Chapter 11

Health Care Reform

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The proposed Health Security Act of 1993, referred to as the Clinton Plan, has reenergized the health care reform movement. It challenges federal and state legislators, insurance companies, businesses, health care providers, scientists and private citizens to examine health care delivery in this country and invent a better system. As law-makers and interest groups debate the Clinton Plan's strengths and weaknesses and compromise on alternatives, Asian Pacific Americans must confront four major issues that affect them: access to and utilization of health care services, cost of care, quality of care, and culturally sensitive care.

In addressing the impact of health care reform on Asian Pacific Americans, this chapter provides a historical perspective for the present environment of reform; describes the extent of popular support for reform; delineates general reform issues and advocated strategies; examines specific Asian Pacific American health care needs and reform issues; and outlines recommended Asian Pacific American positions in relation to health care reform.

Historical Perspective

Movements to reform the health care system are neither new nor limited to governmental initiatives. During the late 19th centuries, the public, not the health profession, saw the need for professional training to optimize care (Starr, 1982, p. 155). For example, three schools for nurses opened in New York, New Haven, and Boston during this era. These outsiders who drove the reformation of health care during this time were upper-class women. Beginning in the 1880s, the precursor of today's Mayo

Clinics served citizens near Rochester, Minnesota. The high standards and impressive success rate of their services helped change the negative perception of hospitals as places of death to a more positive image. Hospitals improved with better communication (the telephone), better transportation (the automobile), and technical advances in medicine such as better sanitation, pharmacological interventions, and surgical strategies (Starr, 1982; Litman and Robins, 1984).

Table 1. Key Dates in the History of Guaranteed Health Coverage

Date	Event
1929	First HMO, Ross Loos, established in Los Angeles.
1935	Social Security Act with medical benefits for elderly signed by President F.D. Roosevelt.
1945	President Truman unsuccessfully asks Congress to provide health care security for all Americans.
1956	Disability insurance added to social security.
1965	Medicare (federal health insurance for all $\geq$ 65 years) and Medicaid (health care for the poor) bills signed by President Johnson.
1973	HMO Act establishes more HMOs signed by President Nixon.
1979	National health insurance plan unsuccessfully proposed by President Carter.
1981	Restrictions on federal health expenditures and greater responsibility on states per President Reagan.
1985	Employers required to continue health coverage for 18 months at employee's expense for retired/ terminated (Comprehensive Ommnibus Budget Reconciliation Act).
1988-89	Medicare protection of elderly for catastrophic illness passed and repealed.
1993	Health Security Act guaranteeing health coverage for all Americans proposed by President Clinton.

Based on *Los Angeles Times*, September 19, 1993, pp. A20-A21.

The turn of the century brought with it additional progress in the quality of health care. From the early 1900s to the present day, increasing government regulation and professional standards have promoted the quality of health care and the competence of care providers. State boards of nursing, medicine, pharmacy, etc,. issue licenses to health care providers. Hospitals and other institutions are monitored by state and national organizations and regulated by state laws. Government also became more involved in increasing access and controlling costs.

Congress passed the Pure Food and Drug Act in 1906 in response to Upton Sinclair's book, *The Jungle*. This work exposed improprieties in the meat packing industry, giving rise to federal regulation of drugs. This Act, amended many times, controls advertising, research, and unsubstantiated claims of effectiveness. State workers compensation laws began to appear around 1910, on the heels of the industrial revolution. The Flexner report, released in 1910, outlined specific recommendations designed to raise the standards of medical education. This report is frequently cited as the impetus for the professionalization and scientific basis of medical practice (Flexner, 1910). The influence of hospital associations extended to the financial structure of health care delivery. For example, they required second opinions for surgery and reviewed the length of hospital stays, restricted medical fees, and refused payment when charges were excessive (Starr, 1982, p. 205).

In the 1920s, government intervention into the health care system came through the passage of the Sheppard-Towner Act which encouraged the creation of centers for prenatal and child health by providing matching funds to states. In this decade, the Committee on the Costs of Medical Care (CCMC) began the work of examining the costs and environment of medical care delivery (Committee on the Costs of Medical Care, 1932). Unfortunately, the medical community reacted adversely to the CCMC health care reform recom-mendations.

