Another major challenge emphasized by the majority of the 19 respondents was the limited government subsidized reimbursements they received in order to operate their business enterprise. For example, one of the nurse participants, Crespina, 62, who owned an 82-bed government subsidized board and care facility for the elderly stated,

"Well we are only doing SSI. There been barely any increase in four years for the residents. We try to do the best we can, but we are limited too and it sometimes can stress you out."

Interviewer: What can stress you out?

"I mean, well you have to worry about so many expenses like the food, supplies, and the monthly bills and not just that, how about the…the property tax, the workers comp and the different insurances for the building…and also the staff, make sure they are paid too. We also have to take care of the upkeep of the building, changing furnitures when they are not good anymore… also...oh and how about the vehicles we use to drive clients to doctors appointments…like that. You see...there's really a lot and you have to make sure you can make it every month."

Another respondent, Marytess, 45, who also owned a government subsidized board and care facility for the elderly stated,

"Trying to fill up the facility and trying to break even because you're only getting SSI...it took us five years to really feel comfortable. Hmm..you're also always trying to be building good relationships with social workers, conservators, doctors, everyone who possibly having a connection to referring clients and just balancing all aspects of the business I guess…like also the marketing, the accounting, the administration of it and just doing all that and at the same time taking care of the clients, and following all the regs. When licensing and ombudsman would come, I'm always thinking, why are they here?! Did I do something wrong?…you know its like a lot of second guessing thinkings, even though you're trying to do all of this and so…umm..its…it can be very stressful too, the behind the scenes to running something like this."

The above-mentioned examples pointed to challenges related to operating on limited, fixed government subsidized budgets. Their revenue and profit is completely based on "filling up the facility" and staying within a meager monthly budget. The majority of their residents had a chronic mental health diagnosis and received SSI and Medi-Cal benefits. These means-tested federal/state benefit programs attempted to provide modest monthly cash benefits and access to health care services for low-income individuals who could not afford to meet the basic needs of

subsistence such as food, housing and medical care. However due to low reimbursement rates, Cora pointed out that very few board and care homes accept individuals who rely on the SSI cash benefit program. According to the California Advocates for Nursing Home Reform (CANHR), "fewer and fewer facilities are willing to take this low payment rate."[63] Similar to a study carried out on the inadequate Medicaid funding for nursing home care (Seidman 2002), SSI rates may in fact also be lower than the actual costs of providing care in a board and care/assisted living setting.

For example, the U.S. Census Bureau issued an annual public report called the *Income, Poverty, and Health Insurance Coverage in the United States* that provided information on how many individuals and families were living below the poverty threshold in the U.S. This report acted as an official poverty report and served as an initial guideline for determining financial eligibility for various federal programs.[64] The most recent report stated that an individual with no dependents was considered impoverished if they fell below the annual income threshold of $12,119 for those under the age of 65 and $11,173 for individuals over the age of 65. [65] However, research institutions such as the Institute for Research on Poverty at University of Madison-Wisconsin criticized these official poverty measures because the survey did not take into consideration the diverse makeup of households (e.g., unmarried partners, adopted and

[63] Established in 1983, CANHR is a nonprofit organization that primarily advocates for consumers who reside in long-term care facilities such a nursing facilities and board and care homes. http://www.canhr.org/factsheets/rcfe_fs/html/rcfe_ssi_fs.htm Retrieved July 1, 20014

[64] This report is based on the U.S. Census Bureau's American Community Survey (ACS), the largest household survey in the United States. Per year, the ACS surveys 3 million addresses via face-to- face interviews, telephone or mail. The survey provides the country, individual states, countries and districts with social, economic, demographic, housing data.

[65] U.S. Census Bureau. Housing and Economic Statistics Division, "Poverty Thresholds", https://www.census.gov/hhes/www/poverty/data/threshld/ Retrieved June 29, 2014

foster children), nor does it account for various expenses (e.g. taxes, out-of-pocket medical expenses and job expenses) and in-kind benefits (e.g., food stamps, health care, child care).[66]

Since 2010, the Census Bureau introduced the Supplemental Poverty Measure (SPM) annual report to account for some of the variables missing in the annual Income, Poverty, and Health Insurance Coverage report. This report attempted to include tax payments, work expenses and government programs in order to better reflect the social and economic realities of individuals and families. These poverty threshold measures also accounted for basic necessities (e.g., food, shelter, utilities, clothing) and adjusted for differences in housing costs in various geographic locations.[67] The most recent SPM report stated that an individual (without any dependents) who had an annual income below $15,103 was considered impoverished. The report also suggested that despite incorporating for the safety net programs and the higher cost of living, California's poverty rate was still even higher in comparison to other states. In fact, according to the Glasmeier Living Wage Calculator, an individual residing in California without dependents required an annual income of $23,295 in order to meet minimum cost thresholds and afford basic household and living expenses.[68] However, the SPM report did not replace the official U.S. Census Bureau poverty report and did not influence the eligibility for government programs. Instead, the report simply acted as a supplement and provided additional information on current economic conditions and policy impacts.

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[66] University of Wisconsin-Madison's Institute for Research on Poverty http://www.irp.wisc.edu/faqs/faq1.htm Retrieved June 29, 2014

[67] U.S. Census Bureau. Housing and Household Economic Statistics Division, "Supplemental Poverty Measure: Examining the Incidence and Depth of Poverty in the U.S. Taking Account of Taxes and Transfers in 2012." http://www.census.gov/hhes/povmeas/publications/kshort.sea2013.pdf Retrieved June 30, 2014

[68] Calculator created by Ann K. Glasmeier, an MIT professor of urban planning http://livingwage.mit.edu http://blogs.kqed.org/lowdown/2013/07/23/calculating-the-real-cost-of-living-in-calfornia/ Retrieved on July 12, 2014

Thirty-Three Dollars Per Day

Out of the 25 employers in my sample, 14 Filipino women owned government subsidized board and care/assisted living facilities in California (Refer to Figure 3). I found that they operated on an annual budget of approximately $12,036 ($1003x12) per individual resident to provide care and supervision/room and board.[69] They received an average of $33 per day to provide a resident with a shared room, assistance with daily living tasks (e.g., grooming, bathing, toileting), housekeeping, three meals/two snacks per day, medication management, daily activities, medical appointment coordination and daily transportation. In other words, they were operating on a fixed, fiscal budget that was well below the annual poverty threshold level set by both reports by the U.S. Census Bureau. According to the Glasmeier Living Wage Calculator, their budget per resident made up just a little over half (52%) of the overall estimated annual income necessary for an individual to afford basic living expenses in California. Just for a crude comparison, a room at a Motel 6 in San Bernardino County costs between $45-$59 per night. In the same county, it costs $39 to board your pet in a shared kennel and $49 for your pet to be in a private suite per night.[70] Given such constrained budgets, I posed follow-up questions to the immigrant Filipina owners, "How do you make a profit if you are only receiving SSI government subsidized funding?" Crespina, owner of an 82-bed facility stated,

"Well this is how…you can't make it if you only have a 6 bedder, or it can be very hard for you…you will be the owner and caregiver at the same time. You have to have a bigger facility….volume. We are 70 plus residents right now but we're not full, we have some vacancy but we can still make it…otherwise its not worth..."

[69] SSI is a federal program that provides modest monthly cash benefits to those who cannot afford to meet the basic needs of subsistence such as food and housing. Currently, over 8 million individuals who are either 65 or older, blind or have a medically determined mental or physical long-term disability receive this cash benefit. In California, the average monthly benefit is $866.40 and $1003.00 if the recipient resides in an assisted living/board and care facility. Administered by the Social Security Administration, SSI is one of the largest welfare programs in the nation. If an individual qualifies and receives SSI, they are automatically eligible for Medicaid benefits as well.

[70] Made a call to Motel 6 and pet boarding and grooming business in San Bernardino, California to attain rate quotes on August 13, 2014

Aside from volume, many of the respondents stated that they managed their budgets and made a profit by buying various items in bulk such as different foods and supplies at various discount stores (e.g. Food for Less, Costco, Marshalls and 99 cent stores). They bought secondhand furnishings at Goodwill or negotiated deals with discount furniture stores often owned by other immigrant groups. For example, Lita shared,

"We save on our furnishings too. I have been buying beds, nightstands, tables, chairs for the residents' rooms and the dining room from a furniture store over here. The owner is Vietnamese and you know…she gives me good deals because we buy a lot from them. They know us for something like 15 years now. Its very close by here."

The respondents also mentioned that they often asked their employees if they could work over time shifts and they themselves have taken care work shifts as well, especially in the beginning stages of operating their respective businesses. Regina, 43, discussed how she could not afford to initially hire any staff members. Below, she shared some of the challenges she faced when she first opened her 6-bed board and care facility stated,

"When I first opened my board and care in 2006, I remember sleeping on the floor by the door for 2 weeks straight because one of my first residents would wake up in the middle of the night and keep saying "Help me, help me…" But she was confused, physically unstable, so I was afraid she might fall…I told her daughter that it was so difficult for me to care for her but her daughter did not have anywhere else to take care of her because of her SSI. So I took care of her for almost a year. So I was the employer, caregiver, licensee, maid...you name it! Sometimes you know the kids are fighting too and you're in the middle. They only pay 1500 but want best care. Some of them, some of the kids tell you, do your job, that that's--what were paying you for…and they don't even know how hard it is to take care of mom."[71]

Many of the respondents shared similar sentiments around the sacrifices made to sustain their long-term care businesses. Thus, I found that sustainable profits for many of the immigrant

[71] This is an example of a family privately subsidizing the SSI rate ($1003 per month). This particular client and her family paid $1500 for care services, however the majority of respondents stated that they did not receive additional funding from their care recipient's relatives. For example, Crespina asserted, "Maybe we'll have some clients who get some help from family or some type of veterans benefits, a little bit from social security disability, but the majority is SSI."

Filipina business owners in my study was based on volume (e.g., 224-bed board and care facility in San Bernardino was the largest business I was able to locate) and the practice of *self-exploitation,* particularly in the first few years of starting their businesses. In other words, they would labor as the "employer, caregiver, licensee, maid...you name it!," sleep at their respective businesses and accept below poverty level reimbursements that other privately owned entities were adverse to taking. Regina went onto disclose that in 2011 she relicensed her facility to particularly oversee and care for individuals with different forms of dementia because the reimbursements were too low.

"I met another Filipina, she owns two facilities over in Loma Linda, she is like my commadre (confidant, friend) now…we met when we were classmates in one of those administrators' classes…like the one for continuing education, like that. She is the one that really helps me a lot, step by step…step by step! So like the…the different requirements, set up for the rooms, how to apply for different license, like that. She told me how it was much better to have this kind of facility and also, there was a lot of demand now for Alzheimer's. Plus, I mean…you can get much more money from this type of population. But we needed to borrow money first from my auntie because we needed to really make the facility meet all the requirements and make it very pretty to attract those type of residents. Thanks God we were able to borrow because it was getting already so hard for me to manage with only SSI! My golly! But now we are doing so good now, really thanks God!"

In supplemental interviews, I found that an initial, overall general assumption from various informants such as executive directors of corporate owned long-term care businesses, instructors of administrator licensing courses and some immigrant entrepreneurs themselves for the vast difference in reimbursement rates between these populations were because individuals with dementia required different forms of assistance and a higher level of care. This rationale has been used to explain why private businesses charged up to roughly seven to ten times more to care for certain populations. However, one of my immigrant Filipina informants who owned a nonsubsidized business that catered to the dementia population challenged this assumption.

Cora, 64, a nurse and owner of a nonsubsidized 6-bed board and care home that predominantly provided care to individuals with a form of dementia challenged this assumption. She stated,

"I rather have the Alzheimer's patients than those SSI, they pay more, you can command more money. You have to do the same thing to them even if they pay 500 and the other pay 2000. You have to do the same services. I mean…there's really not much difference.

Interviewer: How so? How is it the same?

"What I mean to say is you have to clean them, feed them, groom them, take them to doctors appointments, give medications, make sure your facility is always clean and presentable, deal with licensing, etcetera, etcetera...right?...so you might as well get paid more! Because whether someone is paying $1000 or $3000, you have to provide the same care, you can't have favoritism or provide better care to another person. The ombudsman, everybody is looking at you and can report you if you give a different kind of care to somebody. So that's why I rather just go with the Alzheimer's and just private patients....you're providing the same care so why should I go for SSI?"

Cora has owned her board and care home business since 1990 and made the claim that her business provided similar care services in comparison to businesses that catered to the chronic mentally ill population. From her point of view, one is mandated by the state to provide equivalent care services regardless of reimbursement rates. Regina and Cora were two of the four respondents in my study who owned private pay board and care homes. For all of them, it made fiscal economic sense to provide care to the dementia population in order to attain more revenue. From my research, I also found that the geographic location of the facility mattered (e.g., in or nearby affluent cities versus less affluent, lower income areas). Additionally, since they were now competing with corporate owned facilities that also catered to this population, the respondents stressed the importance of ascetics of the facility in order to attract higher private paying care recipients.[72]

[72] These findings pointed to the variation in capital found between inter-ethnic Filipina business owners in respect to purchasing property in a certain geographic area and/or remodeling their facilities in order to attract a certain clientele.

According to Alicia, 74, an owner of a home health agency, "SSI pays nothing, what can you really do with 1000 per month? Now there are more Filipinos trying to open up the ones for Alzheimer's, its much better and we work with many of them too." Alicia is alluding to the growing number of long-term care businesses that are providing formal care services for this particular population. In fact, in the public meeting I referred to earlier, one of the licensing agents stated that their department had approximately 75 pending applications for assisted living/board and care businesses requesting dementia and hospice licensing permits and no new applications for those facilities that cared for government subsidized individuals with chronic mental illness. In the meeting, the licensing agent mentioned that she found that private pay facilities charged anywhere from $1800-$5000 per month and when they have a 6 bed facility, "people want to get the biggest bang for their buck."

Yet, if in fact both types of businesses were providing similar types of care services, this begs the question of whether there were other contributing factors that accounted for their spatial segregations (e.g., different facilities that catered to different diagnoses—mental illness versus dementia) and the vast difference in how these populations were commodified. In the next section I provided possible explanations for these forms of stratification occurring in the U.S. long term care industry.

SECTION IV

HOW THE SOCIAL CONSTRUCTION OF "DISEASES" STRATIFY THE U.S. LONG TERM CARE INDUSTRY

The Role of Biomedicalization

In order to further explore this question, I conducted a supplemental interview with Celina, an immigrant Filipina psychiatrist who graduated from the Philippines in 1974 and has been practicing in the U.S. since 1991. She was contracted with both corporate owned nursing convalescent facilities and co-ethnic board and care facilities to provide outpatient psychiatric services to care recipients.[73] I asked her, "Why do you think the chronic mentally ill and dementia populations live in different facilities? She asserted,

"Hmm…well its their perception and the, the care. With the schizophrenic they are more onto their own care, onto their mental health. But the Alzheimer's cannot process. Its more of their affect and the behavior plus the condition for the chronic mentally ill. For the Alzheimer's, its their ADLs first before their, that they cannot handle, that's why they have to be placed. Because they cannot handle their everyday living situation, that's #1 for them. And then, their behavior has to be controlled, then their cognition."[74]

In this statement, Celina claimed that the focus of care was different. In relation to "mental illness," controlling and treating the symptoms took precedence whereas the care for individuals with Alzheimer's revolved around assistance with daily living tasks. I went onto also

[73] In chapter 3, I discussed my findings that co-ethnic as well as other ethnic minority physicians and pharmacists (e.g, Indians, Armenians, Koreans and Chinese) would develop business relations with the Filipina owners of board and care homes entrepreneurs in my study in order to attain and secure patient referrals as well. Thus, they mutually benefited from these business relations that cultivated reciprocal obligations and reliance between these co-ethnic and intra-ethnic social network of business owners and health care providers.

[74] Affect in clinical terms is defined as "the external expression of emotion attached to ideas or mental representations of objects" http://medical-dictionary.thefreedictionary.com/affect Retrieved August 25, 2014 ADL's refer to activities of daily living that typically include bathing, grooming, feeding, toileting, lifting, assistance with ambulation and companionship.

ask her about whether she thought immigrant Filipina owners provided similar care to both populations. She contended,

"It's not similar care, the level of care is more in that type of patient. Like you know, you have to watch them 24 hours that they have, they have, they're safe. With the chronic mental illness, they might be hallucinating and everything, but in a way…some of them will be defiant if you bathe them because part of their skin is part of their illness, they are dressed in layers but they are protecting themselves actually...the schizophrenics. But then as the ADLs go for the other person, they just don't process their thoughts anymore or even the, the level 4 diagnosis of the Axis 2 diagnosis, the mentally retarded, people who are chronically deficient in their brain too. All they know is to eat and sleep, you know. But the chronic mental illness, they're onset is younger, where dementia patients, its much later. Also, the chronic mentally ill, they think what their perception is the right thing, that's their delusions...but that's their rights."

In the previous section, co-ethnic immigrant Filipina owner Cora utilized a clinical measurement scale of care and applied more of an ADL/IADL task oriented perspective to describe why both populations had similar care service requirements. On the other hand, Celina framed her explanations based on the divergent behaviors of these two populations and their symptoms and dysfunctions that required treatment in order to control them. Nevertheless, both Cora and Celina applied a medicalized lens that reduced the care of recipients to tasks or symptoms to justify why individuals with dementia versus mental illness required similar or different types of long-term care services and board and care placements.

Sociologists framed the concept of *medicalization* in order to theorize the process that occurs when medical terms are used to describe human conditions and behaviors (Conrad 1975, Conrad 2007, Freidson 1970, Szasz 1974, Zola 1972). As a result, humans are reduced to a particular disease and subjected to medical inquiry, diagnosis, labels, specific treatments and interventions. Sociologists utilized the medicalization concept to elucidate how medical knowledge, authority and jurisdiction (rather than religion or law) was increasingly applied to human conditions and behaviors that were not self-evidently medical or biological (e.g., mental

illness, dementia, aging) (Bury 1986, Conrad 1975, Estes and Binney 1989, Fox 1989, Illich 1976, Scull 1984, Zola 1972).

Scholars also argued against the predominant notion that illness and disease were essentially inherent in any specific behavior or condition. Instead, these scholars criticized notions of objective medical science and knowledge and emphasized that definitions are based on subjective social judgments and social norms. Sociologists argued that mental illness and dementia were subjectively experienced and linked into a system of social relations, social organizations that have varying social consequences (Brown 1979, Chaufan et al. 2012, Mechanic and Rochefort 1990., Phinney and Chesla 2003, Scull 1985). Hence, these medicalized knowledges subjectively influenced the collective meanings and symbols attached to human conditions that are now viewed as diseases and labeled as such. For example, the label of disease may assign a stigma to the individual being labeled, exacerbating the person's life experiences as "diseased" or "sick." In addition, social scientists examined the power and role of various stakeholders such as doctors, allied health professionals, insurance companies, pharmaceuticals, advocacy groups, government entities, financial institutions and private investors in perpetuating the medicalization process (Becker 2007, Conrad 2007, Ehrenreich and Ehrenreich 1971, Navarro 2003, Quadagno 2004, Szasz 1960, Zola 1972).

Biomedicalization captured the intensification, reconstitution and reorganization of these medicalization processes in today's society and its institutional infrastructures due to the integration of computer and information technologies and innovations (Clarke et al. 2003). A part of this theoretical framework is used to investigate the consequences for populations and individuals whose self-identities become increasingly biomedicalized to the point where their life changing decisions hinge on this dominant paradigm. Increasingly, humans are analyzed from

sub-cellular levels and new technologies focused on genetic and molecular variations are used as prevailing explanations for their health and illness.

Today, biomedicalization processes are also occurring in the U.S. long-term care industry in relation to the types of research and funding that is allocated. For example, last year, the federal government allocated a record $122 million in new funding for Alzheimer's research to the National Institute on Aging.[75] This allocation was added to the already $484 million in funding for Alzheimer's research from the National Institutes of Health (NIH) for just one fiscal year. In relation to mental illness funding, Harvard University and MIT scientists from the Broad Institute (a biomedical institution) recently announced they received the largest recorded private donation in psychiatric research in the amount of $650 million dollars.[76] The research being funded is predominantly focused on reducing and preventing the diseases and their symptoms. Through using new forms of technology, researchers are attempting to identify certain genetic risk factors for both "diseases" and examining them at the molecular level in order to find and develop new pharmaceutical drug targets.

Yet, while millions of dollars are poured into and invested into these biomedicalized research agendas every year, individual SSI funding for the impoverished mentally ill population residing in long-term board and care facilities has only risen by $10-$11 yearly increments in the last three years (Figure 12).[77] Hence, a kind of "stratified biomedicalization" is occurring whereby "even as technoscientific interventions extend their reach into ever more spaces, many

[75] http://www.alz.org/news_and_events_law_by_obama.asp Retrieved July 8, 2014
[76] http://news.harvard.edu/gazette/story/2014/07/broad_psychiatric_research_gift/ Retrieved July 10, 2014
[77] The Cato Institute has criticized the federal SSI program and the estimated $57 billion in 2013 allocated to impoverished elderly and nonelderly disabled adults and children. http://www.downsizinggovernment.org/ssa/supplemental-security-income. (Retrieved July 22, 2014). Yet, the culmination of all safety net programs account for just 12% of the overall national budget. http://www.cbpp.org/cms/?fa=view&id=1258. (Retrieved July 22, 2014). In comparison, the U.S. defense budget for 2015 is estimated at 1 trillion dollars. http://www.pogo.org/our-work/straus-military-reform-project/defense-budget/2014/americas-one-trillion-national-security-budget.html (Retrieved July 24, 2014)

people are completely by-passed, others impacted unevenly, and while some protest excessive biomedical intervention into their lives, others lack basic care" (Clarke et al., 2003:61). In this case, my findings uncovered that the federal government has allocated below poverty threshold level fiscal subsidies to house, manage and care for a particular sector of the chronic, mentally ill population that may never have access to these new types of clinical interventions. They do not have the kind of private health insurances and/or the income to cover and pay for the high costs of new drug innovations. Such biomedicalization processes are not only more likely to benefit the more affluent sectors of society, but will continue to obscure the social determinants of health and illness and reduce explanations to an even more individualized, subcellular level.

Figure 12: Supplemental Security Insurance (SSI) Reimbursements

Year	SSI Monthly Subsidy paid to facility
2012	$982
2013	$993
2014	$1003

Sources: Social Security Administration[78], Community Residential Care Association of California,[79] California Advocates for Nursing Home Reform[80] and Case Study Respondents

Using Foucault's concept of *Power-Knowledge*, which he believed was a singular entity, we see that modern society has placed such a high prominence on science, technology and medicine and its social construction and dissemination of knowledge formation. Thus, the meanings and knowledge attached through the lens of the dominant biomedicalization *gaze* of mental illness and dementia has defined and pathologized individuals who are unable to verbally

[78] http://www.ssa.gov/oact/ssir/index.html Retrieved July 30, 2014
[79] http://www.crcac.com/9001.html Retrieved July 30, 2014
[80] http://www.canhr.org/factsheets/rcfe_fs/html/rcfe_ssi_fs.htm Retrieved July 30, 2014

interact and communicate one's emotions, thoughts and intentions in normative ways. Accordingly, these views impact how medical practitioners and scientists, deemed experts create discourse and make judgments with exclusive reference to the prevention and management of disease and its symptoms. The biomedicalization of mental illness and dementia and the resulting body of knowledge subsequently coerces the subjective truths, meanings and perceptions routinized into mainstream society.

Such prevailing perceptions emphasize how the tools of biomedicine and habituated social interactions have segregated and categorized these long-term care "disease" labeled populations. My research findings uncovered how these stratified biomedicalization processes have potentially influenced the rationale for long-term care placements (segregated or not) and the reduction of individuals to (dis)similar long-term care need requirements. However, my research findings also uncovered how social class and the biomedicalized onset tied to the notion of "productive" has complicated and further influenced the divergent meanings and symbols attached to dementia and mental illness. In the interview with Celina, I proceeded to mention the cost of care differences between the two populations and asked her, "why do you think there is such a variation in care costs?," she provided this perspective,

"Well it is the part that is related to the connectedness of the people who cares for them…its well, that poor guy, he was the chief C.E.O. and was productive all his life, in the last 50 years and suddenly now he is, he can't even process how to even feed himself, the food is there, but they can't even think anymore, how to…do this and that…you, you have to feed them, they don't even know that they are dressed or not…and it triggers a very different emotional kind of connection…And this is totally different connection than with someone with mental illness, well where some may have never even finished high school because of the onset…and that in a way is because of our society's view of what is acceptable and what is not acceptable. Because by our own development, as we evolve from the agricultural to technology time, the disparity has become so wide."

Celina's statement emphasized how social class and work lives also played into how the two biomedicalized populations that immigrant Filipina cared for were viewed. Specifically, the affluent, "productive" dementia population conjured up emotions of empathy, while the impoverished, "unproductive" mentally ill population invoked apathy. Her statement also pointed to the opposing underlying socially constructed meanings attached to these "disease" labeled populations that may possibly have contributed to the different forms of commodification and the spatial segregation of these populations within the U.S. long term care industry. One major contributing factor included the biomedicalized onset of diagnosis and how this affected their *productive* contributions to U.S. capitalist society.

Celina also emphasized out how individuals living with dementia have most likely developed the disease in the latter part of their work lives or during retirement. They have contributed to the capitalist economic system and were viewed as, "deserving," "productively" integrated members of society who were able to privately pay for care services. On the other hand, she asserted that the onset of mental illness typically occurred much earlier in life.[81] In turn, she pointed out that the various symptoms attached to mental illness have prevented them from integrating into the economic system and therefore could be viewed as "undeserving," "unproductive" members of society who cannot afford to pay for care.[82]

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[81] Celina points to schizophrenia in her excerpt and according to the DSM-5, "The peak age at onset for the first psychotic episode is in the early- to mid-20s for males and in the late-20s for females. The onset may be abrupt or insidious, but the majority of individuals manifest a slow and gradual development of a variety of clinically significant signs and symptoms" (American Psychiatric Association, 2013:102). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) is the official manual for clinicians, researchers, patients and insurers (American Psychiatric Association 2013). The DSM categorizes and legitimates various characteristics, behaviors and syndromes and provides official diagnostic definitions for all mental disorders. The latest edition includes over 300 different psychiatric diagnoses for which psychiatrists can prescribe pharmacological drugs and provide medical treatment.

[82] In terms of schizophrenia, according to the DSM V, the diagnostic criteria are a constellation of behaviors and symptoms that primarily include delusions, hallucinations, lack of emotional expressions, catatonic behavior and disorganized speech (American Psychiatric Association 2013:99).

Furthermore, Regina and Janet (quoted earlier) provided additional perceptions around the spatial segregation of these two biomedicalized populations. Regina asserted, "You can't mix them too because families don't want this, they don't want their relative to be with the SSI! Plus licensing don't allow it either." Janet emphasized various stereotypes placed on the two different populations in her statement,

"As the administrator, I've been continuing to change that bad reputation. Now we're all-private and only take in, you know…grandmas and grandpas…which is so, so much better than those SSI's. I heard it was so filthy before too, they brought drugs in and…hmmm…I don't know…all sorts of bad things were happening. So then I also heard they were closed down. I'm sure the previous owner didn't care and just let it get so bad so he just sold it and my bosses fixed it up and converted it to Sunshine Village Assisted Living."

These public perceptions of "SSIs" as drug users and that "families don't want this, they don't want their relatives to be with the SSI!" kind of attitudes speak to how the stigmas (influenced by the biomedical model) that still surround the mentally ill population in general. However, the stigmatization is intensified due this particular long-term care population's reliance on welfare subsidies versus private funding. The concept of stigma is derived from the Greek language that was adopted by sociologists such as Durkheim and Goffman to describe those individuals who exemplified poor or bad moral character. Sociologist Durkheim (1893, 1964) adopted this term to emphasize how stigma was used as a social mechanism to delineate a boundary between the normal and the deviant. Sociologist Goffman (1963:13) also used stigma to describe "an undesired differentness" and that stigmatization occurs when an individual has an characteristic or attribute that is socially viewed as "deeply discrediting."

The stigmatized person becomes inferior or even viewed "not quite human" to the point that it legitimates the discrimination (Goffman 1963:5). Goffman distinguished three types: stigmas around extremist political and religious beliefs and socially subordinated racial/ethnic

and gender groups; flaws of individual character such as mental illness; and defects of the body. He argued that stigmatized individuals were socially constructed as serving symbolic or tangible threats to an individual or a culture, including physical, moral, and health threats. Thus, Goffman (1963:15) claimed that those socially viewed as "normal" constructed "a stigma theory, an ideology to explain the person's inferiority and account for the danger the person represents."

An extensive examination of U.S. public attitudes on mental health between the years 1950 and 1996 uncovered that "the proportion of Americans who describe mental illness in terms consistent with violent or dangerous behavior nearly doubled" (Pescosolido et al. 2000:3). Correspondingly, the overwhelming majority viewed individuals with mental illnesses as a potential violent threat toward themselves and those around them (Pescosolido et al. 1999). The President's New Freedom Commission on Mental Health reported that, "Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care"(New Freedom Commission on Mental Health 2003:4).