The pain and desperation of the Great Depression of the 1930s softened the resistance to social reforms, including health. While many leaders desired health insurance in some form, most recognized that securing such a radical change in government policies was not politically feasible (Starr, 1982).

The House of Delegates of the American Medical Association would only venture to support voluntary health insurance plans. The Social Security Act of the mid-1930s did not include coverage for health care (Litman and Robins, 1984). Nonetheless, it was an important step in laying the groundwork for continued concern about the need for health care and later attempts at federal involvement in the provision of medical services.

The 1940s witnessed the passage of the Hospital Survey and Construction Act of 1946. More popularly known as the Hill-Burton Act, it encouraged hospital construction (Litman and Robins, 1984). The Veterans Administration expanded its health services to veterans after World War II. Free or low-cost services to deserving individuals emerged quietly and incrementally.

Arguably, the most significant event in the history of American health care reform was the passage of the Medicare and Medicaid bills with President Johnson's signature on July 30, 1965 (Litman and Robins, 1984). The various provisions in these amendments to the Social Security Act were designed to neutralize the opposition of various special interest groups, particularly the hospital industry and medical professionals. Its one glaring flaw was that it lacked cost controls.

In the 1970s, President Nixon began a movement that continues today and is reflected in much of President Clinton's proposal for reform. He announced a new policy designed to encourage the development of Health Maintenance Organizations (HMOs).

In the 1980s, President Reagan further supported the growth in HMOs. Like Nixon, he encouraged development of the proprietary sector in health care delivery. Senator Edward Kennedy broke with the Democratic President, Jimmy Carter, and others by proposing a plan placed strikingly in the private, not public, sector. His legislation would have included a health insurance card much like President Clinton now proposes.

No mention of the 1980s can neglect to consider the influence of Diagnosis Related Groups (DRGs) on health care delivery. These reimbursement categories were designed to control escalating costs of health care. DRGs totally changed the financial incentives for acute hospitals. While DRGs

addressed reimbursement schedules for the Medicare population only, private insurers quickly followed suit. Suddenly, patients were being discharged "quicker and sicker" and a domino effect began that continues to reverberate throughout all of health care. While access issues were major concerns leading up to DRGs, they quickly faded into the background (Starr, 1982, p. 406). Current research is exploring methods comparable to the DRG mechanism for reimbursement of services delivered in other settings such as nursing homes and home health care.

The decade of the '80s is sprinkled with failed attempts to address cost concerns. Some examples include certificates of need, utilization review, price controls, professional standards review organizations, and health systems agencies (Litman and Robins, 1984).

The 1990s are characterized by a growing skepticism about the value of more medical care and high technology. Many believe that much of health care is devoted to alleviating the sequelae of social problems.[1] There is concern over the amount of health dollars consumed by problems resulting from individual behavior. Policymakers and opinion makers are returning to discussions concerning individual "responsibility" for health and "sin" taxes for the use of products detrimental to health. Employers are funding wellness-oriented benefits with the hope of decreasing health care costs and increasing productivity.

Current attitudes toward previously neglected groups are changing, influenced, no doubt, by the civil rights and women's movements and by the onset of AIDS. Health issues unique to women, racial/ethnic groups, the elderly, the disabled, and homosexuals are gaining attention, legitimacy and research support.

The Current Debate

The myriad of problems characteristic of our current system provided the impetus for the present climate of health care reform. The first issue is the lack of accessible health care and presence of utilization barriers for a growing number of recipients. Second is the explosive cost of health care. These costs are fueled by the inordinate complexity of the payment and

reimbursement systems, the profit orientation of health service insurers, providers, institutions, drug companies, and other health-related businesses, the inadequate control of fraud and abuse, and the unwieldy growth of medical malpractice. Third is the quality of care, including the technical and professional competence of health care providers. Fourth is the lack of culturally sensitive care of racially, ethnically, and socioeconomically diverse clients by a similarly diverse pool of providers (General Accounting Office, 1992; General Accounting Office/Office of Controller General, 1992; Millman, 1993).