Thus, previous research and my current study emphasize the ramifications of how the biomedicalization of these two populations have led to dichotomous, hierarchical meanings which in turn have had profound impacts on how these two populations were viewed (ie. productive/unproductive, competent/incompetent), treated (e.g., spatially segregated, reduced and viewed as diseased bodies that needed different forms of care services) and commodified (e.g., private/public) within the U.S. long term care industry. French sociologist Bourdieu's conception of binary symbolic forms of classification in *Distinction*, asserted that,

"All agents in a given social formation share a set of basic perceptual schemes which receive the beginnings of objectification in the pairs of objects in the most varied area of practice. The

network of oppositions between high and low, light and heavy, free and forced…is the matrix of all the commonplaces which find such ready acceptance because behind them lies the whole social order." (1984, p. 468)

Today we could use this concept as a way to assess the hierarchical relationships of difference that are inscribed within the organizational structures of the U.S. long term care industry. My findings revealed that the meanings attached to mental illness and dementia, influenced by the biomedical model and social class element; conjured up opposing emotional connections and cultural schemes such as productive versus unproductive, competent versus incompetent and violent versus nonviolent that also invoked the bifurcated notion of deserving versus undeserving. In addition, I found dominant stereotypes related to government subsidized, welfare state reliant versus privately funded, wealth reliant care services. Namely, "private" perceived as high-end, expensive and exclusive that has translated to better care services for the deserving. However, meanings attached to "public" equating to second-rate, poor care services for the undeserving. Additionally, prevailing perceptions around the owners of long-term care businesses are inscribed as well. Specifically, corporations provided exclusive, high end care while immigrant ethnic owners provided cheaper, substandard care.

Conclusion

On May 22, 2014, I was invited to discuss my research with an audience from the History and Social Studies of Medicine program at UCLA. Social scientists comprised the majority of the audience and were part of NIMH (National Institute for Mental Health) funded projects related to the historical accounts of the mental health system as well as the study and implementation of current and future programs in Los Angeles County.[83] One of the post-doctoral researchers asserted that these immigrant businesses have had a bad reputation in the

[83] http://histpubmh.semel.ucla.edu/research-partnership/history-and-social-studies-medicine-ucla Retrieved on August 22, 2014

long-term care industry and therefore removing individuals with chronic mental illness from these facilities would be optimal. In other words, immigrant Filipina care businesses represented as part of the "problem" in relation to the current state of the U.S. mental health system.

However, I contest that the development and emergence of immigrant Filipino women care businesses is symptomatic of how the overall current U.S. long-term care industry has been structured and organized within an ever-expanding privatized economic system that is fueled by various contributing factors, including the dominant paradigm of biomedicalization. Utilizing a Marxist lens, Navarro (1980) argued that medicalization processes were directly connected to the capitalist system that utilized medicine to explain health and illness as an individualized phenomenon in order to disguise the underlying root causes of sickness such as poverty and social inequalities.

In addition, after the deinstitutionalization era, sociologist Brown (1979) argued that the driving forces that characterized the mental health system included the fiscal "crisis" of the state and the transfer of fiscal responsibility to the federal government; restrictions on government and insurance reimbursements to predominantly private entities; professional vested interests in maintaining the medical model; private enterprise economies of the nursing home, board and care and drug industries; and the overwhelming power of the profit motive. I agree with both Navarro and Brown and argue that these social forces have only intensified due to the scaled down, subsidiary approach of the welfare state, the ever increasing privatization of the public sector, the deregulation and prominence of globalized market forces, the extension of biomedicalization processes and the prevailing perceptions around individualism over public good and collectivistic thought. In general, my findings uncovered that the long-term industry

and system has become an increasingly bifurcated industry of businesses, care providers and care recipients that mirror the vast income inequalities found in the U.S. today.

However, academic circles that research from the perspective of the quality of care for the "patient," do not significantly consider the implications around the meanings, perceptions of these immigrant labor forces and the conditions under which they oversee and provide care (Aneshensel, Phelan and Bierman 2013; Brown 1979; Estes and Harrington 1981; Flores, Bostrom and Newcomer 2009; Mechanic and Rochefort 1990; Scull 1984). In the care work literature, scholars have provided a macro-level of analysis and have emphasized the impacts of the transnational, market based system and the neoliberal, privatized economy on the current immigrant care labor forces (Collins 1999, Espiritu 2003, Guevarra 2010, Hochschild 2004, Hondagneu-Sotelo 2001, Misra, Woodring and Merz 2006, Mohanty 1991, Nakano Glenn 1992, Parreñas 2001, Rodriguez 2010, Romero 1992, Sassen 2008, Zinn and Dill 1994). Other care work scholars have also focused on the micro-personal relationships, particularly the dynamics around care provider/care recipient and employer/employee relations (Ibarra 2003, Stacey 2005). I am attempting to add to and engage with all these bodies of work by providing a meso-level of analysis that emphasizes how the organization of care has sorted, categorized and segregated U.S. long-term care populations, certain "diseases," businesses and labor forces. The organizational structure has determined the institutions that the care provider/care recipient is situated within and subsequently shaped the interpersonal social relations and meanings discussed throughout this chapter.

Of the 19 government subsidized long term care businesses in my study, I found that the experiences of immigrant Filipino women reflected the challenges and limits of their social, political and economic mobility as gendered ethnic entrepreneurs and their role as state

replacements. The perceptions around immigrant Filipina business owners in the U.S. long-term care industry were influenced by various dominant sociocultural paradigms around immigration, care work, social class and entrepreneurship. Additionally, prevailing biomedicalization processes around the populations that they oversaw and cared for, in this case, the impoverished "mentally ill" population in comparison to the affluent "dementia" population, not only influenced the perceptions and the meanings attached to them, but how they were commodified as individualized units of sale and deemed profitable or not profitable enough. In turn, all these social processes have directly impacted the human (inter)actions amongst care providers, care recipients and those around them (e.g., state/federal agents, social workers, family members, etc..) that occur within and around the U.S. long term care industry.

Yet, the meanings and the conditions of care attached to the vulnerable, disenfranchised populations and their displacement into immigrant owned long-term care businesses were not due to a series of random outcomes but rather were the result of intersecting and recurrent patterns of inequalities in the United States. The on-the-ground tensions that mirror these disparities, perpetuate certain meanings and perceptions that supersede and shroud the necessary, more difficult, complex critiques around how the structure and organization of the U.S. long term care industry has created such consequences. Instead, the U.S. maintains a long tradition of attempting to resolve its social "problems" by creating a market and manipulating government policies to subsidize private entities. My findings elucidated the direct effects and conditions of this tradition and the stratification and concomitant intertwining of various inequalities and oppressions that have been created within the private sector of the U.S. long term care industry—particularly the resultant outcome of how a gendered, racialized, cheapened immigrant labor

force has become a major overseer of the long term health and sickness of an impoverished, discarded population for the last 40 years.

The state has not only shifted the responsibility, but simultaneously displaced the blame that has kept the focus off the failures of the state to directly provide social welfare and social protections to some of its most marginalized citizens, made even more vulnerable due to the consequences of today's privatized social order. Instead, the state has made attaining an administrator's license almost as easy as attaining a real estate license in the U.S., but with very different implications. As immigrants attempted to seek upward mobility and attempt to be "good" citizen subjects, they utilized their prescribed gendered, racialized, cheapened care market niche and abided by the dominant notions of "success" through entrepreneurship, they have instead become the scapegoats by other stakeholders and ancillary providers in today's current U.S. long-term care industry in their role as state replacements. The accountability of the state to provide long-term care services is further shrouded and made that much more indiscernible. Instead, immigrant care businesses have become one form of a defacto mental health institution with some facilities reaching bed capacities above two hundred. They currently serve as one of the new gatekeepers after the deinstitutionalization era to not only eradicate from public view a socially stigmatized population considered "unproductive," "dangerous," "incompetent" and "undeserving,"[84] but also contain and isolate them from other "disease" labeled populations (i.e. dementia) considered more "deserving." Immigrant Filipino women

[84] During the Age of Confinement that began in the 17th century, Foucault (1965) argued that society's openness toward the mad was overwhelmed by Christian critiques and men began to confine and repress the mad. Midefort (1995) provided a synopsis of Foucault's arguments and pointed out that Louis XIV in France during the Great Confinement tried to remove begging from public view by confining the poor in general hospitals. In exchange for light labor, the poor would receive food and basic care. From a Marxist perspective, Foucault observed that the new bourgeois order and their virtues around work began to dominate society. Madness was now viewed as a form of immorality and lack of "good" virtues around their disinclination or inability to work. Their confinement was justified by this lack of qualities that rational and moral men possessed.

care business owners are held primarily responsible and perennially cited in violation by state and federal workers for not only being able to provide "good," "quality" care on below poverty level budgets, but are also socially stigmatized as providing "slumlord care" by a society for doing the type of labor that nobody else wants to do. In the next chapter, I discuss how immigrant Filipino women employers perpetuate this vicious cycle underscored by the growing privatization of the long term care industry and the retraction of the welfare state and subsequently displace various forms of exploitation onto their co-ethnic workers.

CHAPTER FIVE

MOBILIZING ETHNICITY:

EMPLOYER RELATIONS WITH CO-ETHNIC EMPLOYEES

In the ethnic entrepreneurship literature, previous scholars have framed employer-employee relations in two major ways-- from a paternalistic standpoint (Portes and Bach 1985; Portes and Manning 1985; Portes and Zhou 1992) and a more exploitative perspective (Bonacich 1973, 1987). Portes and his colleagues argue that ethnic entrepreneurial success is rooted within the paternalist relations and reciprocal exchanges amongst co-ethnic employers and employees as well as the support, enforced trust and solidarity of the ethnic community. In contrast, Bonacich provides an alternative perspective and emphasized how immigrant business owners utilize such mechanisms to obtain labor cheaply and that such enterprises are in fact part of a larger brutal system of exploitation.

My study adds to these scholarly debates by underscoring the role that *employer perceptions* play in hiring co-ethnics and shaping employer relations with their employees. Across the ethnic entrepreneurship literature, studies on how ethnic employers' perceptions impact employee relations are largely absent. The lack of scholarship may be due to the fact that ethnic owned businesses were archetypically once considered small "mom and pop" enterprises comprised of mostly unpaid family members that made up the majority of their employees (Dallafar 1994; Lee 2002; Light 1972; Min 1984). More recent studies have emphasized the growth of the ethnic economy that increasingly employ non-familial, co-ethnic and intra-ethnic labor forces (Bao 2001; Chin 2005; Dhingra 2012; Eckstein and Nguyen 2011; Kang 2010; Verdaguer 2009). Nevertheless, few studies have examined employer perceptions of their

employees and how such views influence employment processes (e.g., hiring practices, working conditions, labor protection standards) (Chin 2005).

Immigrant Filipino women employers asserted that employee relations and finding "good" employees is a top challenge of operating their respective businesses (first mentioned in Chapter 4). The preferred solution of many is the same: they prefer to hire co-ethnics. They attribute their preference to their perception of co-ethnic staff as inherently *more* sacrificial, hardworking and caring than other racial/ethnic groups. Hence, one significant finding I uncovered in my study is the central role the *politics of ethnicity* play, specifically the process by which employers strategically utilize particular ethnic stereotypes in order to extract labor from their co-ethnic employees. In my interviews, I found that employers engage in this process that I term, *mobilizing ethnicity.*

Mobilizing Ethnicity emphasizes how ethnic employer perceptions foregrounded by certain ethnic stereotypes serve as a central mechanism for the simultaneous mobilization and exploitation of their co-ethnic workers in order to maximize profit.[85] The mobilization of ethnicity occurred in three salient ways including 1) the use of co-ethnics as "walking billboards" 2) evoking familial and cultural dynamics such as Filipinos being inherently born with particular caregiving abilities and 3) inciting "utang na loob," meaning indebted relations whereby employers would provide various "favors" such as covering health care costs in order to gain employee loyalty despite receiving low wages. In addition to foregrounding co-ethnic workers as innately more hardworking, sacrificial and caring; they also emphasized other particular ethnic stereotypes including the view that Filipinos are *naturally* compassionate, patient, reliable and loyal.

[85] It is important to note that such ethnic constructions are also indeed gendered. However, in my interviews with employer respondents, I found that they used certain ethnic notions to describe Filipinos and Filipino culture in general.

In the results that follow, I first provide a general overview of the labor structure of the workplace, describing similarities and distinctions across different types of long-term care businesses. In the second section, I examine employer perceptions of their workers and describe the factors they consider in the hiring process. I also analyze the process by which employers *mobilize ethnicity* and utilize ethnic stereotypes of Filipinos that simultaneously mobilize and exploit labor. Moving past the binary split between Portes and his colleagues (Portes and Bach 1985; Portes and Manning 1985; Portes and Zhou 1992) and Bonacich (1973, 1987) that pervades the literature, the concept of *mobilizing ethnicity* draws from the scholarly works of Ann Swidler (1986) and Michèle Lamont (2002). I specifically draw from Swidler's concept of culture as a "tool kit," showing how employers use cultural traits they attribute as Filipino in worker expectations, and Lamont's discussion of "symbolic boundaries" in order to illustrate the simultaneous process of ethnic distinction that employers do when *mobilizing ethnicity.* Together, these two concepts help explain the process by which ethnic affiliations enable the profit maximization of employers. Lastly, in the third section, I examine the tensions that emerge from the contradictory relationship of employers to their employees as a *co-ethnic* to be assisted and an *employee* to be utilized for profit.

SECTION I

THE STRUCTURE OF THE WORKPLACE

Findings

In relation to the employment process, some basic questions posed during interviews to employers were "Who do you hire?," "How much do you pay your staff?" and "What types of benefits do you provide?" From my data, I found that all twenty-five employers of board and

care homes, adult day health care centers, home care agencies and home health care agencies hired mostly co-ethnic, female professionalized and non-professionalized staff members (e.g., care workers, housekeepers, office managers, nurses, activity coordinators and cooks).[86]

They hire them as either full-time employees, part-time employees and/or independent contracted workers. Someone is considered an "employee" if they file W2 tax forms annually and Social Security, Medicare and income tax contributions are withheld from each paycheck. Here, the employer pays one-half of Social Security and Medicare contributions and carried worker's compensation coverage. The employees' earnings count towards eligibility for future unemployment compensation. The Fair Labor Standards Act (FLSA) also protects employees. Hence, if the employer does not reimburse the employee for wages (minimum and/or overtime wages) earned; the employee could file a complaint to the U.S. Department of the Labor for back wages, attorney fees and court costs.[87] These jobs can be more readily viewed as permanent jobs that are part of an enterprise's established payroll and come with standardized, minimum employment protections and benefits.

Independent contract workers are contracted to perform a specific service and therefore are viewed as impermanent labor. They are hired to work on a short-term and as-need-be basis. As they are not considered employees, they do not receive any form of state protections or employer-sponsored benefits. Hence, employers are not required to pay into Social Security and Medicare on behalf of the worker and no taxes are withheld. Instead, these workers are responsible for filing a 1099 tax form and paying various estimated taxes including self-employment taxes. Their earnings do not count towards eligibility for future unemployment

[86] They also reported that a smaller number of their current professionalized staff members were from other racial/ethnic backgrounds such as white, black, Indian, Armenian, Chinese, Vietnamese, Latino and African American as well.

[87] http://www.dol.gov/dol/topic/wages/backpay.htm Accessed March 2, 2015.

compensation. Historically, domestic workers such as Filipino elderly caregivers who labor in private homes were excluded from federal labor and employment laws and protection and benefit standards. However, in September 2013, Governor Brown signed into law the California Domestic Workers Bill of Rights (AB241). Effective since January 2014, domestic workers such as Filipino elderly caregivers are ensured overtime protections (paid time and a half of their regular rate of pay after working more than nine (9) hours in a day or more than forty-five (45) hours in a week).[88] However, they continue to lack some basic protections such as worker's compensation, usage of kitchen facilities, meal breaks, vacation time, rest periods and sleep provisions.