Proponents of health care reform believe that universal health insurance guarantees access to health services. Comprehensive benefits apply regardless of employment status, retirement status, economic level or health status. This may be true in areas with an adequate supply of health care providers and efficient transportation systems. However, other problems may contribute to the lack of access to care. A major barrier to care is the inadequate supply of primary care providers. One strategy advocated by the Clinton Plan is the use of advanced practice nurses such as nurse practitioners and certified nurse midwives to deliver care.

According to the Council on Graduate Medical Education (1993), it may take until 2040 to educate an adequate supply of primary care physicians. "If we expand care to the 37 million uninsured and restructure the delivery system to focus on primary care, it will be impossible to adequately provide primary health care through physicians alone. Nurse practitioners can lead the way here" (Trotter-Betts, 1993, p. 7). According to the American Nurses Association (1993, p. 3) nursing can educate 127,000-143,000 advanced practice nurses to deliver primary care by the year 2000. Such a number should meet 70 percent of the nation's primary care needs in seven years at a cost of $15 billion less than the cost of educating the same number of physicians.

A Gallup Poll of 1,000 adults over 18 years of age (Gallup Poll, July 12-30, 1993, cited by American Nurses Association, September 7, 1993) found that 86 percent of the respondents were willing to see an advanced practice nurse for basic, primary health care in place of a doctor. Another pollster, Peter Hart (May 1990, cited by American Nurses Association (1993), found that 70 percent

of those polled respected nurses more than any other health care provider.

Accessibility can be further promoted as in the Clinton Plan through incentives for providing health care to rural and inner-city communities; federal support for nursing education; emphasis on health promotion and disease prevention which is less expensive than diagnostic and curative procedures; and support for home and community-based care which are less expensive than hospital care.

In addition to the socioeconomic barriers to care, there are recognized racial/ethnic barriers. Lack of adequate translation services, cultural differences that inhibit understanding between providers and receivers of care, and the lack of minority health care providers who can provide culturally sensitive care, all contribute to suboptimal care. As an example, the Clinton Plan offers training and practice incentives for providers to care for the underserved. And the increased choice of plans may make it possible for the culturally underserved to find appropriate health plans.

Along with the question of greater access, the current debate has focused on the cost of health care. There is no doubt in anyone's mind that health care costs are out of hand. For example, the United States, by the year 2000, is likely to spend 18 percent of its gross domestic product on health care. This is far greater than the amount spent by any other industrialized country (General Accounting Office, Office of the Controller General, 1992). Such a steep rise in health care blunts growth in other sectors such as business profits, individual incomes, and federal and state programs. The General Accounting Office predicts that unchecked growth in health care costs will make it impossible to control Medicare/Medicaid costs and balance the federal budget (1990). Despite the large amounts of money spent on health care, this nation has about 34 million with poor access to health care because they are uninsured. Many millions more are in jeopardy of losing access to health care because they are underinsured, may develop a serious illness, or may lose or change jobs (General Accounting Office, 1992).

Proponents of health care reform recommend managed competition among insurers and providers of care to control costs. "Managed competition [is] a system in which insurance

companies and health maintenance organizations (HMOs) bid for business, and consumers pick from among competing health plans" (*Los Angeles Times*, 1993, p. Q6). Managed competition can hold down costs while maintaining quality: a) if it's true that the health care market could stand a more competitive milieu; b) if the American public can yield on the "try-everything-before-giving-up" attitude; c) if providers don't sacrifice necessary care to hold down costs whether or not the government imposes a ceiling on spending; and d) if an efficient watch-dog agency can handle individual complaints and suppress unethical monopolies.

A second cost-control strategy, managed care, means that specific health problems are subject to diagnostic and treatment protocols that provide necessary procedures while avoiding technological frills. Managed care also means that other medical services are closely monitored, a pre-admission approval is required for a hospital stay, doctors agree to a reimbursement schedule for specific services as in a preferred provider organization (PPO) or they are salaried as in an HMO.

A third cost-control strategy is the simplification of payment and reimbursement systems. For example, the Clinton Plan calls for a single claims form to reduce paperwork, simplify record keeping and regulations for insurers and providers of care. The plan offers a comprehensive benefits package that applies to all insured persons making it easier for providers to know what is covered, and for receivers of care to know what their premiums will buy. Simplification may also be acheived through national standards for automation of insurance transactions to promote easier communication between payers, insurers, and providers. Standards of automation should make it easier to control and track fraud and abuse.

A fourth strategy for reducing costs calls for insurance reform. *Newsweek* magazine (Samuelson, 1993, p. 31) explained the cause of the health care spending explosion as, "...the volatile mix of generous insurance and high-tech medicine." As medicine becomes more expensive, people clamor for more insurance protection against the rising cost of care. Greater insurance, in turn, makes it easier for health providers and hospitals to use more expensive technology knowing they will be paid. Insurance reform advocates believe that it's possible to control the profit motive that has led to escalating premiums if:

a) all customers are charged the same for the same comprehensive insurance package; b) insurance companies are required to insure all who apply and guarantee renewal; and c) insurance premium caps are enforced.

A fifth cost-control strategy is to control fraud, abuse and medical malpractice. For example, the Clinton Plan mandates stiff criminal penalties for those who would abuse the health care system. These penalties include seizure of assets derived from fraud, exclusion or fines for guilty providers, reinvestment of fines into anti-fraud efforts, coordination of efforts at the local, state, and national level including sharing data on offenders, and restriction on kickbacks and self-referrals. Advocates of malpractice reform urge caps on awards, penalties for trivial suits, and arbitration.

Costs can also be controlled through the use of less expensive health care providers. From literature reviewed, Safriet (1992) concluded that the costs of training physicians are four to five times greater than the costs of educating nurse practitioners and certified nurse midwives. Furthermore, the salaries of physicians are significantly higher than salaries of nurses (U.S. Congress, 1986). From a meta analysis of studies concerning nurses in primary care roles, Brown and Grimes (1993) found that nurse practitioner utilization costs are lower in general as compared to costs for physician visits. For example, nurses spent more minutes per patient, but the average cost per visit was less. The number of visits per patient was similar for nurse practitioners and physicians. Nurse practitioner patients experienced fewer hospitalizations, and had lower laboratory costs. Lower utilization costs were achieved with comparable or better clinical outcomes than those obtained under physician care (Brown and Grimes, 1993).

Containing cost, however, does not override other concerns. Most acknowledge that the quality of care, based on the competence and professionalism of practitioners as well as the scientific basis of health care, should be maintained. Appropriate training of primary care physicians and nurses is crucial to the mandate of quality health care for all. The support of outcomes research is critical to the development of valid practice guidelines based on scientific data about what works and what doesn't. In addition, public access to performance

records of health care providers and agencies, and patient satisfaction data can serve to promote quality of care.

Support for Health Care Reform

No attempt at health care reform can succeed without a considerable base of support across the country. Princeton Survey Research Associates, on behalf of *Newsweek*, interviewed 751 adults on September 23-24, 1993 (cited in Morganthau and Hager, 1993). Data from this national sample revealed both support and skepticism about the Clinton Plan. On the positive side, the respondents said the plan meant more security concerning the availability of health care whatever a person's medical or financial problems (61 percent) and the same or better quality health care (55 percent). On the negative side, respondents felt that the Clinton Plan meant no real health-cost savings (47 percent), and more taxes (73 percent). To the extent that a reform program supports Medicare, it will receive the endorsement of the elderly. The American Association of Retired Persons praised the Clinton Plan for inclusion of prescription drugs and long-term care benefits (American Health Association, 1993c).

The *Los Angeles Times* (Brownstein, 1993) conducted a nationwide, telephone poll using random digit dialing to interview 1,491 persons in English and Spanish. The poll represented the views of the elderly, Anglos, blacks, Latinos, the uninsured, those insured through their employer or union, those who buy their own coverage, Democrats, Republicans and Independents. Asian Pacific Americans were not categorized, therefore, their specific response to the reform package was not described. This lack of public information concerning Asian Pacific American beliefs, opinions, and needs, is typical of the health care arena. Results were similar to the *Newsweek* poll. Respondents expressed broad but tentative support for the Clinton Health Plan because it provides universal health coverage. The majority did not believe their health care would improve and half of those polled expected to pay more for health care coverage.

A difficult issue in any health care reform proposal is the treatment of undocumented aliens. Any attempt to include

illegals as part of the millions of uninsured Americans and legal residents would raise opposition from all quarters. Yet, to expressly deny all care to illegals would polarize all minority groups including Asian and Pacific Islander Americans.