The Filipino women business owner respondents all reported that they do not provide the vast majority of their workers any form of health care insurance coverage, pension contributions or family medical leave (FMLA) benefits.[89] They are not required to provide health care benefits since all the businesses in my study employed less than 50 full-time employees, the minimum employee requirement of the Affordable Care Act.[90] While the above employment patterns are consistent across various types of facilities, compensations and benefits widely differ among them.

Three Types of Care Workers: Employed, Contracted and Live-In

Given the different types of work forces connected to various long-term care businesses in my study; I summarized my findings and categorized them into three types of care workers: 1)

[88] http://www.dol.gov/whd/homecare/ and http://www.dol.gov/whd/homecare/qa.htm#wage23 Retrieved March 25, 2013

[89] Family Medical Leave Act (FMLA) enables eligible employees to take unpaid, job-protected leave for specified family and medical reasons. The FMLA only applies to employees that work for a private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor. http://www.dol.gov/whd/regs/compliance/whdfs28.pdf Retrieved March 29, 2015.

[90] http://obamacarefacts.com/obamacare-employer-mandate/ Retrieved March 29, 2015.

Employed care workers 2) Contracted care workers and 3) Live-in care workers. I define these groups below and provide a table summary (Figure 13) to more succinctly illustrate my labor force findings. I also incorporate these findings into a previous graph from Chapter 3 (Figure 14) to further show the interconnectedness of these different long-term care businesses and the types of care work forces they each hired.

Employed care workers are predominantly found in mostly all board and care facilities and made up approximately half of the staff of Adult Day Health Care Centers and pay at or a few dollars above the state standardized minimum hourly wage salaries ($9-$13). Under FLSA, they are considered "employees" and receive minimum protections and benefits such as employer contributions to Social Security, Medicare, "back wage" government protections and worker's compensation.

Contracted care workers are mostly made up the labor force of the private-pay Home Care Agencies and Medicare/Medicaid subsidized Home Health Care Agencies. These types of workers also comprise the other half of the staff in the Adult Day Health Care Centers. These workers are both professionalized and non-professionalized workers who are contracted to perform a specific care service (e.g., caregiving, nursing, occupational therapy, physical therapy, social work) and receive no protections or benefits.

In the Home Health Care and Adult Day Care Centers, the employers reported that their contracted workers mostly work part-time and therefore have other positions at other health care related entities. Home Health Care Agency and Adult Day Health Care Center employers also reported that they pay their professionalized care workers a lower salary than other health care settings such as hospitals and nursing homes. However, they were able to attract them by providing more flexible work schedules and smaller care worker-patient ratios. Home care

agency employers reported that they paid contracted live-in care workers a daily wage instead of an hourly minimum wage. Hence, owners reported paying these workers anywhere from $100-$150 per day (24 hour) shift. Length of contracts (e.g., number of days per week) was dependent on the client's needs and the amount of days that they are willing to pay for. Therefore, home care owners reported that contracted care workers would either work for one client or a combination of two or more clients in order to fill up their work-week.

Live-in care workers are found both in home care agencies and board and care facilities and can be further categorized as either *contracted* live-in care workers or *employed* live-in care workers. The majorities of staff for home care agencies are contracted live-in workers and therefore receive no protections or benefits. However, they have recently been ensured overtime pay due to the recent passage of AB241.

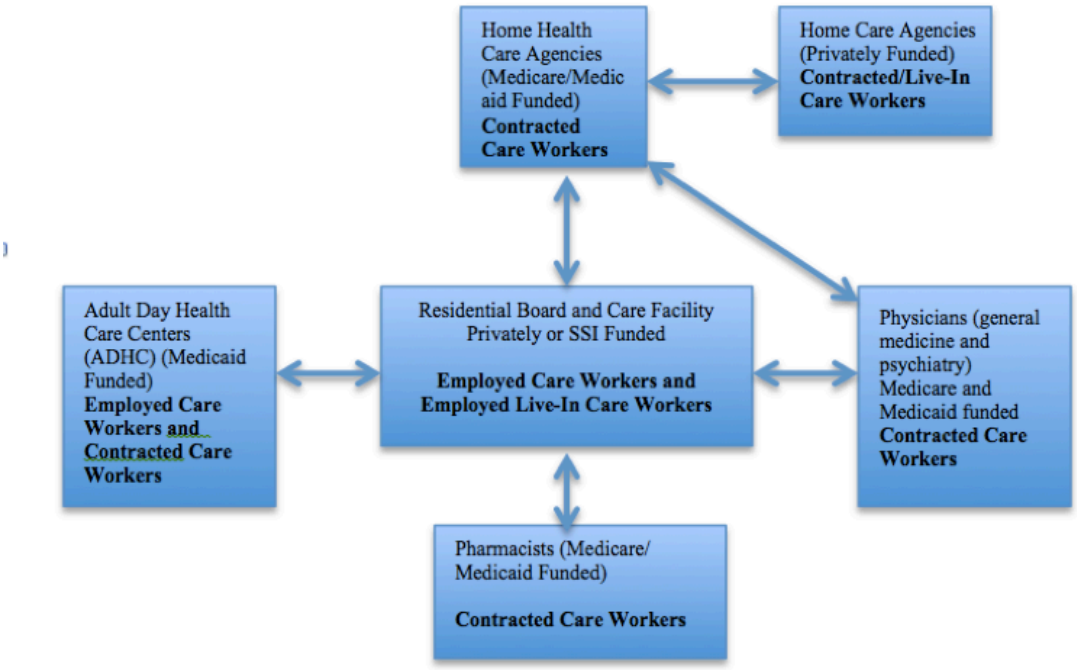
Employed live-in care workers that labor in board and care businesses are considered "employees" and receive minimum wages and minimum protections and benefits. Since they reside in these businesses, the cost of lodging and other facilities are included as part of the worker's wages. The FLSA defines the term "wages" as cash or facilities (e.g., lodging, meals, utilities, transportation). The law permits employers to count the "reasonable cost" of such facilities toward its minimum wage obligations (U.S. Department of Labor).[91] The "reasonable cost" cannot exceed the fair market value of what is provided to the employee and live-in arrangements must be conducted on a voluntary basis.

[91] http://www.dol.gov/elaws/esa/flsa/14c/19a.htm Retrieved April 4, 2015

Figure 13: Long-Term Care Businesses, Type of Care Workers Hired and Labor Protection and Employee Benefits Provided

Long-Term Care Business	Type of Care Worker Labor Force	W2 versus 1099	Employer contribution to Medicare, and Social Security	Worker's Compensation Coverage	Fair Labor Standards Act Protections	Health Care Insurance Coverage Benefits	FMLA	Retirement and Pension Benefits
Board and Care Facilities	Employed Care Workers, Employed/ Live-In Care Workers	W2	Yes	Yes	Yes	No	No	No
Home Care Agencies	Contracted/ Live-In Care Workers	1099	No	No	No	No	No	No
Home Health Care agencies	Contracted Care Workers	1099	No	No	No	No	No	No
Adult Day Health Care Centers	Employed Care Workers, Contracted Care Workers	W2 and 1099	Only for W2 employees	Only for W2 employees	Only for W2 employees	No	No	No

Figure 14: Diagram of the Organizational Structure of Filipino and Intra-Ethnic Enterprises in the Secondary Market of the Long-Term Care Industry and their Labor Forces



Decentralization of the State and the Precarity of Labor

Figure 13 provides an organized illustration of the data that I collected around the labor force. Specifically, I corresponded the type of care worker to their place of employment and the kinds of protections and benefits they received. Figure 14 was first introduced in Chapter 3 and exemplifies the organizational structure within this care market niche and how co-ethnic and intra-ethnic social networks of business owners and health care providers jointly benefit from interconnected business relations and an informal referral system. I slightly altered this figure to include the types of labor forces they hired in order to explicitly illustrate how immigrant Filipino women employers not only extensively interact and network with each other; but also collectively rely on co-ethnic, gendered, cheapened non-professionalized and professionalized care work labor forces in order to sustain their businesses and uphold the secondary market of the U.S. long term care industry. To reiterate, as shown in Figure 13, immigrant Filipino women employers predominantly hire either low minimum wage employees or independent contractors that receive minimal to no labor protections or employee benefits. In other words, the vast majority of these businesses do not provide health care coverage, Family Leave Medical Act (FLMA) benefits, worker's compensation coverage, "back pay" wage protections, contributions to Social Security, Medicare, unemployment, retirement and pension benefits. In addition, the professionalized care workers also receive lower compensation in comparison to their counterparts in other health care-related institutions.

These types of labor conditions highlight the impacts of the *decentralization of the state* and *new* and further entrenched forms of *precarity* occurring amongst care labor forces in the U.S. long-term care industry. In previous chapters, I emphasized how the U.S. has no universal long-term care system and the state has instead outsourced the care provision of some of its most

underserved and vulnerable populations to the market and private enterprise. This form of outsourcing is mirrored in the structure of the workplace and the disintegration of state labor protections and benefits and the outsourcing of employer accountability to the worker.

According to Kalleberg (2011), the work organization and employment relations in the United States (U.S.) have undergone some major transformations in the past four decades. He argues that the combination of globalization, deregulation and ideological shifts toward personal accountability have led to the structural polarization of job quality and the increasing precariousness nature of jobs today. American companies increasingly outsource work to lower-waged countries that have contributed to a crisis for the U.S. middle class who once secured full time jobs with fringe benefits. At the same time, these structural processes have created new sources of workers through immigration. Today's labor forces have become more diverse with increasing numbers of women, immigrants, older and nonwhite workers that now take jobs with minimal levels of formal education required. Thus, today's job markets are increasingly characterized by low-wage, dead-end, jobs, 24/7 work schedules and lack of health insurance and pension benefits that most people would deem as "bad" jobs (Kalleberg 2011).

Kalleberg notably points out that both economic and noneconomic dimensions shape job quality and how we define a "good" job versus a "bad" job. Kalleberg (2011:9) argues that basic objective characteristics that most people would view as a good job and not a bad job would include 1) a wage that is high enough to satisfy a person's basic needs and provide opportunities to increase future earnings 2) provide fringe benefits such as health insurance and retirement benefits 3) have autonomy and control over work activities 4) flexibility and control over terms of employment and 5) have some control over termination of the job.

Similarly, Rogers (2001) argues that temporary work is deliberately both deskilled and devalued. Even if the temporary worker were to demonstrate that they were capable of performing skilled labor, Rogers found that employers were still less likely to hire them as an employee because of temp agency hiring fees and the increase in benefit costs. Also, employers are less motivated to hire temporary workers as employees because they are already providing labor at a comparatively lower rate of pay. Thus, these temporary jobs end up becoming dead-end jobs with no route toward upward mobility.

My findings illuminate the "bad" jobs with little to no possibility of promotion found in the U.S. long term care industry and the precarity of an immigrant care labor workforce who find themselves working with little to no historically standardized state labor protections or employment benefits, simultaneously living and working in the same place of employment and/or contracting with two or more long-term care businesses in order to meet their basic needs. Other scholars have also examined the increasing precariousness of work forces and the emergence of "contingent workers," "new employment contracts" and the increasing employer practice of hiring independent contractors, on-call workers and temp workers (Charness and Levine 2001; Morris and Western 1999; Bernhardt et al., 2001; Cappelli 2001; DiTomaso 2001).[92] The impacts of globalized structural changes and the decentralization of the state have significantly shaped today's workforces that now labor with little to no benefits or labor protections. In the remainder of this chapter, I will demonstrate how employer perceptions foregrounded by ethnic stereotypes also influence employment practices that simultaneously mobilize and exploit co-ethnic labor

[92] The Bureau of Labor Statistics have not consistently accounted for independent workers and the last report that provided some viable statistics was a 2006 Government Accountability Office (GAO) Report that found that these types of workers have dramatically increased in the last twenty years and now make up 30 percent (42.6 million) of the U.S. workforce. http://www.gao.gov/new.items/d06656.pdf Retrieved April 20, 2015

forces, including the perpetuation of suboptimal labor conditions.

SECTION II

MOBILIZING ETHNICITY

Employer Perceptions and the Role of Ethnic Stereotypes

In examining the social processes that employers used to rationalize *why* they hire a particular type of work force; my findings uncovered that *all* immigrant Filipino women business owners in my sample (n=25) utilized ethnic stereotypes to explain their hiring practices. The most popular descriptive adjectives used by respondents to describe their co-ethnic labor force as innately *more* hardworking, sacrificial, caring, compassionate, patient, reliable and loyal. For example, when asked, "Why do you choose to hire Filipinos?," Sharon, 52, nurse who owns residential care/board and care facility for the elderly stated the following,

"Most of them have patience. Filipinos basically lets face it, Filipino tends to be, they tend to be a good care provider because of the fact they like to work in this kind of industry. A lot of Filipinos you could see are nurses because you know, because that's part of being a care provider so basically that's the main issue. Some other nationalities if you look at other nationalities, sometimes they look for pay more so, more concerned about the pay than you know, than what the job is about."

Alicia, 74, nurse who owns a home health care agency stated the following:

"We provide a good care. You know I hear it from so many and I even see it now in my business. When we have a new patients, you know they always request for a Filipino. You know that? Not a white or black, but a Filipino one."

Interviewer: Why do you think that happens?

Alicia: "Well, its because we are very caring and very hardworking!"

Marisol, 35, owner of a home care agency stated the following after I asked her, "Who did you mostly hire to work as care workers?"

"A lot of Filipinos…Mostly women. We have blacks, Mexicans, we have white but you can see the difference….especially even if they have families, they are willing to sacrifice and take the job and willing to sacrifice….this is what I notice with non-Filipino caregivers, most of them don't like live-in jobs. A lot of them want to go home."

Labor Paternalism vs. Labor Exploitation

Portes and Zhou's (1992) central views around co-ethnic employer-employee relations emphasize the role of paternalism and characterize these relations via a reciprocal exchange of benefits and mutual obligations. For example, while employers attain a low-wage, reliable and disciplined work force; employees benefit by learning certain skills to hasten upward socioeconomic mobility, enjoy less formal, flexible working conditions and preferential treatment. According to these scholars, co-ethnic employer/employee relations are characterized by bounded solidarity due to shared cultural backgrounds, common origins and mutual obligations that shape strong ties amongst the co-ethnic community.[93] Portes and Zhou (1992) also assert that a kind of enforceable trust is developed amongst the co-ethnic community that reinforces commonly accepted group norms and standards.