The actions and positions of special interest groups are also factors that will shape health care reform. The American Nurses Association (ANA) supports health care reform that provides universal access to care, mandated comprehensive benefits, insurance reforms, and recognition of advanced practice nurses and registered professional nurses who can provide quality care for a variety of health care services. The ANA believes that health care reform needs to address the needs of children, the underserved and the elderly (Trotter-Betts, 1993).

Hospital associations, like the American Hospital Association (AHA), are in favor of health care reform that supports universal coverage and develops systems that are not difficult to administer and enforce, impose price controls, impose limits on private health expenditures, or go against deeply held religious beliefs ("American Health Association, 1993c). The AHA and 19 other organizations oppose reforms that reduce Medicare and Medicaid spending (Gearon and Kostreski, 1993). HMOs generally support health care reform since they are already in the forefront of cost control through managed care (Sponselli, McGurk, and Bronson-Gray, 1993).

While the American Medical Association (AMA) strongly supports the notion of universal access to health care, it opposes government regulation, unrealistic evaluation strategies like quality report cards proposed by the Clinton Plan, and insufficient action concerning malpractice reform (American Health Association, 1993a and 1993d). Despite opposition to government regulation to limit health care costs, it is unlikely that cost savings will occur without such regulation. It is also unlikely that providers will self-impose limits on costs without some form of government mandate.

The AMA also opposes health care reform programs that set quotas for training of primary care physicians (American Health Association, 1993a and 1993d). Yet, the Council on Graduate Medical Education, a congressional advisory committee, stated that 50 percent of physicians should be in primary care. At present only one-third of MDs are in primary care practices

(Council on Graduate Medical Education, 1993).

Finally, it is important to consider the position of the health insurance industry (e.g., Group Health Association of America, Blue Cross and Blue Shield Association, Health Insurance Association of America). The industry generally supports health care reform, as exemplified in the Clinton Plan. Understandably, the industry opposes the creation of structures that would replace them and government control of premium increases (American Health Association, 1993b).

Health Care Needs of Asian Pacific Americans

Understanding population growth, demographic patterns, and morbidity and mortality trends in Asian Pacific American people is basic to forming meaningful public policy. While specific projections may differ, there is consensus that Asian Pacific Americans are the fastest growing minority. The Asian Pacific population is projected to reach between 17.9 million and 20.2 million by the year 2020 (Ong and Hee, 1993). The U.S. Bureau of Census (1992) expects Asian Pacific Americans to reach 10.7 percent of the U.S. population by the year 2050.

A major problem in evaluating the impact of any health reform program on Asian Pacific Americans is the lack of information concerning this population. Neither the *Healthy People 2000* policy guidelines (U.S. Department of Health and Human Services, 1990), nor the *Health Status of Minorities and Low-Income Groups* report (U.S. Department of Health and Human Services, 1993) provide satisfactory data on Asian Pacific American health issues. For a health reform program to adequately address the physical and mental health care needs of Asian Pacific Americans, it is necessary to know the extent of potential or real health problems of these groups (Guillermo, 1993; Sue, 1993).

Special health problems of Asian Pacific Americans are summarized by Lin-Fu (1993) whose report is based on a number of published studies. Important genetic problems concern alpha and beta thalassemia and hemoglobin E. According to Choi and Necheles, about 5 percent of Chinese Americans in Boston are carriers of alpha and beta thalassemia. Another study found in the Crocker report stated that 28 percent of Laotians and 26 percent of Cambodians are carriers of

hemoglobin E. Rowley, Loader, Sutera and colleagues found that 14 percent of Southeast Asians in Rochester, New York, are carriers of hemoglobinopathy. Lactase deficiency is common among Asian Pacific Americans. Genetic screening and counseling would be important services to offer Asian Pacific Americans under any health reform pro-gram. Providers are not always aware of these problems.

Lin-Fu (1993) further reports that two infectious diseases are of grave importance in Asian Pacific Americans: hepatitis B and tuberculosis. Hepatitis B is of particular concern in new immigrants from Southeast Asia where the problem is widespread. Infants born to infected mothers have a high risk of acquiring HBV infection and of remaining chronically infected. Chronic infection with HBV contributes to primary hepatoma and cirrhosis. For this reason, preventive prenatal care and post-delivery care of the infant are critical in controlling the spread of HBV. Tuberculosis, the other prevalent disease, also occurs with greater frequency in Southeast Asian refugees. Unfortunately, many Asian Pacific Americans are infected with drug resistant strains of the disease. Diagnosis and treatment for tuberculosis and other problems such as intestinal parasites should also be covered under any health reform plan.

The Lin-Fu report (1993) also describes the seriousness of the cancer problem among native Hawaiians who have the highest incidence of cancer of the stomach, breast, corpus uteri, and ovaries; and second highest incidence of lung cancer. Stomach cancer is also high among Japanese, while liver cancer is high among Chinese. Prevention services, if covered by a health reform plan, may decrease the incidence of some cancers. However, culturally targeted education programs would be needed to promote cancer prevention and detection practices among Asian Pacific Americans. Other notable health problems are nocturnal death in seemingly healthy young people, particularly Hmong and Laotians (Lin-Fu, 1987); cardiovascular disease (Chen, 1993a); and smoking (Centers for Disease Control, 1992).

Despite the myriad of health problems, the *Healthy People 2000* position paper includes only eight objectives for Asian Pacific Americans. Chen (1993b) summarized the U.S. Office of Disease Prevention and Health Promotion's 1992 publication, *Progress Reports on Healthy People 2000 Objectives*. He found that

only one out of the eight objectives, the reduction of viral hepatitis B in children of Asian Pacific Americans, was on target. The following three objectives were not on target for Asian Pacific Americans: a) appropriate reduction in growth retardation in children, b) reduction in tuberculosis, and c) at least a 50 percent increase in recommended screening, immunization, and counseling services appropriate for age and gender. Three other objectives could not be adequately evaluated due to insufficient data for Asian Pacific Americans: a) reduction of cigarette smoking to no more than 15 percent among those 20 years or older; b) increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs; and c) development and implementation of a national process to identify significant gaps in the nation's disease prevention and health promotion data, including information for racial and ethnic minorities. One objective was inappropriate as an objective targeted to Asian Pacific Americans: the implementation at the state level of periodic analysis and publication of data regarding progress toward objectives.

For many, access to health care is hindered by the lack of insurance coverage. Asian Pacific Americans, like the rest of the U.S. population, are burdened with the increasing weight of health care costs. They undergo the same hardships as the rest of the nation: stymied growth in wages, increased costs of conducting business and producing goods, and larger deductibles and co-payments. Uninsured Asian Pacific Americans, like other uninsured Americans, can be further impoverished by a costly illness, and only seek care for acute and serious illnesses from overcrowded public hospital emergency rooms.

Financial and cultural barriers contribute to underutilization. Underutilization of mental health services is common among Asian Pacific Americans (Matsuoka, 1990). This underutilization need not represent less severe conditions. Asian Pacific Americans have been found to have greater disturbance levels (Sue and Sue, 1974). Factors that influence utilization of mental health services include location, availability, and cultural and linguistic appropriateness of services (Sue, 1993; Sue and Morishima, 1982; Tracey, Leong and Glidden, 1986). When there are few accessible services, then

utilization is low.

This problem is also present in health services. Hafner-Eaton (1993) shows that Asians have considerably less access to the American health care system than other racial groups. The study controlled for insurance, health and income status. Ong and Azores in Chapter 7 speculate that less access may be due to culturally determined behavior, language and other barriers. Income and education are other determinants to access for Asian Pacific Americans. While fee-for-service plans may offer the best service, the expensive price can be a major barrier for those with limited financial means.

There exists a misconception shared by the public and legislators that Asian Pacific Americans already have an adequate number of health care providers to serve their community. The problem of access is further limited by a lack of providers in many communities. This misperception is compounded by the increase in Asian Americans admitted to medical schools, currently 15.9 percent of entering students in the U.S. (Guang et al., 1993). While some Asian Pacific American groups are well represented, others are not. For example, there is an inadequate supply of Vietnamese, Cambodian, and Laotian health care providers. Misperceptions stem from aggregating data for all Asian Pacific groups. The majority of Asian Pacific physicians practice in the northeast and northcentral states, while the majority of Asian Pacific Americans reside in the West. While Asian Americans are being accepted into U.S. medical schools in greater numbers than ever before, they elect specialty fields rather than primary care.