In contrast, Bonacich (1973) notably argues that ethnic owned businesses serve as "middleman minorities" that act as an intermediary between absentee white capitalistic owners and nonwhite urban poor communities. Bonacich (1987) asserts that these types of enterprises are actually a disguised vehicle for capitalist exploitations. Corporate capitalists and large manufacturers ultimately benefit by subcontracting certain franchises (e.g., liquor stores, gas

[93] Bounded solidarity is a kind of social capital in the form of principled group-oriented type of behavior created amongst groups in situational circumstances (Portes and Zhou 1992). By virtue of their foreign status in the U.S. and by being treated culturally different, Portes and Zhou (1992) argued that bounded solidarity could be formed amongst immigrant groups that faced similar forms of discrimination and were unable to attain jobs in the mainstream market.

stations, convenient stores) to immigrant entrepreneurs. They act as the "middleman" and sell the products of major corporations to racial/ethnic minority residents living in these low-income neighborhoods. Due to ethnic entrepreneurs' predominant reliance on unpaid family members and low-wage workers, Bonacich argued that these conditions thwart unionization, lower labor standards and uphold the conditions of institutionalized injustices.

Mobilizing Ethnicity

My data does not fit either of these models. Instead, my findings uncovered the significance of employer perceptions in shaping labor relations with their co-ethnic workers. The ethnic entrepreneurs in my study *mobilize ethnicity* by utilizing certain ethnic stereotypes (e.g., inherently more hardworking, sacrificial, caring, reliable, patient, loyal) in order to subsequently extract labor and maximize profit. They also use these ethnic constructions to frame Filipinos as preferred workers over other racial/ethnic immigrant groups and even white dominant groups to provide care to elderly and disabled individuals. Similar to Guevarra's (2010:125-126) findings, she claimed that Filipino labor brokers and employment agencies in the Philippines market and manufacture co-ethnic Filipino women as inherently suitable to provide domestic/care work and actually market and sell *Filipinas* as trade marked labor. She coined the concept "added export value" to emphasize a racialized form of labor power that is used to construct Filipino women nurses and domestic workers as *ideal*, *superior* and *better* than other workers from other ethnic groups. Guevarra (2010: 127-145) argues that labor brokers and employment agencies play a critical role in hyper-commodifying Filipino women workers and brokering such images to attract employers from wealthier countries.

My findings suggest that such ethnic notions invoke a *cultural sense of collectivity.* In other words, ethnic employers invoke cultural and ethnic stereotypes in order to align themselves

with their co-ethnic workers. These ethnic affiliations allow employers to ultimately maximize the labor of these workers for their own benefit and gain. For example, When asked, "Is there a reason why you tend to hire mostly Filipinos?,"

Carmina, 50, who owned a residential care/board and care facility stated,

"Because, well that's the thing because mostly Filipinos are used to this kind of job. I have an applicant the other day, he's from next door, he wanted to ask for his wife. But the way I see her, she works as a waitress. But first she already told me she's not into diapers and I have clients who are incontinent. So how do you accept, you know? Like that and then umm because the applicants too are well I have some Hispanic applicants too but maybe because I'm used to Filipinos….. I'm also, I'm used to Filipinos…. Its easy, more convenient for us to tell them, "Hey, you have to do this" or tell them their duties, what they're supposed to do for the clients."

Later, in the interview Carmina also stated,

"This is a messy job. Its not a white collar job and why will you hire like whites or others because they don't, whites, most especially they don't like jobs like this. Filipinos are very patient to have a job like this."

These findings do not only emphasize how small capitalists maintain their competitiveness by extracting as much labor from their workers as possible at the cheapest possible cost (Tucker 1978), but they also show how ethnic stereotypes serve as a central mechanism by which immigrant Filipino women employers can more conveniently and strategically extract cheapened labor from their co-ethnic labor force.

Culture as a "Tool Kit"

Swidler (1986, 2001) argues that culture can be viewed as a "tool kit" from which actors select and deploy various elements for constructing "strategies of action." Culture consists of such symbolic vehicles of meaning, including beliefs, ritual practices and informal cultural practices such as language, stories and gossip (Swidler 1986: 273). According to Swidler, an actors' tool kit can include symbols, stories, habits, moods, sensibilities, worldviews as well as social networks and skills. These symbolic forms serve as a mechanism through which "social

processes of sharing modes of behavior and outlook" occur in a community (Hannerz 1969:184). As opposed to simply living within a culture and being passively affected by it, Swidler offers an image of culture as equipment that people strategically use to solve different problems and attain respective goals. My findings suggest that ethnic employers utilize culture as a tool kit in a variety of ways to mobilize ethnic stereotypes and profit from them. These "strategies of action" include 1) using co-ethnics as "walking billboards" 2) evoking familial and cultural dynamics and 3) inciting "utang na loob" reciprocal obligations.

Walking Billboards

Through my interviews, I found that one significant way that Filipino ethnic employers in my study, tactically use prescribed ethnic stereotypes in order to attain upward socioeconomic mobility was by using actual co-ethnic employees' corporeal bodies as forms of *walking billboards* in order to increase their clientele census and secure worker loyalty.[94] This "strategy of action" was particularly exercised by owners of home health and home care agencies in my sample (n=5) that provided services in the care recipients' private homes. When posed the question, "What are some of your marketing strategies to sustain your business?," Four out of the five employers reported that their employees were valuable marketing tools for attracting future referrals from their patient's friends, neighbors and relatives. Since home care workers provide companionship services, employers also reported that another marketing opportunity arises when the home care worker accompanies their care recipient to doctor's appointments, shopping malls, restaurants and other public venues. They reported that strangers approach their care workers and

[94] *Homecare services* provide long-term care clients assistance with their activities of daily living (ADLs) which typically include bathing, grooming, feeding, toileting, lifting, assistance with ambulation and companionship. They can also provide assistance with instrumental activities of daily living (IADLs) such as cooking, finances, shopping and transportation. Home care businesses do not provide any type of medical or nursing care. Many individuals hire a home care aide to continue to live at home.

inquire about services, cost and the name of their agency. Marisol, 35, quoted earlier, reveals how she employs this "strategy of action" in the following way,

"So sometimes we have this, what do you call this, "the best caregiver." Like in everything, you have the best caregiver you have…overall in customer service. Although we don't ask them to know all of the different services, we don't ask them to be our marketers too (laughter) but sometimes it happens. When they are walking their elderly, somebody will approach them, "What's your agency? I need a caregiver." Its nice to know this happens, I just tell them, just give them the number and I'll take care of everything. But we are nice enough to give them referral fee. Although we don't push them to find someone, but we encourage because that's motivation. So when they are walking them it really happens all the time. They don't have to do anything, just give them our number and once we assess and we get the patient then we give them the referral fee. You know the others if you don't offer, they take advantage, instead of giving it to you, they give it to their friends. Plus…we gain their loyalty. They give it to us, you don't have to do anything. We will take care of everything."

Marisol reported that live-in care workers are expected to wear scrubs and work badges so that they look more professional and potential clients could more easily identify her agency. She also reported that the referral fee that she would pay to her care workers was $350. This ethnic entrepreneur utilized very common marketing tactics of requiring workers to wear business logo badges and incentivizing them via referral fees in order to promote her business and grow revenues. In addition, Marisol pointed out that she was well aware of how care workers have attained referrals independently on their own and may subsequently refer one of their own friends in her statement, "You know the others if you don't offer, they take advantage, instead of giving it to you, they give it to their friends." Within these types of more informal business negotiations, Marisol is alluding to an arrangement amongst friends wherein the referring friend often gets a "cut" for helping their other friend secure a job.[95] Hence, Marisol has attempted to intervene and

[95] In a separate study and policy report published with Rhacel Parreñas and Yu-Kang Fan for UCLA Institute for Research on Labor and Employment (IRLE) and Pilpino Workers Center, we found that long-term care workers would learn about various live-in jobs through friends and other informal networks and then would negotiate certain financial arrangements that involved the referring friend receiving a percentage of the wages or a referral fee. http://www.irle.ucla.edu/publications/documents/CanIEverRetirePolicyReportIRLE.pdf Retrieved April 5, 2015.

prevent these types of micro-business practices by strategically enticing care workers with a referral fee and handling all business matters with the future care recipient. This example points to how both the employer and employee strategically use prescribed ethnic stereotypes in order to attain upward socioeconomic mobility. Yet, the employer significantly reaps more rewards.

Through this marketing strategy, the employer is not only extracting labor from her co-ethnic worker in a multitude of ways (e.g., care worker simultaneously providing caregiving services and acting as marketing tool), she also secures their loyalty and increases the clientele census for her home care enterprise. It is also important to emphasize that this "strategy of action" takes place at the expense of the public shame of the worker. From a social interactionist perspective, the body is not a static, corporeal object but rather a social object attached to varying and mutable social meanings.

Waskul and van der Riet (2002:488) asserted that 'a person does not 'inhabit' a static object body but is subjectively embodied in a fluid, emergent and negotiated process of being. In this process, body, self and social interaction are interrelated to such a extent that distinctions between them are not only permeable and shifting but also actively manipulated and configured." As immigrant Filipino women publicly stroll around wealthy neighborhoods with their elderly care recipients as ***walking billboards*** for caregiver businesses, these corporeal marketing social practices have also led to the further entrenchment of the "glaring hurdle confronted by Filipino women and their occupational segregation in care work" (Parreñas 2001:14). In *mobilizing ethnicity*, the employer's usage of the worker's actual bodies as walking endorsements have in turn manipulated, exploited and reduced their transnational experiences into commodified corporeal marketing tools in order to increase their own profit margins.

Evoking Familial and Cultural Dynamics

In my interviews I also found that the majority of the immigrant Filipino women employers invoked specific Filipino familial and cultural dynamics to explain their hiring practices, extract labor as well as justify poor working/living conditions. When asked, "Why do you think Filipinos are predominantly in this business?," The majority reported culture and/or family dynamics as a leading explanation. Marytess, 45, owner of 48-bed government subsidized board and care facility stated, "It's our family values that really helps us really…like really decide to build our business and take care of the elderly, its an extension of who we are. " Nita, 53, owner of privately funded 6-bed board and care home, stated, "Ganyan ang mga Pilipino [That's how Filipinos are], we really take care of our own parents so going into this kind of business is not hard for us. "

Sharon (quoted earlier) also stated,

"It's culture. It's part of our culture. This is, this is part of our custom and basically we do. It's not, you know, where we came from its not, its not common for us in the Philippines to have a nursing home we could just dump our moms and dads there and stuff, we tend to take care of them so and I always remind my employees, imagine this is like your mom and dad."

Previously, Sharon stated that she prefers to hire Filipinos because they are more focused on providing care and less concerned about the pay rate. Coupled with invoking such familial and cultural dynamics and expecting employees to view their care recipients "like your mom and dad," completely downplays employee caregiving skills and accentuates a familial paradigm. Thus, employers perpetuate a dominant cultural narrative that engenders that Filipinos are inherently born with particular caregiving abilities or acquire them through prior familial and cultural socialization versus skills that are learned on the job or through training. Similar to

Collins (2002) findings on the deskilling of racial/ethnic women workers in the garment industry, the naturalization of such skills provide employers with a powerful tool to de-politicalize their co-ethnic workforce's capabilities, undervalue their work and rationalize lower wages. These paradigms are socially constructed via ethnic stereotypes that shape particular discourse, narratives and frameworks that continue to influence how employers perceive their co-ethnic labor force. As a result, care work still very much hinges on deeply held familial and cultural beliefs that continue to devalue and cheapen the care labor of Filipinos.

I also found that Filipino familial and cultural dynamics influenced the types of workplace/live-in conditions that employers provide their co-ethnic workers. As mentioned earlier, all Filipino-owned board and care facilities have previously employed or continue to employ live-in care work staff. In my visits to these businesses, I was able to observe the workplace/live in conditions of such workers. In my sample, I interviewed 25 Filipino employees who worked for co-ethnic employers and 12 of them worked in a co-ethnic owned board and care facility. Of these 12, seven reported that they also resided in these facilities. Three of them claimed that they had a separate, private bedroom in the facility. However, the other four employees reported that they did not have a permanent area designated for sleep. Instead, they showed me that they either slept in a foldable cot in either the office or the storage room, on the couch and even in the garage.[96] In an interview with one of the employers, Regina, 43, owner of 6-bed private pay board and care facility for the elderly disclosed the living conditions of her live-in staff member, she stated,

"I have an employee that does a 12-hour shift and they sleep in the couch and their stuff is in the closet in the living room. Either way because, because Filipinos naman [translated to English means: too or also] we're used to sleep on the floor. So you know, you know, plus, um my family,

[96] Total sample of Filipino care workers equated to 25. They worked in co-ethnic board and care facilities (n=12), home care agencies (n=8), home health care agencies (n=3) and adult day care centers (n=2).

we barely eat in the Philippines like 3 times a day. I mean you are so blessed if you eat three times a day so...plus when I first start my business I am sleeping on the floor too next to the patient door."[97]

Hence, Regina uses old Filipino customs and previous living standards in the Philippines to justify poor labor protections for her co-ethnic staff in the U.S. Historically, Filipinos lived in bamboo houses and slept on the floor made out of soft palm leaves. However, in contemporary times, houses in the Philippines are now made out of cement and mattresses can be found in many of these homes. In the previous chapter, I also asserted that Filipino women employers practice self-exploitation (particularly in the first few years of starting their businesses) in the form of simultaneously working as the employer, caregiver, licensee, housekeeper as well as sleeping at their respective businesses. Thus, the combination of these findings suggests that employers subsequently displace various forms of exploitation onto their employees and use historical cultural customs to justify substandard live-in/workplace conditions.

Inciting "Utang Na Loob" Indebted Relations

Another major strategy that several employers utilized to *mobilize ethnicity* is by inciting a Filipino cultural notion of indebtedness, also known as "utang na loob." The concept "utang na loob" translated and described in English means "debt of prime obligation" and "internal debt of gratitude" (Kaut 1961; Berganio, Tacata Jr., and Jamero 1997). Filipino American scholars have mentioned this concept in their own works and view this sense of indebtedness as a cultural norm and value that Filipinos possess (Manalang 2013; Gonzales 2009; Root 1998). The cultural concept "utang na loob" is also viewed as a cultural system of social interactions rooted in interdependence and mutual support that imposes reciprocal obligations and behavioral

[97] Naman: nam´an particular response marker, also, too, rather, again, on the other hand usually emphasizing the fact or the feeling involved in the expression. http://www.tagalog-dictionary.com/cgi-bin/search.pl?s=naman Retrieved on April 30, 2015

expectations (Kaut 1961; Berganio, Tacata Jr., and Jamero, 1997). According to Dancel (2005:125), it is also a moral force and that "one must fulfill utang na loob because without it, he must bear the burden that is *hiya"* (translated to English as *shame*). More than half of the employers directly referred to obligatory, reciprocal relations that they developed with their co-ethnic staff and certain kinds of expectations placed on them. This was clearly demonstrated in Carmina's (quoted earlier) statement around a "favor" she provided her co-ethnic employee and the reciprocal obligations she expected afterward,

"You know, there is this time I even give a *favor* for a staff, I do them a favor, I help her and her husband before and let them have a room and board, so live in one of the vacant rooms. But then I ask her for a favor, if she can work an extra shift, so-and-so called in sick. Omigosh, can you believe, she didn't want at first?! I mean, I don't expect…but come on!" [Emphasis added by me]

Carmina stated that she provided her employees a "favor" and then became upset when her employee initially hesitated in taking an extra work shift. However, it is important to point out that employers deduct room and board and food costs from employees' wages so it could hardly be viewed as a favor. Also, Carmina more substantially benefitted from having live-in staff members because she now has readily accessible care workers who she could constantly turn to and ask to work more hours.[98]

[98] This excerpt exemplified how co-ethnic immigrant owners of board and care facilities can take advantage of having live-in care work staff by constantly asking them to work extra hours and not fully compensating them for their overtime work. These types of live-in care work arrangements intensified certain vulnerabilities since they resided and worked in the same place. These findings were reminiscent of a feudalistic economy wherein which employees were in some ways bartering some of their labor in exchange for food and lodging. Evidence of bartered exchanges of goods and services were found during the Middle Ages and during the 1930's Great Depression (Simmel 1991; Boyd 2000). Today, *bartered labor* in care work has denoted new and reverted forms of vulnerabilities and constraints found amongst co-ethnic employer-employee relations in a service sector economy that carry evocative strands of lord-serf relations. Though serfs were bound to the land they lived and worked on and could not move away; I found that live-in care workers also felt constrained to live in these board and care businesses because they could not afford to live outside of these facilities and had few other feasible options. These constrained live-in care work arrangements have not only reinforced power differentials and labor hierarchies; but unequal, indebted relations as well.

These relations of indebtedness were also evident in another interview I conducted with Minda (also quoted earlier). Minda proudly discussed her strategy for gaining an employee's loyalty and 10-year tenure at her board and care facility even though her employee was overqualified. When asked, "Have you ever helped any of your employees with immigration matters and sponsorship?," Minda stated,

"Oh yes, we have to help them too, process their papers, we have to loan them money, we have to loan them their fare, you know stuff like that so they come and work for us."

Interviewer: So you did help some of your employees in this way…do you have an example of this?

"Yeah, you have to so that they can stay with you longer. Example, see, I have to tell you! Just like there was nurse in the Philippines who came over okay and uh she got pregnant, she got pregnant in the Philippines and she came over pregnant. She's all alone, she did not have any medical insurance so she didn't have you know, she stayed with me, I got her into see one of my doctor friends! She don't pay, I got her covered from my insurance. And then what happened, she worked for me for 10 years…she had 3 kids already and then I said to her because she's an LVN, she's an RN in the Philippines and I said, "I hate, I hate for you to, you know, I have to let you go because you have a better opportunity out there. You have 3 kids. I was not paying, I was just paying her a little higher minimum wage but she'll make more money working in the hospital. So finally she, she did after ten years…but she didn't even want to leave me because of all the things that I did to her…see that's loyalty right there!"

My findings critique a dominant perspective in the ethnic entrepreneurship literature around reciprocal ties that have often led to the romanticization of such bonds in the previous discussions of immigrant employers. Instead, my findings suggest that co-ethnic employer-employee ties have more significantly led to various relations of indebtedness. Another example that exemplifies this is the following, Alicia, (quoted earlier), also later stated, "I don't mind sponsoring *because it will be to our benefit*. If they can afford it, we will. I really don't mind. I'd like to help." [Emphasis added by me]

In other words, oftentimes, the mobility of the employer is achieved at the expense of the immobility or constrained mobility of their employees. Instead of this notion of "favors," the act of providing live-in/work arrangements, covering health care costs and sponsoring employees actually creates a web of expectations around employee loyalty and laboring beyond their assigned work shifts and responsibilities that more greatly benefits the employer. In turn, these obligations interfered with employees either finding or delay finding more profitable economic job opportunities and the ability to say "no" to their employers out of a sense of "utang na loob," indebtedness and shame.

SECTION III:

I'M LIKE YOU BUT NOT LIKE YOU

"Symbolic Boundaries"

While Ann Swidler emphasizes how culture can be used as a medium to incite ethnic collectivity in order for employers to extract labor through "strategies of action," Michèle Lamont's scholarly work emphasizes how cultural practices can also evoke "symbolic boundaries" and map social hierarchies amongst groups. Thus, culture is always both inclusive and exclusive (DeNora 1994). The term "symbolic boundaries" refers to "conceptual distinctions made by social actors…that separate people into groups and generate feelings of similarity and group membership" (Lamont and Molnar 2002:168). Similarly, Epstein (1992:232) describes this term as the lines that define and include particular individuals, groups and things while excluding others. In my interviews with employers, I also uncovered limits to the ethnic affiliation that they engage with their co-ethnic workers.

White Public Faces

In my study I found that in the initial stages of building their businesses, seven out of the 25 Filipino women employers reported that they hired a white woman manager, activity director or marketing associate to perform as the **"public face"** of their enterprise. They all reported that they engaged in this social practice in order to strategically attract patients/residents, develop business relations with outside vendors and gain more legitimacy as a business. For example, Alicia reported that when she first began her own home health care agency in the year 2000, she hired a white employee to handle the marketing component and develop various relations with local doctor's offices, hospitals and nursing homes who served as potential patient referral sources.

Another owner, Minda, also claimed that when she first started her long-term care business in the 1970s, she initially hired one white employee to assist with advertising and provide activity coordination for the residents. She stated,

"For some reason people who are white, the others you know, the social workers, the others will warm up to them. Of course there's a stereotype! (Laughter) They think that the white one are superior than you. So I hire a puti (white) first, for more of the marketing and activities director. Yeah…but then when she quit then I get a replacement who's Filipino."

Even though Filipino employers utilized ethnic notions to insinuate that their co-ethnic labor forces were preferred over other racial/ethnic groups; this finding elucidates that these workers did not have front stage legitimacy. In other words, they viewed Filipinos as "back stage" employees.[99] Playing off of Goffman's (1959) dramaturgical analysis and his front stage/back stage concepts; Filipino women employers distinguish themselves from their co-ethnic employees

[99] In *Presentation of Self in Everyday Life* (1959), Goffman's discusses the concepts of "front stage" and "back stage" behaviors. He argues that we have two different ways of presenting ourselves. The front stage is reserved for when we are "on" and performing for others while the back stage refers to when we are practicing our performance and letting our guard down.

by not considering them as leaders and supervisors that could also suitably carry out this "front stage" role in the general public audience. This finding challenges Portes and Manning's (1986:56) assertion that,

"…working in the ethnic economy frequently entails the obligation of accepting low pay and long hours in exchange for on-the-job training and possible future assistance in establishing a small business. Hence, employment in the ethnic economy possesses a potential for advancement entirely absent from comparable low-wage labor in the secondary labor market."

My study suggests that co-ethnic employers actively participate in *limiting* the mobility of their co-ethnics and instead hire and align themselves with white "front stage" staff members. The seven employer respondents reported that their white women employees would share the office space and were provided a designated desk to make and take phone calls, greet residents and visitors and carry out daily operations of working as either a manager, activities director or marketing director. Hence, hierarchical distinctions and classifications between the ethnic employer and their co-ethnic labor force are also spatially, visually and cognitively formed (Wagner-Pacifici 2000; Zerubavel 1997).

As Minda pointed out, immigrant Filipino women owners are well aware of the racialized injustices embedded within their own social practices. However, they simultaneously viewed hiring white employees as a strategy to develop and further legitimize their respective enterprises and thus relegated their co-ethnic labor force to "back stage" workers.

As mentioned earlier, Filipino employees served as *walking billboards* and became public marketing tools. However, it is important to point out that a different form of marketing is taking place here in relation to the utilization of the social construction of race. Specifically, Filipino employers used co-ethnic employees' corporeal bodies imbued with prescribed racial/ethnic stereotypes as walking endorsements in order to drum up business at the expense of the public shame of the worker. However, Filipino employers strategically hired white women to further

legitimize and increase the social status of their respective businesses. They utilized white women employees to build referral relations with ancillary providers and other health care professionals that were often white as well.

Those that reported initially hiring a white women employee later stated that they no longer employed these individuals and eventually replaced them with (often cheaper) co-ethnic workers. They claimed that their white employees often left on their own accord in order to pursue more lucrative positions. Nevertheless, in the employer respondents' attempt to develop their businesses and heighten their socioeconomic standing; it was simultaneously done at the expense of inferiorizing and distancing themselves from their co-ethnic labor force. Such cultural practices highlight the limits of the employer's alliance with their co-ethnic workers and exhibited how they practiced boundary making and drew symbolic lines of exclusion.

Contradicting Ethnic Stereotypes

Lines of exclusion in the form of warnings and the firing of staff are also carried out when co-ethnic employees contradict the ethnic stereotypes. Some employers in my study also made contradictory statements in regards to their co-ethnic workers. For example, Florencia, 36, owner of a government subsidized board and care home, explicitly highlighted such tensions when asked, "Who do you mostly hire?"

"Filipinos. Its easier to hire Filipinos, there's a comfort there, their patient with the clients….Most of my staff are still Filipino since the beginning."

However, later in the interview, when posed the question regarding the challenges that she faced as a business owner, she angrily responded,

"My main problem is the staff. The clients are good. I sometimes can't sleep because I can't trust anyone, the staff don't care. I've even caught some of my employees stealing! It was really a bad thing. So now I have a surveillance camera. Also, they're lazy, they don't want to clean. I can see it on the camera. I understand I pay them just minimum wage….but it's a job!"

Crespina, 62, nurse and owner of a government subsidized board and care facility stated,

"Its hard to find a good worker, sometimes I found that they can't wait to get off their shift. They won't stay even after, just to make sure all their job is done. Once its 5:00, they leave. Some, maybe not even 5 yet, they are already gone."

Susan, 72, nurse and owner of a home health care agency also discussed the challenges with her professionalized staff members. In the beginning of my interview with Susan, she touted Filipino women care workers (nurses) as hardworking, compassionate and "good" workers. Yet, in the same interview, she went on to report that instead of taking care of the patient and doing their job, some of her Filipino care workers were "bad" because,

"They do whatever they want to do, especially when we are out…you know the saying…when the cat is away, the mice will play. They go out and smoke, on their cell phone and all that."

When referring to assistance with fiscal loans or sponsoring a staff member to attain permanent citizenship status, another employer, Donia, 65, nurse and owner private-pay board and care homes, stretched out her left arm and used her right hand to create an invisible line of demarcation on her left arm's wrist and stated the following,

"You give them this much…then they will want and ask for this! (Laughter)." At that time, moving her right hand up to where her left-elbow bends and creating a larger invisible line of demarcation. "The minute you give, they will keep asking for more so I don't give any favors or help them anymore!"

This finding reinforces the unequal power dynamics between employer and employees and highlights how employers have the implicit power to praise and complain about their employees at the same time. However, these examples also highlight how employer reported challenges were centered around the times that their co-ethnic employees strayed away from ethnic stereotypes such as acting unreliable (e.g., stealing), not caring (e.g., not putting the patients first and instead on their cell phones and smoking), not sacrificial (e.g., leaving before

their work shift ends) and not hard working (e.g., lazy and not really doing their job). Also, instead of having a sense of "utang na loob," they are constantly asking for more "favors."

When ethnic employers found it challenging to *mobilize ethnicity*, many of the employer respondents reported that they would attempt to employ control mechanisms by initially providing a series of warnings. Also, they reported having a serious talk with their co-ethnic employee to discuss their concerns. If talks and warning did not work, they then would resort to firing them. My findings suggest that replacing workers was not a difficult task. As discussed in Chapter Three, informal social networks served as an integral source for employers to learn more about and improve their respective businesses as well as attain potential patient/resident and co-ethnic employee referrals. Specific cultural and social forms of capital have allowed employers to exercise the social practice of simply picking up the phone and calling relatives, old co-workers and friends in the same business and inquire if they know anyone that was looking for a care work job. Also, they often turned to their employees for referrals as well. In fact, when asked, "How do you find workers?," Minda confidently stated,

"Oh if you are in the board and care business, they come to you, they come to you! You don't even have to advertise, its just a word of mouth, lets put it that way. You can even just talk to your employees and recruit their family members too!"

Thus, these findings suggest that there is a large pool of low-wage co-ethnic workers to choose from. As mentioned earlier, the structural changes in work organization and employment relations have led to the increasing number of low wage, immigrant workers in the U.S. (Kalleburg 2011). Economists Autor and Dorn (2013) found that between 1980-2005, the labor hours in service occupations with low educational requirements and involved assisting or caring for others including home health aides, child care workers, janitors, food service workers, hairdressers and security guards grew by 30 percent after steady to decreased rates in previous

decades. Sociologists such as Sassen (2008) Portes and Borocz (1989); and Wallerstein (1974, 1984) have long warned about the impacts of global economic processes and the heightened demand for services from low-wage laborers in wealthy countries like the U.S. As discussed in the beginning of the chapter, employers reported that finding a "good" worker was a top challenge of running this type of business. Yet, the culmination of my findings exemplified how such challenges are more so based on finding a worker that consistently fit and conformed to certain ethnic stereotypes that they (the employer) perceived and defined as "good" in order to *mobilize ethnicity.*

Conclusion

Situated in the ethnic entrepreneurship literature, I did find some forms of labor paternalism within the ethnic owned businesses in my study (Portes and Zhou 1992). However, I found that majority of long-term upper level positions are most often reserved for family members and relatives (e.g., spouses, adult children, siblings and cousins). Thus, the vast majority of workers remains in their care work low-wage employee and independent contract positions and do not enjoy notable flexible working conditions, preferential treatment, socioeconomic mobility or training. In reference to Bonacich's (1973) work, I also found various exploitative relations in my own study as well. Yet, what remains predominantly missing in the literature and what my findings exemplified was the key role that the *politics of ethnicity* play in employer relations with their co-ethnic work force. Specifically, ethnic perceptions foregrounded by ethnic stereotypes, attributes and customs (e.g., cultural "tool kits") serve as a central mechanism for profit maximization schemes of Filipino women business owners. Employers tout that Filipinos are preferred labor forces over other racial/ethnic groups and are *better* and *superior* in providing care work services. Yet, they also engage in the practice of using their co-ethnic workforces as

walking billboards, conjure familial and cultural dynamics and incite "utang na loob" indebted relations that have led to public shaming, the rationalization of poor labor conditions and the limited mobility of workers due to inequitable forms of indebted relations. Hence, these "strategies of action" simultaneously mobilize and exploit their workers. Further tensions and contradictions occur with ethnic employer's practice of "symbolic boundaries" and the strategic hiring of front stage *public white faces* that reduce co-ethnics to the *back stage*. Therefore, these ethnic practices also emphasized the limits of such ethnic affiliations and the social hierarchies and boundaries that continue to distinguish and separate ethnic employers from their co-ethnic employees. My findings also demonstrated that the majority of workers receive low wages (or lower compensation than their professionalized care work counterparts), little to no benefits and are exempt from various labor protections. I also found many of the care workers in my study labor multiple jobs or live and work in the same place of employment in order to meet their basic needs.

Hence, these findings also exemplify the impacts of the *decentralization of the state* and the multiple *patterns of outsourcing* that intersect and undergird one of today's expanding ethnic enterprises—1) government-subsidized immigrant Filipino women owned long-term care businesses who operate on below poverty level and stringent budgets and 2) hire low wage co-ethnic, gendered labor forces with minimal to no benefits and labor protections to 3) provide care work services to some of our most underserved and impoverished chronic mentally ill and physically disabled elderly populations in the United States.