Given the myriad of health care problems, Asian Pacific Americans have a large stake in the current debate over reforming the health care system. The outcomes will determine whether many Asian Pacific Americans will have a healthy future or a future with poor and limited services.

Recommendations

Health care reform challenges Asian Pacific Americans to take a proactive stance in controlling the health care system that will affect them. To this end, Asian Pacific Americans have spoken out in support of health care reform as exemplified by the Clinton Plan, but do so with reservation. This section

discusses recommendations from the caucus of Asian American Health Care Workers of the American Public Health Association; the Asian Pacific Health Care Venture, Inc., a community-based health organization that coordinates health care services for low-income Asian Pacific Americans; and the Asian and Pacific Islander American Health Forum, a national, nonprofit health advocacy organization.

Asian Pacific American groups urge universal access to health care for American citizens, legal residents, undocumented workers, and illegal aliens (Asian Pacific Health Care Venture, Inc., 1993; Guillermo, 1994; Shibata, 1994). This recommendation is based on the belief that coverage of undocumented and illegal persons is beneficial in the long term. For example, illnesses are likely to be treated at earlier stages when they cost less; prenatal care and immunization will protect everyone and cost less; agencies that provide care to undocumented and illegal persons can be reimbursed and will not be overburdened with costs; and some states will not be disadvantaged because of the large numbers of undocumented and illegal persons who use their public hospitals. Further, Medicaid recipients should be treated like all others to insure better care for these persons.

Unless health care programs/systems are adequately explained to Asian Pacific Americans who face cultural, linguistic or educational barriers to information, Asian Pacific Americans may make uninformed, poor choices. Despite health care reform efforts to provide comprehensive benefits, race and ethnicity will continue to be strong determinants of ability to receive timely, effective treatment.

The movement to provide more universal health care coverage, however, should not place undue financial burdens on Asian Pacific small business (Shibata, 1994). Many Asian Pacific small businesses operate at small profit margins. Requiring them to pay for insurance coverage for owners and employees would effectively put many out of business. Therefore, caps on premium payments by these small businesses should be low. Taxes on tobacco, alcohol, firearems and payroll (with protection for low-income workers) would spread the burden of supporting universal coverage.

Increased support for community-based service agencies is

seen as a priority because of their pivotal role in Asian Pacific communities (Guillermo, 1994). For example, native Hawaiian health care centers should be supported in any health care reform program. They play a key role in facilitating access to the larger health care delivery system for small, rural and underserved communities. While universal coverage may facilitate access to health care services, it does not address the issue of utilization. Here is where culturally responsive, community-based clinics offer a safety net. These clinics: a) are easy to access and negotiate, b) can understand the needs of the Asian Pacific client, and c) are staffed by personnel who share the same background as the clients. In addition, these clinics serve the underserved, particularly those who would otherwise be ineligible for health care. Thus, they control the costs for the greater health care system. The very smallness of these community-based clinics puts them at risk for closure, if a place is not allocated to them in any future health reform program.

Asian Pacific Americans also have a stake in reforming the health professions. Most Asian nurses, like nurses in general, are hospital-based. There is a great need to retool hospital nurses to work in communities, outpatient settings, and primary care environments. There is also a need to educate youth to recognize the value of a nursing career if we are to have well-educated nurses to care for Asian Pacific Americans. A study of high school students in an eastern state showed that of all ethnic groups, Asian females were less likely to perceive nursing as being appreciated, making a lot of money, working in safe places, and being respected by others (Reiskin and Haussler, 1994).

The cost of higher education can serve as a formidable barrier. It is important for Asian Pacific Americans to capitalize on the opportunity offered by the Clinton Plan, if it is adopted, to expand the number of Asian Pacific physician and nurse primary care providers as well as mental health care providers. The Clinton Plan will support additional training of advanced practice nurses who offer less expensive primary care services that promote health and prevent disease.