Lastly, this chapter also emphasizes the structure/culture nexus occurring in ethnic enterprise. Building off of Ann Swidler and Michelle Marmot's theoretical frameworks, I was able to bring in a critical missing piece in the ethnic entrepreneurship literature around the

significant role of *culture* in *mobilizing ethnicity* that broadens the long-standing binary debate between Portes and his colleagues (Portes and Bach 1985; Portes and Manning 1985; Portes and Zhou 1992) and Bonacich (1973, 1987). The process of *mobilizing ethnicity* adds to the ethnic entrepreneurship literature by providing a nuanced perspective on the significant role that culture and ethnic constructions play in shaping employer perceptions and how such ethnic stereotypes are strategically used in hiring (and firing) co-ethnics and the perpetuation of substandard labor conditions.

CHAPTER 6

CONCLUSIONS

This study was focused at the juncture of globalization, aging, socioeconomic and racial/ethnic inequalities in the U.S. long-term care industry. The study topic was historically contextualized within the deinstitutionalization era (1955-1980) and the U.S. government's broken promise to provide sufficient funding for public housing alternatives, community mental health and health care centers. This led to the historical and current displacement of this population into skilled nursing facilities (Gronfein 1985, Mechanic and Rochefort 1990., Scull 1985), jails (Schnittker, Massoglia and Uggen 2012), the streets (Mechanic and Rochefort 1990., Phelan et al. 2000) and board and care homes (Emerson, Rochford and Shaw 1981; Goplerud 1979; Kruzich 1985). A major finding in my research was the emergence of a spectrum of small and medium-sized Filipino owned long-term care businesses, including board and care homes, adult day care centers, home care and home health care agencies. For over the past forty years, they have directly provided the long-term care, custodial care, medical care, day care and housing to the underserved, low-income, older adults with severe mental illness, physical impairments and other chronic medical conditions. It is the only known study that has specifically examined immigrant Filipino women owned enterprises that oversee, manage and care for the long-term health and sickness of some of the most marginalized older populations in the country.

Theoretical Implications

The core of the project was to illuminate the globalized structural and organizational changes of the U.S. long term care industry in order to elucidate the entry point for a group of immigrants to become entrepreneurial. In my study, I made four overarching, interrelated

assertions that account for the rise and sustainment of this form of ethnic entrepreneurship that pertained to 1) the restructuring of the long term care industry and the blurring of the private/public divide 2) the opportunity structure for Filipino-owned businesses and their role as state replacements in the secondary market 3) the strategic utilization of nursing and gendered forms of capital and social networks found within an ethnic niche in the U.S. health care industry and 4) mobilizing ethnicity.

In Chapter 2, I underscored the structural and organization changes brought forth by the retraction of the welfare state and the 1965 enactment of Medicare, Medicaid and Social Security government funded policies that led to the blurring of the private-public divide in long-term care system. First, I emphasized how the U.S. has no universal long-term care system and the state has instead outsourced the care provision of some of its most underserved and vulnerable populations to the market and private enterprise. Thus, my *first* assertion highlighted that the long-term care industry is increasingly characterized by a two-tiered, two class system that mirrors the growing social inequalities and wealth disparities that characterize the U.S. population. This bifurcation is established by stringent eligibility requirements for government-subsidized programs. Only individuals who meet official poverty income levels can qualify. The rest of the individuals in need of formal long-term care assistance must privately pay for services. I offered a conceptual model titled, *Organization of Care* that elucidated how people access formal long-term care services. This model not only emphasized a two-tiered, two class industry, but also aided in illustrating the entry point and opportunity structure for Filipino entrepreneurs to establish themselves in the industry.

I further underscored this opportunity structure by drawing attention to how Medicare, Medicaid and Social Security social policy programs strictly subsidized private long-term care

enterprises rather than the public sector. As a result, huge market industries have formed whereby corporate owned chains and franchises profited from not only providing services to the wealthy private sector, but also having encroached and profited from the public sector as well. Therefore, the blurring of the private-public divide has occurred and is characterized by how corporations have also encroached and profited from the public sector through government contracts and subsidies.

However, private businesses are not obligated to provide services to all who need care. Despite receiving government subsidies, they can choose to accept or deny based on anticipated profitability of the individual. Thus, the *second* assertion from my research study relates to the role that immigrant enterprises play in the U.S. long-term care industry discussed in Chapter 4. Specifically, I argue that Filipino-owned businesses have become *state replacements* as government subsidized, ethnic enterprises that have stepped in to meet the needs that have resulted from not only a retracted welfare state, but from corporations choosing not to provide care to a population deemed less profitable and considered "economically undesirable."[100]

Consequently, I underscored the point that previous scholars have made that privately owned corporations operate in accordance with principles of profit motive and risk avoidance (Hollar 2009; Feder 2004; Woodlander, Himmelstein, et al. 2003). They do not necessarily compete by lowering prices or improving quality. Instead, they evade less profitable elderly and disabled individuals and shift back these costs to individuals, their families and/or the state. Hence, my findings further indicated that the entry point for Filipino immigrant women entrepreneurs is based on developing businesses around these populations and providing care

[100] I define "economic undesirable" population as the elderly poor, or formerly middle class elderly that require assistance with ADLS/IADLS, have chronic mental and/or physical disabilities and weak social supports. Many of them rely on Medicaid to cover medical expenses and qualify for SSI benefits as well.

labor to some of the least cared for in society at *below poverty-level budgets* and cheaper rates. In line with my assertion around state replacements, I also argue that a *secondary market* in the U.S. long-term care industry has emerged whereby Filipino immigrants have been able to develop a spectrum of government-subsidized long-term care enterprises that cater to the underserved. Despite the fiscal conditions under which they provide care, my findings also highlighted the various derogatory meanings with racist, anti-immigrant sentiments (as reported by the ethnic entrepreneurs) that were placed on them by other stakeholders in the U.S. long term care industry. This finding brings to light how our society differently defines various forms of entrepreneurship.

In Chapter 3, I highlighted the spaces of recurrent disparities, uneven vulnerabilities as well as sites of opportunities and resistance that more accurately depicted the complex constrained agencies of immigrant Filipino women entrepreneurs. This chapter focused on labor migration policies and how the intersection of race/ ethnicity, class and gender shaped their access to capital and how Filipino women strategically utilized their constrained agency and renegotiated a gendered and racialized niche in order to become entrepreneurial in the secondary market. Thus, I emphasized the early U.S. colonization of the Philippines and the subsequent perpetual mass U.S. recruitment of a cheaper immigrant Filipino nursing labor force that dates back to the mid-1960s. This also led to the development of an ethnic niche in the U.S. health care industry and the active position of the Philippine state in producing a cheaper, gendered, racialized and exportable workforce that have significantly contributed to the growing concentrations of migrant Filipinos in health care related fields in the U.S. and other wealthier countries. Instead of catering to co-ethnic patrons and selling cultural foods and products that typically characterize ethnic niche enterprises (Aldrich and Waldinger 1990), the majority of Filipino businesses were established

outside of the ethnic community and instead predominantly catered to a disenfranchised, low-income sector of the U.S. aging and chronically ill population.

Based on my findings, my *third* assertion relates to how Filipino immigrants have attempted to renegotiate the way in which they negotiate power relations, revealing what sociologists call, constrained agency. Here, I show how business owners strategically capitalize on these racialized and gendered tropes concerning nursing and care labor in the workplace. Despite the opportunity to attain wage labor positions in U.S. mainstream society, I found that the majority of my participants utilized their nursing capital and social networks resulting from an expanding ethnic niche around the U.S. health care industry to accumulate and transmit information and social capital into more profitable, entrepreneurial opportunities. Since most of the businesses in my study relied on low government reimbursements, I also found that they practiced self-exploitation, particularly in the first few years of starting their businesses. In other words, they would labor as the "employer, caregiver, licensee, maid...you name it!," sleep at their respective businesses and accepted below poverty level reimbursements that other privately owned entities were adverse to taking. Additionally, they also sustained their businesses via volume and the securement of patient and resident referrals through "weak ties" found in their informal social networks. Thus, my findings also uncovered that given the expanding ethnic niche in the U.S. health care industry, Filipino-owned home health and adult day care centers would compete against each other to attain the business opportunity to work in partnership with co-ethnic owned board and care/assisted living facilities in order to secure them as consistent patient/resident referral sources. I also found that co-ethnic as well as other ethnic minority physicians and pharmacists also sought to develop business relations with them in order to attain and secure patient referrals as well (e.g, Filipinos, Indians, Armenians, Chinese). Thus, they

mutually benefited from these business relations that cultivated reciprocal obligations and reliance between these co-ethnic and intra-ethnic social network of business owners and health care providers that has led to the growth and sustainment of the secondary market of the U.S. long term care industry.

Lastly, in Chapter 5, my findings suggest that the sustainment and profitability of their businesses also depended on *mobilizing ethnicity* that emphasized how ethnic employer perceptions foregrounded by certain ethnic stereotypes serve as a central mechanism for the simultaneous mobilization and exploitation of their co-ethnic workers in order to maximize profit. Thus, my *fourth* assertion revolved around the mobilization of ethnicity that occurred through the simultaneous deployment of culture as a "tool kit" and "symbolic boundaries" that led to the exploitative and strategic practice of evoking co-ethnics as "walking billboards," the evoking of familial and cultural dynamics and inciting "utang na loob," meaning indebted relations. My findings broadened the ethnic entrepreneurship literature by providing a nuanced perspective on the significant role that culture and ethnic constructions play in shaping employer perceptions and how such ethnic stereotypes are strategically used in hiring (and firing) co-ethnics and the perpetuation of substandard labor standards. This chapter also exemplified the organizational labor force structure within this care market niche and the types of labor forces they hired (e.g., employed, contracted and live-in care workers). Specifically, immigrant Filipino women employers predominantly hired either low minimum wage employees or independent contractors that received minimal to no labor protections or employee benefits in order to sustain their businesses and uphold the secondary market of the U.S. long term care industry. The culmination of these theoretical assertions expand and interconnect previous sociological

literature on the political economy of the U.S. long term care industry and aging, gendered labor migration, care work, ethnic entrepreneurship and intersectionality.

Policy Implications

Despite the growing demand for services, threats of defunding persist around an already inadequate long-term care safety net. Yet, the push for private responsibility reproduces and masks certain social conditions and uneven inequalities that interlink the global North and South regions of the world. In other words, the hierarchical, two-tiered long-term care industry mirrors the recurrent patterns of disparities, which have only exacerbated over time in an ever-expanding globalized, privatized economy. In sum, my study expanded on previous scholars' works and exposed the changing structural conditions and organizational dynamics of a major U.S. industry such as the U.S. long term care industry. My study has provided a nuanced globalized framework for how we can examine the policy implications of a retracted welfare state in an age of privatization and the new forms of segmentation occurring in major U.S. industries and markets today.

The resulting stratification occurring *within* the increasingly privatized U.S. long term care industry has served as a microcosm for this framework and the social and public policy consequences of a retracted, austere welfare state including 1) The growing segmentation of a major U.S. industry divided by a primary market made up of corporate-owned businesses that tend to cater to more profitable private-pay, wealth-reliant individuals and a secondary market made up of smaller, individually-owned enterprises that profit from the growing influx of state-reliant, poor and formerly middle class elderly and disabled individuals that have largely resulted from state outsourcing and privatization schemes. 2) The predominant hiring of either low minimum wage employees or independent contractors that receive minimal to no labor

protections or employee benefits. In other words, the vast majority of these businesses do not provide health care coverage, Family Leave Medical Act (FLMA) benefits, worker's compensation coverage, "back pay" wage protections, contributions to Social Security, Medicare, unemployment, retirement and pension benefits. Hence, another form of outsourcing is mirrored in the structure of the workplace and the disintegration of state labor protections and benefits and the outsourcing of employer accountability to the worker. 3) Given our retracted welfare state and the ever-increasing privatization of health and social services; in some ways the secondary market of the U.S. long-term care industry has significantly *replaced the state* by aiding in absolving the state of having primary responsibility for providing health and social services to its own citizens. In addition, these ethnic businesses may continue to grow due to a new demographic shift occurring in the U.S. Currently, 39.6 million individuals comprise the older population of those who are 65 years or older. They make up 12.9% of the U.S. population, approximately one in every eight Americans. Their number is expected to double to 72.1 million by 2030 (U.S. Department of Health and Human Services 2012).[101] Though family members provide the majority of assistance and caregiving in the U.S., recent studies have shown a growing number of families are turning to care institutions and/or hiring care workers to assist and care for their elderly and disabled family members (Boris and Klein 2012, Browne, Braun and Arnsberger 2007, Solis 2011, Tung 2000). The secondary market is increasingly made up of a spectrum of immigrant owned businesses that received government subsidies or charged lower rates in order to enter into and sustain themselves in the U.S. long term care industry. Thus, the emergence of ethnic entrepreneurship represent the intersecting *patterns of outsourcing* and the culmination of policies related to the *decentralization of the state* that have led to one way we now over see and

[101] U.S. Department of Health and Human Services. 2012. *National Clearinghouse for Long Term Care Information,* U.S. Department of Health and Human Services: Planning for Long Term Care. http://www.nasuad.org/documentation/hcbs2011/Presentations/M2RegencyC.pdf Last accessed March 13, 2014.

care for the growing poor and new poor elderly and mentally and physically disabled individuals in a time of ***The Outsourced State: The Retraction of Public Caregiving in America*.**

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APPENDIX

APPENDIX A: FLYER

If you are a Filipino woman that currently owns and operates a long term care business or currently work as a long-term care worker, we want to learn more about your experiences!

We are currently conducting a research project on Filipino women through the University of California, San Francisco. We want to interview you about your experiences as either a care worker and/or an administrator. The interview will take place at the location of your choice.

One interview of no more than 1-2 hours, and possibly a follow-up session.

If you are interested or would like to learn more, please call or email for further details: Jennifer Nazareno xxx.xxx.xxxx or xxxxxxxxxxx@gmail.com.

APPENDIX B: INFORMATION SHEET

A UCSF RESEARCH STUDY ON FILIPINO LONG-TERM CARE PROVIDERS

Information Sheet

Jennifer Nazareno, a Ph.D. student at the University of California, San Francisco is doing a study on Filipino care workers and long-term care business operators. We are looking for Filipino women that work in long-term care businesses that are also owned by Filipino women. We want to hear about your experience and understanding of how you became a caregiver and/or became a care business owner and administrator. Sharing your knowledge may provide further insight into on long-term care work and the impacts of gender ideologies on migration, care labor and economic globalization. Your insights are so important.

Here's what would happen if you decided to take part in the study:

• Jennifer Nazareno will interview you for approximately 1-2 hours. You will be asked questions about your experiences and the residents you have worked with.
• It is possible that a second interview will be requested, and you may be asked a few further brief questions.
• The interview will be audio-taped. Only members of the research team will hear what you said.
• Taking part in the study is voluntary. You can decline to answer questions, or stop taking part in the study at anytime. Time and location of interview(s) based on what is more convenient for you.