The training and retraining should include programs to ensure the cultural sensitivity and relevancy of health services and consumer education (Asian Pacific Health Care Venture,

Inc., 1993; Guillermo, 1993; Lin-Fu, 1994; Shibata, 1994). At present, the Asian Pacific American health care workforce is largely immigrant with 21 percent of all physicians being foreign medical graduates (Roback, Randolph and Seidman, 1992). One would expect more culturally sensitive care from Asian Pacific American providers. However, Asian Pacific Americans represent a very diverse, heterogeneous group who speak different languages and have different cultures. Many health care providers do not understand their own cultural orientation, nor the important role of culture in lifestyle and health behavior (Lin-Fu, 1993). Communication and cultural sensitivity between a recently immigrated, young Chinese doctor and an elderly Filipina may not be any better than that between an Anglo doctor and the same patient. Without training in culturally competent care, Asian Pacific providers may not be able to deliver culturally sensitive care to Asian Pacific American clients.

Training programs are needed to teach nurses, physicians, dentists, and other providers strategies for delivering culturally competent health care to Asian Pacific groups in urban and rural areas. These training programs may be funded by agencies in the Bureau of Health Professions of the Department of Health and Human Services. Providers need to be aware and use traditional medicines when appropriate, recognize folk medicines that pose a danger to the consumer, and learn how folk medicines may interact with Western drugs to the detriment of the patient. Asian Pacific Americans also urge the promotion of standards for translators working in the health care field. Reimbursement can be tied to the use of certified translators. This will likely increase the number of bilingual translators in health care agencies. Institutional barriers that jeopardize the care of Asian Pacific Americans include: long telephone waiting periods for appointments, extensive interview procedures to obtain services, restrictions in the use of emergency services, difficulties in arranging transportation, and general confusion when faced with negotiating a complex health care delivery system.

It is also important to provide consumers with health education material that is culturally and linguistically relevant.

It is especially important to innoculate Asian Pacific American consumers against unethical persons who may take money for health "insurance" or "services," and then provide no or substandard care. Also needed is educational material that addresses the unique health risks of diverse Asian Pacific groups and information regarding consumer rights and participation.

Finally, there is a need to improve quality management measures and racial/ethnic specific health data (Guillermo, 1994; Lin-Fu, 1994; Shibata, 1994). Asian Pacific Americans urge changes in standardized claim or other health forms and the data/information systems used by providers, insurance companies, health plans, state and federal governments so as to codify Asian Pacific Americans by major groups (Asian, Pacific Islander) and subgroups (e.g., Pilipino, Hmong, Korean). Since Asian Pacific Americans represent very heterogeneous subgroups, specificity in codification generates more useful data to describe health problems, service utilization, satisfaction with care, etc., by specific group and region. These data are essential to the development of effective health care guidelines for Asian Pacific American clients.

Concluding Remarks

It is important for Asian Pacific Americans to increase their participation in health care reform program development and governance (Asian Pacific Health Care Venture, Inc., 1993; Shibata, 1994). Asian Pacific Americans must lobby to be appointed to federal and state regulatory boards such as the proposed National Health Board and state boards (U.S. Office of the President, 1993). Any national regulatory board with the responsibility of setting federal standards and policies will have a major impact on health practices that affect the quality of care extended to Asian Pacific Americans. Likewise, any state board expected to monitor and assure compliance with federal guidelines will have a significant impact on health practices that affect Asian Pacific Americans. By participating in federal and state regulatory boards, Asian Pacific Americans can craft health reform programs to insure that reforms are responsive to the needs of Asian Pacific Americans in the following ways:

1) the plan covers the alternative health care services of herbalists, acupuncturists, nutritionists and other health care providers who meet the needs of Asian Pacific Americans;

2) the plan ensures access to care using outreach, follow-up, home visits, and transportation services for Asian Pacific American members when necessary;

3) the plan coordinates services of primary, secondary and tertiary care providers for Asian Pacific American clients.

While Asian Pacific Americans are overrepresented in the medical and nursing professions, they are underrepresented in administrative positions (see Chapter 7). It is important for Asian Pacific Americans to require that health care reform programs provide opportunities for Asian Pacific Americans to move into decision-making and policymaking positions to better serve their client counterparts.

Notes

1. For more information, see Starr (1982) in the chapter, "The Generalization of Doubt," especially pp. 408-411.
2. Chen (1993, p. 37) states that Asian Pacific Americans are "among the most neglected minority group with regards to health status surveillance..."