If you think you might be interested in participating in the study, you can:

• Give Jennifer Nazareno your name and telephone number. She will call you to set up a time to talk.
• Or, you can call Jennifer Nazareno (951) 990-8462 or email her at jennazareno@gmail.com to make arrangements.

Permission to contact me:

Name: _____

Telephone number: _____

APPENDIX C: Telephone Screen Script

A UCSF RESEARCH STUDY ON FILIPINO LONG-TERM CARE PROVIDERS

Telephone Screening Script

Thank you for (contacting me or granting me permission to contact you) to express your interest in the UCSF Study on Filipino Long-Term Care Providers. As you know from the information sheet you received, I am a doctoral student at the University of California, San Francisco. I'd like to describe the study to you again and get any questions you have answered so that you can make a decision about being in the study.

We are conducting a study to learn more about your experiences as a care worker and/or administrator for long-term care businesses. We want to learn more about how you came to this line of work, your job responsibilities and more about the practical everyday setting of these residential care environments.

You are being asked to take part in this study because of your experience as a care worker and/or administrator and long-term care business operator. If you agree to be in the study and meet the criteria for being in the study, I will schedule an interview with you. May I ask you a few questions to determine if you meet the criteria for being in the study?

If answer yes:

Are you at least 18 years old? *If yes,*

Do you speak English and/or Tagalog? *If yes,*

Are you a long-term care worker and/or a long-term care business owner? *If yes,*

Are you able to participate in an estimated 1-2 hour interview and possibly a follow up interview? *If yes,*

You are eligible to participate in the research study. Do you have any other questions before we set a time to meet?

Schedule a meeting time and place.

Thank you for (contacting me or granting me permission to contact you) about being in my research study on Filipino long-term care providers. I look forward to meeting with you and hearing about your experiences.

If participants answered no to any question, no further questions will be asked and they will be told:

Since the study is only looking at (criteria they answered no to), you are not eligible to participate at this time. I appreciate your interest in the study and the time you have taken to inquire about your eligibility. Do you have any questions?

APPENDIX D: INFORMATION SHEET

A UCSF RESEARCH STUDY ON FILIPINO LONG-TERM CARE PROVIDERS

Demographic Information Sheet

Age:_____
Gender: ____
Race/Ethnicity:_____
Highest Education:
Some High School _____
High School _____
Some College _____
College Degree _____
Master's Degree _____
Ph.D. Degree _____
Job Title _____
How long have you worked in the long-term care work industry_____
Length of time at this particular business_____
How many long-term care businesses have you worked for in the past?_____

APPENDIX E : CONSENT FORM

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Study Title: The Outsourced State: The Retraction of Public Caregiving in America

Jennifer Nazareno, a doctoral student from the UCSF Department of and Social and Behavioral Sciences are conducting a study to describe the experiences of Filipino care workers, owners and operators that provide long term care businesses. You are being asked to take part in this study because of your experience working in these long term care work environments.

Participation in this study is voluntary.
Research studies only include people who agree to take part in them. You may choose not to be in this study or may choose not to continue to be in the study at any time after you have started participating. Please take your time in making your decision to participate. If you need more time to decide whether or not to be in the study, Ms. Nazareno will reschedule another time to talk with you once you have decided that you would like to be in the study.

Why is this study being done?
The purpose of this study is to describe the experiences of care workers and owners and operators of long-term care businesses.

How many people will take part in this study?
The researchers will be interviewing about 40-50 care workers and care business operators.

What will happen if I take part in this study?
If you agree to take part in this study the following will occur:
1. You will meet privately with Ms. Nazareno, for 1-2 hours, at a time convenient to you. It is possible that Ms. Nazareno may contact you a second time, to ask a few further questions.

2. You will be interviewed in person about your experiences as a long term care provider and your experiences an employee and/or employer as well as your interactions with the residents which you provide care for in these long-term care businesses. You will also be asked about some basic demographic information about yourself.

3. This interview will be audiotape recorded. The interviews will be typed into a computer, and all names will be removed. All tapes will be destroyed once they are transcribed and checked for accuracy.

4. Upon your consent, Ms. Nazareno may also be conducting participant observation and field notes of your interactions with other staff and residents during usual work time in the

residential care facility. These observations will occur 1-2 times and last no more than 30-45 minutes. Ms. Nazareno will also be making hand written notes to record her observations and thoughts during the study. These notes will remain confidential.

How long will I be in the study?
Participation in the study will take at the most about four hours spread over several weeks.

This time includes the phone screening to determine if you were eligible to participate, reviewing the study's purpose and consent form, and one to two interviews.

If you consent to be re-contacted for possible participation in a follow-up study that is being planned, the time requirements of that study will be described to you at that time. At the completion of your interview, you will be asked if you are willing to be contacted in the future.

Can I stop being in the study?
Yes. You can decide to stop at any time. Just tell the study researcher right away if you wish to stop being in the study. Also, the study researcher may stop you from taking part in this study at any time if he or she believes it is in your best interest, or if the study is stopped.

What risks can I expect from being in the study?
1. Some of the interview questions may make you anxious or uncomfortable. You are free to refuse to answer any questions. You are also free to end the interview and/or observation at any time.

2. If you become tired, you may end the interview, and with your permission a second interview will be scheduled at a time and place convenient for you.

3. *Confidentiality*: Participation in research may involve a loss of privacy; however your records will be handled as confidentially as possible. Only Ms. Nazareno and those working on the research project will have access to your study records. After the interview information has been transcribed from the audiotape and the study is complete, the tapes will be destroyed. Your name or other information that identifies you will not be used in any reports or publication that may result from this study.

4. *Suspected Elder Abuse Reporting*: If during the interview or during the observation period it is revealed you or another individual have been the victim of physical, verbal, emotional, sexual or financial abuse or neglect, Ms. Nazareno is required to report this to the Long-Term Care Ombudsman for further investigation.

Are there benefits to taking part in the study?
There will be no direct benefit to you from participating in this study. However, the information that you provide may help researchers better understand the experiences of care workers and owners and operators of these kinds of long-term care businesses.

What other choices do I have if I do not take part in this study?

You are free to choose to not participate in the study. There will be no penalty to you if you choose not to participate.

Will information about me be kept private?
We will do our best to keep your personal information private, but total privacy cannot be guaranteed. Your name and other identifying information will not be kept with the answers you give.

What are the costs of taking part in this study?
There will be no costs to you for taking part in this study.

Will I be paid for taking part in this study?
No, you will not be paid for taking part in the study

What are my rights if I take part in this study?
It is your choice to take part in the study. You also have the choice to leave the study at any time.

Who can answer my questions about the study?
You may talk with the researcher about any questions or concerns you may have about the study, at any time. Please contact Jennifer Nazareno at (951) 990-8462 or jennazareno@gmail.com

If you have any questions, comments, or concerns about the study or your participation, first talk with the researcher (above). If, for any reason you do not wish to talk with the researcher, or have further concerns after doing so, you may contact the office of the **Committee on Human Research**, UCSF's Institutional Review Board (a group of people who review research procedures to protect your rights).

You can reach the CHR office at (415) 476-1814 (8 am to 5 pm, Monday through Friday)or by writing to: Committee on Human Research, Box 0962,
University of California, San Francisco (UCSF), San Francisco, CA 94143.
****

CONSENT
You have been given a copy of this consent form to keep.
PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.
If you wish to participate in this study, you should sign below.

_____ _____
Date Participant's Signature for Consent

_____ _____
Date Person Obtaining Consent

APPENDIX F: INTERVIEW QUESTIONS/PROBES:

For All Employer and Employee Respondents

1) Personal history/demographic information

- How did you decide to get into this line of work?
- Do you live close to work?
- What is your educational background?
- What is your citizenship status?
- What type of work did you used to do prior to pursuing this kind of work and prior to migrating?
- What is your marital status? Do you have children? [If married and/or have kids, ask]: do see your partner and/or kids regularly?

2) Gendered Migration, International Division of Care Work

- When did you migrate to the United States?
- What type of resources did you utilize and/or have that enabled you to come here? (e.g., family members that were already in the U.S., a contract with a job/travel agency that assisted you in coming here)
- Prior to coming to the U.S. did you attain training/work experience as a caregiver and/or a nurse? If not, what type of job did you have prior to migrating here?
- Do you have family members, friends, co-workers that migrated abroad? If so, were they also care workers?
- What do you think are the benefits and sacrifices you've had to make by migrating here?

3) For Filipino Long-Term Care Employers/Owners

How are Filipino women strategically utilizing their gender, class, social and ethnic resources to become more entrepreneurial and establish themselves as small business owners in long-term care settings?

- How did you first learn about opening a long-term care business?
- Why did you decide to become a long- term care business operator and administrator?
- Do you have family members, friends, relatives that are also in the same type of business?
- What types of education, courses and licenses did you have to attain in order to run this business?
- What kinds of resources did you need in order to start your business? How much did it cost to purchase this type of business? Did you need to loan money in order to purchase your business?
- Would you encourage other Filipinos to venture into this type of business? Why or why not?

Ethnic Entrepreneurship in Care Work/ Business Profile

- What type of services does your business provide?
- What type of residents/patients do you provide services to?
- Could you describe the size and composition of your staff and their responsibilities?
- What is the hourly wage that you pay your care work staff?
- What kinds of regulations do you need to abide by and enforce in order to be in compliance with state regulations?
- Do many of these elderly residents have a chronic illness and/or a disability?
- What is the gender and racial make up of the residents/patients you care for?
- Are these residents/patients reliant on SSI (Supplemental Security Income), receive Medicare, Medicaid or are they able to pay privately for long-term care services?
- How long have you been running this type of business?
- What is the overall cost for your services to residents/patients you care for?
- How do you attain these residents/patients?
- How do you recruit staff to provide care work services?
- How many long-term care businesses do you own? Where are they located? Why did you choose that location to run your business?

2) Job Responsibilities/Roles

- Could you describe your roles and responsibilities?
- What are the least and most desirable tasks in your job as an administrator? What are some of the major stressors you deal with on a daily basis?
- What types of challenges did you face in running your business? How did you meet these challenges?
- Approximately what is your yearly salary? Is this significantly much more than you were making prior to becoming a long-term care business operator?
- How do you like your job?
- What types of opportunities have you been able to afford by owning your own business?
- What types of sacrifices have you had to make in order to become a successful business owner?

Employer-Employee Relations

What kinds of dynamics ensue between women entrepreneurs and their employees that are part of the same ethnic background?

- How many employees do you oversee?
- How do you choose your staff? Are there certain characteristics, qualifications you look for that influence your decision to hire a care worker?
- Do you hire Filipino care workers? If so, why? If not, why not?
- How do you like working with your staff? (Ask for positive experiences as well as challenges)

- How much do you pay your care work employees? Does your staff receive certain benefits (e.g., health care, dental, vision, paid vacation days)

For Filipino Employees that work in long-term care institutions

1) Job responsibilities/roles

- How long have you worked as a care worker?
- Describe the types of tasks you do as part of your job?
- What are the least and most desirable tasks?
- What do you enjoy about your job, what do you least enjoy about what you do?
- Do your tasks change with seniority?
- What are your work hours, breaks? Describe a typical work day.
- What is the typical pay wage scale for caregivers in this business? Are you paid on time?
- Do you enjoy the work that you do?

2) Social networks, resources and capital

What kinds of resources, social networks and capital do Filipino long term-care employees have? How is this similar and/or different from Filipino care worker employers?

- How did you find out about this long-term care business? (e.g., job agency, friend) Do you prefer to work in this business or provide care work in a private home?
- Are you part of any union group and/or organization with other care workers?
- Do you live close to your place of work? Do you live with family members, friends? Or are you a live-in?
- Do you have friends that are caregivers that you socialize with regularly? Who are your social supports?
- How do you attain health care, dental, vision services?
- How do you get to and from work? (e.g., car, public transportation, family member provides rides)
- While you take care of elderly persons that may have chronic health problems or disabilities, do you yourself have any health care and/or disability issues that you are currently dealing with?
- If you get sick or have an emergency, are there people around you that assist in helping to take care of you if you ever need assistance?
- Would you encourage other Filipinos to venture into becoming a caregiver?
- Would you ever consider becoming an administrator for a long term care business?
- Do you have children? If so, do your children do this type of work? Would you want them to do this? Why or why not?

3) Employee-Employer Relations

What kinds of dynamics ensue within these co-ethnic work spaces of care work?

- How long have you worked for this employer?
- Have you worked for other long term care businesses? Were they Filipino-owned?
- How was your experience working with previous employers?
- What type of employers do you like?
- What was the longest amount of time that you have worked with an employer?
- Is working for Filipino owners different from working for non-Filipino owners? If so, how?
- How much do you get paid to work as a care worker? Have you ever received a raise?
- Have you had time to take vacations?
- When are your days off? What are some of the things that you do during your day off?
- Why did you choose to work for this employer?
- What kinds of questions did your employer ask you when you were interviewed for your job?
- Did you have to go through certain processes such as attain various caregiver trainings in order to work as a caregiver for this business?
- How would you describe your relationship with your employer?
- Has there been a time where you felt mistreated by an employer? If yes, please explain? Or do you feel you have a good working relationship?

Thank you for your participating in this interview and for sharing your views with me. Could I contact you for a second interview so that I am sure that I understand your views?
Probing questions will be used to elicit examples of what participants describe response to questions:

1. Please tell me more about…
2. What do you mean…
3. Could you give me an example of…
4. What can you tell me about….

SUPPLEMENTAL STAKEHOLDER/ANCILLIARY PROVIDER INTERVIEWS

1) Personal history/demographic information

- How did you decide to get into this line of work?
- What is your educational background?
- What is your citizenship status?
- What type of work did you used to do prior to pursuing this kind of work?
- What is your marital status? Do you have children?

2) Job Responsibilities/Roles

- Specifically, how is your office, company, department, business or agency involved in the long-term care industry?
- Could you describe your roles and responsibilities?
- How long have you been working in this capacity?
- What type of services to do you provide in the long term care industry?

- What are the least and most desirable tasks in your job? What are some of the major stressors you deal with on a daily basis?
- What types of challenges did you face? How did you meet these challenges?

3) What kinds of dynamics ensue between various stakeholders and Filipino owned businesses?

- Do you collaborate with long-term care businesses? If so, which ones?
- Can you describe your relationship with these businesses?
- How often are you in contact and/or visit these businesses?
- Who are the owners and operators of these enterprises?
    - Do you work with long-term care businesses that are corporately owned? If so, how would you describe these businesses? How would you describe your relationship with these businesses?

    - Do you work with enterprises that are owned by immigrant Filipinos or other immigrants? If so, how would you describe these businesses?
      How would you describe your relationship with these businesses?

    - How are these businesses similar and different from each other?
    - How would you describe the role that these types of businesses play in the long-term care industry?
    - What populations do they provide services to?
    - How have your experiences been in working with these various types of businesses?

Thank you for your participating in this interview and for sharing your views with me. Could I contact you for a second interview so that I am sure that I understand your views?
Probing questions will be used to elicit examples of what participants describe response to questions:

5. Please tell me more about…
6. What do you mean…
7. Could you give me an example of…
8. What can you tell me about….

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Author Signature July 29, 2015